Neutral Citation Number: [2018] EWCA Civ 1307

Case No: B3/2016/0826

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE COUNTY COURT AT BIRMINGHAM
His Honour Judge Worster
Claim No: 1IQ15454

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 07/06/2018

Before:

LORD JUSTICE HAMBLEN
LORD JUSTICE NEWEY
and
LORD JUSTICE LEGGATT

- -

Between:

Gail Marie Duce	**Appellant**
- and -	
Worcestershire Acute Hospitals NHS Trust	**Respondent**

- -
- -

Joel Donovan QC and Nathan Roberts (instructed by **Fairweathers Solicitors LLP**) for the **Appellant**
Philip Havers QC and Richard Mumford (instructed by **Capsticks Solicitors LLP**) for the **Respondent**

Hearing date: 17 May 2018

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Judgment Approved

Lord Justice Hamblen:

Introduction

1. This appeal concerns the claim of Mrs Gail Duce, the appellant, made against Worcestershire Acute Hospitals NHS Trust, the respondent, for damages for negligence in relation to a total abdominal hysterectomy and bilateral salpingo-oophorectomy (TAH & BSO) performed at Worcester Royal Hospital on 25 March 2008.

2. As a consequence of the operation the appellant suffered nerve damage and now suffers serious and permanent pain, described by pain experts as Chronic Post Surgical Pain ("CPSP"). There is no suggestion that the operation was performed negligently. The appellant's case is that she was not adequately warned of the risk of pain in relation to the operation.

3. Following a four day trial before HHJ Worster in Birmingham County Court in September 2015, in a judgment dated 5 February 2016 the judge dismissed the claim, finding that the respondent was not negligent and that in any event causation had not been established. Both those findings are now appealed.

Factual background

4. The background facts are set out at [5]-[34] of the judgment.

5. In summary, the appellant was born on 15 October 1966. Prior to the operation, she had a history of painful and heavy periods, which had worsened in the period leading up to the operation. She also suffered from lower back pain from around January 2006.

6. In December 2007 the appellant sought medical advice in respect of her heavy periods. On 18 December she saw a Mrs Arya in clinic to discuss the possibility of undergoing a TAH to relieve the symptoms of her heavy periods [7]-[8].

7. On 8 February 2008 a medical note made by Dr Stanley indicated that the appellant was insistent that she wanted a TAH, notwithstanding that he had explained it as a "major operation which has associated risks". She wanted it "all taken away" [9].

8. On 15 February 2008 Dr Stanley wrote to the Consultant Gynaecologist asking him to review the option of a TAH with the appellant. Dr Stanley wrote that he had explained to the appellant that TAH is "a very major surgical procedure" and that "our recommendation would be to try less invasive methods" [10].

9. On 4 March 2008 the appellant had a further review with Mrs Arya which again confirmed that she wished to have a TAH and would not consider other treatment options. She did not want to go through the process of attempting these, only to have them fail. Mrs Arya's note of that meeting concludes with 'risks explained' [12]-[13]. Mrs Arya gave evidence that normal practice would be to provide a leaflet at this stage, although she could not remember the meeting and so could not say for sure whether it had been given on this occasion.

10. Following these consultations, the appellant chose to go ahead with the operation. Her initial appointment was cancelled and it appears that a letter giving the date of the new appointment was not received by her, meaning that she was only notified that she was to have the operation on the morning of the new appointment on 25 March 2008. As a result of this and travel difficulties, she was five minutes late to the appointment. On arrival, the receptionist noted that she was late, which unnerved and upset her, leaving her feeling flustered [23].

11. Once at the hospital, the appellant met with the surgeon, Mr Elneil, and the Registrar, Mrs Singh, at around 08:20am. As the appellant had difficulty understanding Mr Elneil's accent, Mrs Singh dealt with consent. Mrs Singh filled out the consent form and passed it to the appellant to read and sign, which she did, although she said that she felt that the staff were in a hurry and therefore felt under pressure to complete the form quickly. The consent form makes no reference to pain, but the judge accepted that there had been a discussion between the appellant and Mrs Singh to the effect that the operation might not relieve the appellant's existing pain, as confirmed by Mrs Singh's notes. Mrs Singh accepted in cross-examination that in 2008 she would not have said that there was a risk of developing chronic pain or neuropathic pain as a result of the surgery [31]. She would only have warned of the post-operative pain normally associated with surgery. The evidence of the anaesthetist, Dr Bhardwaj, was that she too would only have warned of normal post-operative pain [32].

