Neutral Citation Number: [2018] EWCA Civ 1745

Case No:B3/2016/1573

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM CARDIFF COUNTY COURT
(RECORDER TREVERTON-JONES QC)

The Royal Courts of Justice
Strand, London WC2A 2LL

Thursday, 28 June 2018

Before
LORD JUSTICE UNDERHILL

LADY JUSTICE KING

LORD JUSTICE NEWEY

Between:

KEITH WILLIAMS

Appellant

- and -

CWM TAF LOCAL HEALTH BOARD

Respondent

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Mr H Preston QC & Leslie Keegan (instructed by Thompsons Solicitors) appeared on behalf of the **Appellant**

Mr Giles Colin (instructed by Shared Services Partnership Legal and Risk) appeared on behalf of the **Respondent**

Judgment
(Approved)

LORD JUSTICE UNDERHILL:

1. This is an appeal against a decision of Mr Recorder Treverton-Jones QC, sitting in the Cardiff County Court, dismissing the appellant's claim of clinical negligence against the respondent Board. I believe that this appeal is suitable for a short form judgment (see Deutsche Trustee Co Ltd v Cheyne Capital Management (UK) Ltd [2016] EWCA Civ 743), and I can accordingly take the background very shortly.

2. The appellant, Mr Williams, suffered from a number of health problems including type 2 diabetes. In about 2008 he began to suffer from a painful right foot owing to blocked arteries from calcification, which is a common problem with diabetic patients, leading to insufficient blood flow. On 14 January 2010 he was seen as an out-patient at the respondent's Royal Glamorgan Hospital, complaining of pain in his right foot. Various investigations were carried out and he was diagnosed, wrongly, as suffering from gout. His condition deteriorated and he was re-referred as an emergency on 19 January and admitted. Investigations over the following ten days or so showed dense calcification characteristic of diabetes with consequent critical ischaemia in the right foot. In particular, a Doppler scan showed that two of the main arteries supplying the foot, the anterior and posterior tibial arteries, were blocked. The third and smaller such artery, the peroneal artery, could not be seen, but that in itself demonstrated that it also was at least severely compromised.

3. Once that diagnosis was confirmed there were in principle three options for treatment. The first was angioplasty, by which a balloon is inserted into the affected artery and inflated in an attempt to clear a blockage. The second was sympathectomy, by which the

sympathetic nerves are disabled: this would not as such improve flow in the main arteries but would promote a better flow in other smaller vessels supplying blood to the foot. The third option was amputation, which is obviously a last resort.

4. The appellant's case was discussed at a meeting on 1 February by a multi-disciplinary team which included, most relevantly for our purposes, Mr Michael Lewis, an experienced consultant vascular surgeon, and Mr Gareth Davies, a consultant radiologist with expertise in vascular radiology. The decision was made to recommend sympathectomy. The appellant accepted that advice and Mr Lewis performed the operation on 3 February.

5. In the immediate aftermath of the operation there was a short-term improvement in the foot, but the appellant's condition then deteriorated again, raising the spectre that amputation would be necessary. An angiogram was done on 19 February. In his report, based on the angiogram, Mr Davies did not in fact recommend angioplasty on the basis it had little prospect of success. However, the decision was made to proceed nevertheless because the only alternative was amputation. An angioplasty on the peroneal artery was performed on 23 February. Against expectation, that was successful and the need for amputation was avoided.

6. Unfortunately, the appellant then developed complications at the site of the sympathectomy: a haematoma developed where the operation had been performed. He underwent emergency surgery. He went into septic shock and subsequently suffered from a urine infection which led to renal failure. He also became resistant to any antibiotics and had to take a very strong antibiotic which gave him an intestinal condition which caused bowel incontinence for 18 months or so.

7. It is worth emphasising before I proceed to the issues that the consultants throughout were not optimistic about the chances of avoiding amputation, although happily that has been the result. The improvements in blood flow achieved by sympathectomy would be, at best, modest, and the condition of the arteries was already so bad that angioplasty would be, as they judged, either impracticable or unlikely to clear the blockage. But their approach was that these courses were worth trying in order to avoid amputation.