12. The operation was performed, non-negligently, by Mr Elniel between 09:12 and 10:10am on 25 March 2008 [33].

13. Following the surgery, it became apparent that the appellant had sustained nerve damage as a result of which she suffered from pain in her abdominal wall which is "significantly different in type to the pain she was suffering prior to her operation" [34]. Essentially, as explained by the pain experts, she has developed what is now recognised as CPSP [35]-[37].

The appellant's case at trial

14. The appellant's case as originally pleaded was that the respondent was negligent in failing to warn her of the risk of CPSP. This was defined in [10] of the Particulars of Claim as meaning "neuropathic chronic post-surgical pain".

15. This case was not supported by the appellant's gynaecological expert, Mr Abouzeid. In his expert report he stated:

> "….in relation to the specific risk of developing chronic post-surgical pain (CPSP) my judgment is that there was no breach of duty, as there was no clear evidence of that specific risk in March 2008."

16. Mr Abouzeid was asked by his instructing solicitors "what advice about the likely duration of post operative pain should Mrs Duce have been given in March 2008" to which he replied:

> "The risk of short term post operative pain which could last for weeks should have been explained."

17. In the light of Mr Abouzeid's evidence the Particulars of Claim were amended to delete the allegation of failure to warn of CPSP and instead to allege a failure to warn of "post operative pain".

18. As the judge noted at [47]-[48], the appellant's case "evolved" at trial so as to encompass a duty to warn of neuropathic pain and "some" chronic neuropathic pain. Chronic was said to mean pain persisting beyond 3 months, but it could not mean long term pain given the concession that there was no duty to warn of CPSP. In various closing submissions the case was therefore put as being "short lived" chronic pain. Despite indications to the contrary in his written skeleton argument, Mr Donovan QC for the appellant has confirmed that he does not seek to put the case in a different or wider way to that put at trial.

19. As the judge observed at [47], and as is apparent from the trial transcripts, this "evolved" case was based on what was argued to be the effect of Guidance dated May 2009 provided by the Royal College of Obstetricians and Gynaecologists ("the RCOG Guidance"). Although published the year after the events in question, this was agreed by the experts to represent best practice as to the content of warnings of risk in relation to TAH.

20. The RCOG Guidance distinguished between "Serious risks" (including death) and "Frequent risks". Among the "Frequent risks" was "numbness, tingling or burning sensation around the scar (the woman should be reassured that this is usually self-limiting but warned that it could take weeks or months to resolve)". It was argued that this amounted to a risk of neuropathic symptoms which could last more than 3 months. As the judge noted, the RCOG Guidance does not refer to a risk of chronic (or long term) or neuropathic (or nerve) pain.

The judgment

21. The judgment is divided up into various sections: The Background Facts [5]-[22]; The Operation [23]-[34]; The Expert Evidence [35]-[46]; Medical Causation [53]-[59].

22. As the judge states at [3]-[4], at the trial he heard evidence from the appellant; her employer Kerry Mahoney; Mrs Arya, Mrs Singh, and Dr Bhardwaj. He also had witness statements of Susan Forester-Morgan, Kieran Duce and Melissa Duce going to the issue of care.

23. There was written and oral expert evidence from experts in pain medicine, Dr Gauci for the appellant and Dr Evans for the respondent, and in gynaecology, Mr Abouzeid for the appellant and Mr Pyper for the respondent.

24. The judge discussed the expert evidence of the gynaecologists in some detail. He found aspects of Mr Abouzeid's evidence to be "confused" and that of the respondent's expert, Mr Pyper, to be "altogether more convincing". His "overall" conclusion was that "where the two experts disagreed, I should accept Mr Pyper's evidence".

25. The judge found at [41] that in their joint report Mr Abouzeid and Mr Pyper agreed that CPSP was not common knowledge amongst gynaecologists in 2008 and that it

would not normally be mentioned in taking consent for hysterectomy. They also noted that it is not mentioned in the 2009 RCOG Guidance.

26. In addressing breach of duty, having set out how the appellant's case on the duty to warn had "evolved" from the pleaded case, he said that whilst that "may suffice of itself to defeat the claim", he would nevertheless consider "the issue as it was presented at trial".

27. He then found as follows:

> "49. The parties referred me to the decision in Montgomery, and in particular to the discussion of the doctor's duty to take reasonable care to ensure that the patient is aware of any material risks involved in the recommended treatment, and of any reasonable alternative treatment. The test of materiality is whether in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it. The further points set out under paragraphs [89] and [90] of the judgment of Lords Kerr and Reed are also of relevance on the facts of this case. The assessment of whether a risk is material is fact sensitive, and the duty is not fulfilled by bombarding the patient with technical information.
>
> 50. I find the following:
>
> (i) Mrs Duce was well aware of the alternative treatment on offer.
>
> (ii) It is agreed that there was no duty to warn of CPSP.
>
> (iii) I find (on the basis of Mr Pyper's evidence) that in 2008 there was no duty to warn a patient such as Mrs Duce of the risk of chronic pain, or of neuropathic (or nerve) pain, whether that was long term or short term. The understanding of such pain by Gynaecologists in 2008 does not justify the imposition of such a duty. Nor does it follow from the RCOG Guidance.
>
> (iv) Further, on the facts I find that Mrs Duce understood that the operation would cause her some pain, and that Mrs Arya did warn her of the risk of 3-6 months of numbness and or pain. She did not use words like chronic or neuropathic, but Mr Pyper's point about how to approach this process is obviously right."

28. In addressing causation, he found that:

> "53. The essence of the Claimant's case is that if she had been warned that there was a risk of chronic pain or "nerve pain", she would either have decided not to have the operation, had

> second thoughts/sought a second opinion, or at least put things off.
>
> 54. Given the history of her condition, and the attempts to steer her towards other treatments prior to this operation, I have no doubt that she would not have simply changed her mind. The only question is whether she might have paused to explore further what the detailed risks might be.
>
> …..
>
> 59. I have to consider whether, on the balance of probabilities, a warning of nerve pain (or something similar) which might last for months would have caused the Claimant to have second thoughts and not proceed with the operation on the day. Given that she knew the operation would cause her some pain, that a warning of 4-6 weeks of pain would not have put her off, that she was warned that the operation might not relieve her abdominal pain, and that there were a number of other quite serious risks, I have concluded that it is more likely than not that she would have proceeded with the operation on the day."

The grounds of appeal

29. The grounds of appeal are:

Ground 1: Breach of Duty

(1) The judge failed to apply the test set out in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430 ("*Montgomery*"), particularly in that he failed to consider whether the risk in question was 'material' in view of the fact that the appellant's motivation for the surgery was to relieve her pre-existing pain;

(2) The judge instead adopted an analysis akin to the 'old' law of consent set out in *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871 ("*Sidaway*") and *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 (*"Bolam*"), and relied unduly on the evidence of the respondent's expert gynaecologist Mr Pyper which was framed in terms of the law as established in *Sidaway/ Bolam*.

Ground 2: The Test for Causation

(1) The judge erred in failing to apply the test of causation set out in *Chester v Afshar* [2004] UKHL 41 ("*Chester*");

(2) Had that test been applied, the appellant would have succeeded in establishing causation.

Ground 3: The Application of the Test for Causation

(1) Alternatively, the judge misapplied the test for causation stated in the judgment;

(2) Properly applying this test, he would have found that the appellant's desire for the surgery was motivated by pain relief, and therefore had she been appropriately warned of the risks she would at the very least have had second thoughts.

Ground 1: Breach of Duty

30. In *Montgomery* the Supreme Court highlighted the importance of patient autonomy and the patient's entitlement to make decisions as to whether to incur risks of injury inherent in treatment. That entitlement was held to point to "a fundamental distinction between, on the one hand, the doctor's role when considering possible investigatory or treatment options and, on the other, her role in discussing with the patient any recommended treatment and possible alternatives, and the risks of injury which may be involved" [83].

31. The former role was said to be "an exercise of professional skill and judgment: what risks of injury are involved in an operation, for example, is a matter falling within the expertise of members of the medical profession", but the latter role was not so limited as one cannot leave "out of account the patient's entitlement to decide on the risks to her health which she is willing to run (a decision which may be influenced by non-medical considerations)" [84].

32. The nature of the duty was held at [87] to be:

> "a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments."

33. In the light of the differing roles identified this involves a twofold test:

(1) What risks associated with an operation were or should have been known to the medical professional in question. That is a matter falling within the expertise of medical professionals [83].

(2) Whether the patient should have been told about such risks by reference to whether they were material. That is a matter for the Court to determine [83]. This issue is not therefore the subject of the *Bolam* test and not something that can be determined by reference to expert evidence alone [84-85].

34. The test of materiality is:

> "…whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it."[87]

35. Factors of relevance to determining materiality may include: the odds of the risk materialising; the nature of the risk; the effect its occurrence would have on the life of the patient; the importance to the patient of the benefits sought to be achieved by the treatment; the alternatives available and the risks associated with them.