8. The appellant makes no criticism of the way in which Mr Lewis performed the sympathectomy, and the development of a haematoma at the site is a recognised complication of which he was warned. Rather, the case against the Board is, at least as now pursued, that it was negligent to perform a sympathectomy without first doing an angiogram in order to assess whether angioplasty was practicable. It is the appellant's case that if that had been done the angioplasty which was in fact performed later would have been performed first and would have succeeded, so that the sympathectomy would have been unnecessary and the consequent complications would have been avoided.

9. That case of negligence was supported by expert evidence from Professor Sir Peter Bell, an eminent consultant vascular surgeon. The respondent adduced evidence from Mr Jonathan Earnshaw, also an eminent consultant vascular surgeon, whose evidence was that it was reasonable of the multidisciplinary team to decide on 1 February to proceed with sympathectomy on the basis of the information available – that is, essentially the results of the Doppler scan – without first conducting an angiogram with a view to angioplasty. Evidence to the same effect was of course also given by Mr Lewis and Dr Davies who were responsible for the decisions in question. There was also in evidence a report from Professor Peter Gaines, a consultant vascular radiologist. Both

Professor Bell and Mr Earnshaw gave oral evidence at the trial, as did Mr Lewis and Dr Davies. The evidence of Professor Gaines was not challenged and so it was available to the court simply in report form.

9. The Recorder's reasons for dismissing the claim can be summarised as follows. He found it, as he put it at paragraph 44 of his judgment, "difficult to place great reliance on Professor Bell's evidence". Professor Bell had adopted an extreme position that sympathectomy was a worthless procedure, but that position was unsupported by the medical literature, which showed real, albeit qualified, support for its value; and it was also inconsistent with his own acknowledgement that sympathectomy was a reasonable procedure to adopt in the case of this kind as a last resort, that is to say after angioplasty. By contrast the judge found Mr Earnshaw "altogether more impressive" as a witness - see paragraph 45 of his judgment. He was also impressed by Mr Lewis and Dr Davies who gave their evidence "carefully and thoughtfully" - see paragraph 37. Having reviewed the evidence and made those assessments of the witnesses, he said at paragraphs 46 to 48 of the judgment:

> "46. In the light of all of the evidence that I have summarised, I return to the crucial question that I referred to earlier in this judgment, am I satisfied on the balance of probabilities that the defendant was negligent in proceeding to do a sympathectomy without obtaining an angiogram? I have been reminded by both parties of the well-known authorities in this area, *Bolam v Friern Barnet Hospital Management Committee* [1957] 1 WLR 582 and *Bolitho v City of Hackney Health Authority* [1998] AC 332 and the judgment of Mc Nair J in the first case and the speech of Lord Browne-Wilkinson in the second case. They are familiar passages and I take them into account. I am bound by them and they guide me in making the decision which I have to make in this case and it is unnecessary for me to set out those well-known passages.
>
> 47. In this case, the court is faced with the decision of an MDT and not the decision of a single medical practitioner. That decision was made after a

> number of investigations had been carried out and after the claimant had been observed in hospital for almost two weeks. If I were to be persuaded that the decision was not one that could properly have been made by medical practitioners behaving reasonably I would need to be so persuaded by expert evidence. It is not for me as a layman to seek to criticise medical professionals for making a decision which turned out, with the benefit of hindsight, to have been unfortunate in that it led to the complications which I have briefly summarised.
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> 48. I am not persuaded by Professor Bell's evidence that this was a negligent decision. I have already set out my reasons for finding that Professor Bell was a most unsatisfactory expert witness and on this crucial issue I found Mr Earnshaw' evidence much more compelling, backed up by the literature which he produced exhibited to his supplemental report in the supplementary bundle. In some senses, the proof of the pudding is in the eating. When an angiogram was obtained on 19th February Dr Gareth Davies remained of the view that this was not a case for an angioplasty. The angiogram did not have the effect of changing his mind about that. He still felt that an angioplasty was too risky and was unlikely to save the leg. Likewise, Professor Gaines considered that even in the light of all of the investigations that were eventually made, including the angiogram, he would not have expected the angioplasty to have saved the leg. This does tend to suggest that it was a reasonable decision to plan Mr Williams' treatment on the basis of the Doppler scan and without requiring further investigation by means of an angiogram. It would be a bold judge who would find a decision made after discussion by an expert team was negligent in the *Bolam* sense and I am not able to make such a finding on the evidence before me."