36. At the time of the pleadings and expert reports in the present case *Montgomery* had not been decided and they had been prepared by reference to the *Bolam* test. Mr Donovan QC for the appellant submits that the mistaken *Bolam* approach was followed through into the evidence given by Mr Pyper at trial, which evidence the judge accepted and relied upon.

37. In these circumstances it is contended that, although the judge referred to and correctly set out the test in *Montgomery,* he failed to apply it but instead mistakenly applied the *Bolam* approach.

38. It is said that this is borne out by the fact that, properly understood, the first sentence of [50](iii) is a finding that there was knowledge of the "risk of chronic pain, or of neuropathic (or nerve) pain". The judge should accordingly have found that the first limb of the *Montgomery* test was satisfied and then gone on to consider the second limb of the test, materiality. The judge does not, however, address materiality at all.

39. It is clear that the judge was referred to *Montgomery* in both opening and closing submissions. He himself refers to the case in the first paragraph of his judgment in which he describes the claim as involving a consideration of the effect of the judgment of the Supreme Court in *Montgomery.*

40. In [49] he again refers to the case, to the nature of the duty there set out and to the test of materiality.

41. In these circumstances it is inconceivable that he did not have *Montgomery* well in mind when making his findings on breach of duty in the very next paragraph. Indeed [50](i) refers to the fact the appellant was aware of alternative treatments, one of the matters specifically referred to in *Montgomery.*

42. I agree with Mr Havers QC for the respondent that the reason that the judge did not address the issue of materiality is that he had found that the claim failed at the first hurdle: proof that gynaecologists were or should have been aware of the relevant risks, which is a matter for expert evidence.

43. This is clear if [50](iii) is read as a whole rather than in the fragmented way suggested by Mr Donovan QC. The judge is finding that in 2008 there was insufficient understanding among gynaecologists of the existence of a risk of "chronic pain, or of neuropathic (or nerve) pain, whether that was long term or short term" to justify the imposition of a duty to warn of such a risk. That reasoning is consistent with the *Montgomery* approach – a clinician is not required to warn of a risk of which he cannot reasonably be taken to be aware.

44. Such a finding is consistent with the evidence and, in particular, the expert gynaecological evidence. It was common ground between the experts that CPSP was not common knowledge among gynaecologists at that time and, as Mr Abouzeid put it, "there was no clear evidence of that specific risk" at that time. On the appellant's

own pleaded case CPSP is "neuropathic chronic" pain. In such circumstances a finding that there was insufficient knowledge of the risk of "chronic" or "neuropathic" pain is entirely unsurprising.

45. The appellant had sought to get round the difficulties created by the fundamental but necessary amendment to the pleaded claim by reliance on the RCOG Guidance. But the judge held that the alleged knowledge of risk in the appellant's "evolved" case did not follow from that Guidance. That was a conclusion he was entitled to draw and indeed is not challenged.

46. Mr Donovan QC submitted that the judge ought to have found that there was knowledge of the alleged risks, and referred us to the witness statement and oral evidence of Mrs Singh. The passages relied upon are, however, at least as consistent with references being made to CPSP, as to which it is accepted there was no duty to warn. Further, Mrs Singh was not cross examined about the passage in her witness statement which is now sought to be relied upon. I have carefully considered the evidence referred to by Mr Donovan QC in his written and oral arguments but I am wholly unpersuaded that it justifies even an arguable challenge to the judge's findings.

47. For all these reasons, I reject Ground 1.

Ground 2: The Test for Causation

48. The appellant's case on causation at trial was that had a warning been given she would not have had surgery on that day. That was the pleaded case and the case put in argument at trial.

49. The judge rejected that case on the evidence and found at [59] that even if there had been a warning to the effect said to be required the appellant "would have proceeded with the operation on that day".

50. The appellant now submits that as a matter of law there was no need to prove this. Reliance is placed on Lord Hope's judgment in *Chester* at [86]-[87]:

> "86. I start with the proposition that the law which imposed the duty to warn on the doctor has at its heart the right of the patient to make an informed choice as to whether, and if so when and by whom, to be operated on. Patients may have, and are entitled to have, different views about these matters. All sorts of factors may be at work here—the patient's hopes and fears and personal circumstances, the nature of the condition that has to be treated and, above all, the patient's own views about whether the risk is worth running for the benefits that may come if the operation is carried out. For some the choice may be easy—simply to agree to or to decline the operation. But for many the choice will be a difficult one, requiring time to think, to take advice and to weigh up the alternatives. The duty is owed as much to the patient who, if warned, would find the decision difficult as to the patient who would find it simple

> and could give a clear answer to the doctor one way or the other immediately.
>
> 87. To leave the patient who would find the decision difficult without a remedy, as the normal approach to causation would indicate, would render the duty useless in the cases where it may be needed most. This would discriminate against those who cannot honestly say that they would have declined the operation once and for all if they had been warned. I would find that result unacceptable. The function of the law is to enable rights to be vindicated and to provide remedies when duties have been breached. Unless this is done the duty is a hollow one, stripped of all practical force and devoid of all content. It will have lost its ability to protect the patient and thus to fulfil the only purpose which brought it into existence. 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. The duty was owed by the doctor who performed the surgery that Miss Chester consented to. It was the product of the very risk that she should have been warned about when she gave her consent. So I would hold that it can be regarded as having been caused, in the legal sense, by the breach of that duty."

51. It is submitted that this creates an alternative pathway to causation in consent cases, subject to three requirements:

    (1) The injury was intimately involved with the duty to warn.

    (2) The duty was owed by the doctor who performed the surgery to which the patient had consented.

    (3) The injury was the product of the very risk that the patient should have been warned about when they gave their consent.

52. The appellant contends that all three of those requirements are satisfied in this case.

53. Mr Donovan QC submits that this broad reading of the causation test established in *Chester* is bolstered by the policy arguments identified by the Supreme Court in *Montgomery*. Reliance is placed, in particular, on references made to the change in doctor-patient relationships, such that patients are now widely regarded as holding rights and treated as consumers exercising choices [75]; changes in general society such that patients should no longer be viewed as generally uninformed [76]; the shift in medical practice towards informed consent [77]; the recognition of informed consent as a human right [80] and to the statements that "the need for informed consent [is] firmly part of English law" [107].

54. As Mr Havers QC points out, this argument, if correct, amounts to a wholesale disapplication of conventional causation principles in consent cases.

55. The passages from Lord Hope's judgment which are relied upon need to be considered in their factual context.

56. In his majority judgment Lord Steyn summarised the facts at [11]. His summary included the following:

> "…..The judge found that if the claimant had been properly warned the operation would not have taken place when it did, if at all. The judge was unable to find whether if the claimant had been duly warned she would with the benefit of further medical advice have given or refused consent to surgery. What is clear is that if she had agreed to surgery at a subsequent date, the risk attendant upon it would have been the same, i.e. 1%–2%. It is therefore improbable that she would have sustained neurological damage." (underlining added)

57. The significance of the underlined passages is explained at [19] of Lord Steyn's judgment where he says:

> "…..it is a distinctive feature of the present case that but for the surgeon's negligent failure to warn the claimant of the small risk of serious injury the actual injury would not have occurred when it did and the chance of it occurring on a subsequent occasion was very small. It could therefore be said that the breach of the surgeon resulted in the very injury about which the claimant was entitled to be warned." (underlining added)

58. This is a finding of "but for" causation, or causation in fact. The injury was a result of the breach of duty because (i) the operation would not have taken place when it did and (ii) the risk of injury was very small and so was unlikely to have occurred if the operation had been carried out on a subsequent occasion.

59. Lord Hope at the outset of his judgment at [39] emphasises that the issue of law "rests upon two findings of fact". The first was the finding of failure to warn and the second was that "if she had known of the actual risks of the proposed surgery, Miss Chester would not have consented to the operation taking place on 21 November 1994 and that before deciding what to do she would have sought a second, or possibly, a third opinion."

60. At [40] Lord Hope then identified the "question of law which arises from these findings" as being "whether it was sufficient for Miss Chester to prove that, if properly warned, she would not have consented to the operation which was in fact performed and which resulted in the injury, or whether it was necessary for her to prove also that she would never have had that operation" (underlining added).

61. At [61] Lord Hope explained that proof that, if properly warned, she would not have consented to the operation establishes "but for" causation:

> "It can be said that Miss Chester would not have suffered her injury "but for" Mr Afshar's failure to warn her of the risks, as

> she would have declined to be operated on by him on 21 November 1994."

The same point is made at [81].

62. He also notes at [61] that it is difficult to say that Mr Afshar's failure to warn was "the effective cause of the injury" given that it had not been proved that she would never have had the operation or that the failure to warn had exposed her to an increased risk of injury – see also [73].

63. At [62] he stresses the fact that the risk of injury from any subsequent injury would have been very small:

> "If she had been given the warning she would have avoided that risk, and the chances of her being injured in that way if she had had the operation later would have been very small— between 1% and 2% on Mr Findlay's evidence."

64. Lord Hope then discusses the issue of causation more generally, noting at [73] that:

> "It is plain that the "but for" test is not in itself a sufficient test of causation"

65. In the section of his judgment headed "The answer to the problem of causation in this case" Lord Hope stresses the relevance of the particular facts of the case and considers whether "in the unusual circumstances of this case justice requires the normal approach to be modified". He then concludes that justice does so require for the reasons set out at [86]-[87] and, in particular, the fact that the injury "was the product of the very risk that she should have been warned about when she gave her consent" [87].

66. When paragraphs [86]-[87] of Lord Hope's judgment are considered in context in my judgment it is clear that he is not setting out a free-standing test, as the appellant contends, but rather the circumstances which justify the normal approach to causation being modified. That modification was to treat a "but for" cause that was not an effective cause as a sufficient cause in law in the "unusual" circumstances of the case.

67. This is also how the third member of the majority, Lord Walker, approached the matter. At [94] he observes that in this case:

> "Bare "but for" causation is powerfully reinforced by the fact that the misfortune which befell the claimant was the very misfortune which was the focus of the surgeon's duty to warn."

68. It was the powerful reinforcement provided by the close link between the injury suffered and the duty to warn that led Lord Walker also to conclude that "but for" causation was sufficient.

69. I accordingly agree with the respondent that the majority decision in *Chester* does not negate the requirement for a claimant to demonstrate a "but for" causative effect of the breach of duty, as that requirement was interpreted by the majority, and specifically that the operation would have not have taken place when it did.

70. It is also to be noted that in the recent case of *Correia v University Hospital of North Staffordshire NHS Trust* [2017] EWCA Civ 356 the court emphasised at [28] that if "the exceptional principle of causation" established by *Chester* is to be relied upon it is necessary to plead and prove that, if warned of the risk, the claimant would have deferred the operation.

71. For all these reasons, I reject Ground 2. For completeness it should be noted that Mr Havers QC reserved the right to argue that *Chester* was wrongly decided if this case was to go to the Supreme Court.

Ground 3: The Application of the Test for Causation

72. This is a challenge to the finding of fact made by the judge that even if the appellant had been warned as it was contended she should have been, she would still have proceeded with the operation as she did.

73. This finding is set out in [59] of the judgment. Mr Donovan QC treats the factors identified in that paragraph as being the sole factors considered by the judge and contends that this shows that the judge failed to take into account a highly material consideration, namely that, since the predominant reason for seeking the operation was pain relief, a warning of the risk of further and different chronic pain would have caused her to reconsider.

74. The finding made by the judge in [59] was made against the background of all the evidence at trial. This includes relevant evidence referred to at various earlier parts of the judgment, such as [6](i)(v)(vii) and [9]-[13]. It also includes the compelling evidential points made at [56]-[58].

75. As the respondent submits, there was abundant evidence to support the judge's finding. The appellant had on several occasions been urged by medical practitioners (both GPs and gynaecological surgeons) to consider the less invasive alternatives to TAH, which she was aware was major surgery which carried significant risks; she nonetheless declined to pursue those less invasive options and elected instead to undergo TAH.

76. Further, paragraph [59] itself stresses the important point that the appellant was willing to go ahead despite the fact that there were "a number of other quite serious risks". As the judge found, "she wanted it all taken away" despite known serious risks.

77. There is in any event no substance in the suggestion that the judge omitted from consideration the appellant's motivation(s) for proceeding to surgery. The judge considered in detail the applicant's long history of symptoms from which she hoped to gain relief by undergoing surgery. That history was justifiably rightly considered to weigh in favour of her choosing to undergo surgery when she did, even if a different warning as to the risk of pain had been given.

78. For all these reasons, I reject Ground 3.

Conclusion

79. For the reasons outlined above, I would reject all three grounds of appeal and dismiss the appeal.

Lord Justice Newey

80. I agree.

Lord Justice Leggatt

81. I also agree. In support of the second ground of appeal, Mr Donovan QC was able to point to some passages in the judgment of Lord Hope in *Chester* which can be read as suggesting that a doctor who negligently fails to warn a patient of a material risk of injury inherent in a proposed surgical operation will, without more, be held liable for the injury if the patient consents to the operation and the injury occurs. For example, Lord Hope said at [56] that the law will fail to fulfil its function "if an appropriate remedy cannot be given if the duty is breached and the very risk that the patient should have been told about occurs and she suffers injury."

82. Such an approach would not have involved what Lord Steyn described at [24] as "a narrow and modest departure from traditional causation principles". Rather, as Lord Bingham pointed out at [9], it would have dispensed altogether with the requirement to show that the defendant's breach of duty caused the injury for which compensation is claimed. Hamblen LJ has shown that, on a proper reading of the *Chester* case, this is not what the majority of the House of Lords decided. It was essential to their decision that, on the facts found, if the claimant had been adequately warned she would not have consented to the operation on the day when it took place – albeit that the trial judge had found it impossible to say what the claimant would have done subsequently.

83. The injury which the claimant in *Chester* sustained was found to be a small (1%-2%) but unavoidable risk of the proposed operation, however expertly performed: see [5]. The finding of the trial judge that, if properly warned, she would not have consented to have the operation when she did was therefore sufficient to establish factual or 'but for' causation on the balance of probabilities. In the words of Lord Steyn at [19]:

> "it is a distinctive feature of the present case that but for the surgeon's negligent failure to warn the claimant of the small risk of serious injury the actual injury would not have occurred when it did and the chance of it occurring on a subsequent occasion was very small."

See also Lord Hope at [61]-[62] and [81] and Lord Walker at [94].

84. The decision in *Chester* is nevertheless problematic because on the facts, applying the normal burden of proof, the surgeon's failure to warn did not expose the claimant to a risk which she would not willingly have accepted. In law as in everyday life A's wrongful act is not normally regarded as having caused B's injury if the act made no difference to the probability of the injury occurring. In such a case the fact that the injury would not have occurred but for the wrongful act is merely a coincidence. To

take an example given by Lord Walker, if a taxi driver drives too fast and the cab is hit by a falling tree, injuring the passenger, it would not be said that the negligent driving caused the injury: the driver might equally well have avoided the tree by driving too fast, and passenger might equally well have been injured if the driver had been observing the speed limit. Similarly, in *Chester* if the operation had taken place on a later date the risk of a serious injury occurring would have been exactly the same. As Lord Hope accepted at [81], "to expose someone to a risk to which that person is exposed anyhow is not to cause anything". It was for this reason that Lords Bingham and Hoffmann dissented: see [8] and [31].

85. There is also a question about the scope of the relevant duty. Lord Hope thought there was no doubt that the injury which Miss Chester sustained was within the scope of Dr Afshar's duty to warn: see [62]. That would be so if the duty owed was a duty of care to avoid the risk of the claimant sustaining serious nerve damage. But the point can be made that the defendant owed no duty to protect the claimant from that risk of injury as such. There was no suggestion that it was negligent to carry out the operation because it carried the small risk of serious injury that it did. The purpose of warning of the risk was to enable the claimant to decide whether or not she considered the risk acceptable. Thus, the injury which the defendant owed a duty of care to prevent was injury attributable to a risk which the claimant was not prepared to accept: see Lord Steyn at [18]. This is how the High Court of Australia analysed the scope of the medical practitioner's duty to warn in the more recent case of *Wallace v Kam* [2013] HCA 19; (2013) 250 CLR 375 at [32]–[40]. On that basis, again applying the normal burden of proof, the position of Miss Chester when considered for the purposes of causation was no different in principle from what it would have been if she had been informed of the risk of neurological damage and decided to proceed with the operation.

86. *Chester v Afshar* was, at least on one view, materially different in these respects from the decision of the High Court of Australia in *Chappel v Hart* [1998] HCA 55; (1998) 195 CLR 233, which influenced the majority in *Chester*. In *Chappel v Hart* the Court of Appeal of the Supreme Court of New South Wales had concluded that the claimant, if warned of the relevant risk, would not have accepted it but would have gone to another surgeon, the most experienced who could be found, in which event the chance of the injury which she sustained occurring would have been less. In the High Court, two of the three judges in the majority, Gaudron and Kirby JJ, held on the strength of that finding that causation had been proved: see [17]-[19], [97]-[98]. McHugh and Hayne JJ dissented on the basis that the Court of Appeal's finding was not supported by the evidence: see [38]-[41], [146]. The fifth member of the court, Gummow J, did not consider the question relevant: see [81]. In *Chester* Lord Bingham accepted that the claimant would have been entitled to damages if on the evidence she would, if properly warned, "have minimised the risk of surgery by entrusting herself to a different surgeon, or undergoing a different form of surgery, or (in another kind of case) losing weight or giving up smoking": see [6]. But on the facts found in *Chester* the injury suffered would have been just as liable to occur whenever the surgery was performed and whoever performed it: see [8] and also [11], [31], [61].

87. The majority in *Chester* justified departure from ordinary principles of causation on policy grounds. For Lord Steyn, the critical consideration was the need to vindicate the patient's right to make an informed choice. His conclusion at [24] was that:

> "as a result of the surgeon's failure to warn the patient, she cannot be said to have given informed consent to the surgery in the full legal sense. Her right of autonomy and dignity can and ought to be vindicated …"

Lord Hope also emphasised the "fundamental importance" of the patient's right to decide whether to accept or reject the treatment proposed by the doctor, stating that "the function of the law is to protect the patient's right to choose": see [54] and [56].

88. The difficulties with this justification are, first, that the right to make an informed choice is not a right that is traditionally protected by the tort of negligence. Rather, the purpose of the tort is to protect a person from being exposed to injury through the carelessness of another. The language used by Lord Steyn seems more apt to a claim in trespass to the person than to a claim founded on negligence. Secondly, if exceptionally the law of negligence is to be used to protect a patient's right "of autonomy and dignity", then it is for the invasion of that right that damages should be awarded and not for the physical injury resulting from the operation. It was on this basis that Lord Hoffmann saw the case for "a modest solatium" in respect of the affront to the claimant's personality and feeling of grievance caused by failure to warn – though he rejected the case for such an award on practical grounds. More recently, in *Shaw v Kovac* [2017] EWCA Civ 1028; [2017] 1 WLR 4773, the Court of Appeal comprehensively rejected a claim for damages for invasion of the claimant's personal autonomy by negligently failing to warn of a material risk of an operation. It is therefore not open to Mrs Duce in the present case to claim damages on this basis.

89. Another policy factor on which Lord Hope and Lord Walker placed weight was the difficulty in many cases of proving what the claimant would have done in the relevant hypothetical situation and concern that this would deprive an honest claimant of a remedy. Lord Hope said at [87]:

> "To leave the patient who would find the decision difficult without a remedy, as the normal approach to causation would indicate, would render the duty useless in the cases where it may be needed most. This would discriminate against those who cannot honestly say that they would have declined the operation once and for all if they had been warned. I would find that result unacceptable."

Similarly, Lord Walker said at [101] that:

> "there are real difficulties (especially, perhaps, for a conscientious claimant aware of the fallibility of hindsight) in a claimant asserting that (if warned of the risks) she would never in any circumstances have submitted to surgery. There would be a danger, as Lord Hope points out, of an honest claimant finding herself without a remedy …"

90. Although expressed as a reason to modify the normal approach to causation, this concern appears to relate to difficulty in the proof of causation in a situation where the trial judge had found that it was impossible to say what the probable outcome would have been if the claimant had been given an appropriate warning. The assumption that the claimant would have been prepared to accept the risk to which she was exposed was therefore based not on any finding to that effect but on her inability to prove otherwise. The general rule that the burden lies on the claimant to prove her case applies to proof of causation just as it does to other elements of the claimant's cause of action. But sometimes the fact that the defendant has by his wrong caused particular difficulty of proof is treated as a reason to reverse the burden. For example, in the law of contract a claimant is entitled to recover wasted expenditure, unless the defendant can prove that the expenditure would not have been recouped if the contract had been performed. As explained by the great American judge, Learned Hand CJ, in *L Albert & Son v Armstrong Rubber Co* 178 F 2d 182 (1949):

> "It is often very hard to learn what the value of the performance would have been; and it is a common expedient, and a just one, in such situations to put the peril of the answer upon that party who by his wrong has made the issue relevant to the rights of the other."

A similar principle has sometimes been applied in negligence cases in tort, for example where the defendant's negligence has deprived the claimant of the chance of recovering damages in a claim against a third party: see e.g. *Allen v Sir Alfred MacAlpine & Sons Ltd* [1968] 2 QB 229, 256-7; *Phillips v Whatley* [2007] UKPC 28, [2007] PNLR 27 at [45].

91. Difficulty in proving what the claimant would have done if the defendant had not been negligent is not normally treated as a sufficient reason for putting the burden of proof on the defendant, even though in any case where such difficulty arises it could always be said that it has been created by the defendant. But particular policy considerations including the importance of vindicating a patient's right to make an informed choice can perhaps be invoked in this context to justify departure from the normal rule.

92. These are all matters which may be thought ripe for further consideration by the Supreme Court when the opportunity arises. They do not, however, assist Mrs Duce in this case, as there is no reasonable interpretation of the decision of the House of Lords in *Chester* which justifies extending liability for negligent failure to warn of a material risk of a surgical operation to a situation where, as here, it has been found as a fact that, if she had been warned of the risk, the claimant would still have proceeded with the operation as and when she did.