After dealing with a distinct point with which we are not concerned he said at paragraph 50:

> "I therefore conclude that the allegation that the sympathectomy was an unnecessary operation must fail. I find that it was reasonably selected as the best option by the medical professionals who were treating Mr Williams."

10. Mr Hugh Preston QC appears before us for the appellant, leading Mr Leslie Keegan, who conducted the case before the judge. He accepts that the evidence before the judge, and in particular that of Mr Earnshaw, entitled him to conclude that to proceed to sympathectomy without first conducting an angiogram with a view to a possible angioplasty was a course that would be regarded as acceptable by a responsible body of medical opinion and so satisfied the primary Bolam test (*Bolam v Friern Barnet Hospital Management Committee*

[1957] 1 WLR 582). But he submitted that the judge did not consider the important qualification emphasised in (*Bolitho v City and Hackney Health Authority* [1998] AC 232) namely that there must be a logical basis for any such view; and that if he had done so he would have appreciated that the course taken was in fact illogical. Mr Preston disclaimed any reliance on the evidence of Professor Bell, given the Recorder's rejection of it, but he contended that the unchallenged evidence of Professor Gaines and Mr Earnshaw's own evidence in cross-examination clearly showed that sympathectomy was a procedure with a markedly more limited chance of achieving any improvement in the appellant's condition than angioplasty and that it had a markedly more significant risk of complications. The only logical course therefore, he submitted, was to perform an angiogram, with a view to angioplasty, first.

11. Well though Mr Preston developed that argument, I cannot accept it. The Recorder was, of course, well aware of Bolitho, to which he referred in the passage of his judgment from which I have quoted. Although he does not in the passages in question use the language of "a logical basis", he does at paragraph 47 use the phrase "acting reasonably". In Bolitho Lord Browne-Wilkinson expressly picks up on McNair J's reference to a "reasonable" body of opinion as connoting the same element, which he went on to gloss by reference to the existence of a logical basis - see pages 241 to 242. In my view, it is adequately clear from his judgment, read as whole, that the Recorder did indeed consider the decision made by the multi-disciplinary team to be objectively reasonable.

12. I further believe that that was a conclusion which was open to the Recorder on the evidence. There are, I think, two overlapping answers to Mr Preston's submission to the contrary.

13. First, it would not, in all ordinary circumstances, be appropriate for a judge to hold that a particular clinical decision had no logical basis or was unreasonable without the support of expert evidence. The burden of proving that an impugned decision, supported by a responsible body of medical opinion, was nevertheless unreasonable is self-evidently a heavy one, as Lord Browne-Wilkinson himself emphasised in Bolitho - see page 243D. A judge would normally only find that the burden had been shifted on the basis of expert evidence exposing the illogicality in question. Here, the appellant does not and cannot rely on the evidence of Professor Bell. He could in principle rely on admissions made by Mr Earnshaw, but it is clear from the passages in the transcript of his cross-examination, to which we have been taken, that he stuck to his guns in defending the reasonableness of the decision taken by the clinicians in this case. It was therefore entirely reasonable for the judge to say, as he does at paragraph 47 of his judgment, that in order to find the claimant's case proved he needed expert evidence which he did not have. Despite that, I am prepared to concede that in principle it is open to a judge, if any facts in the case which depend on specialist expertise are sufficiently clearly established and are uncontroversial, to use his or her own judgment and reasoning to say that the evidence before him about the reasonableness of a clinical decision simply does not make sense. That is, it goes without saying, an exercise to be undertaken with the utmost caution in a specialist field but, as I say, I am prepared to accept it is not inappropriate in principle.

14. That therefore brings me to my second reason for rejecting Mr Preston's submissions. That reason is that I do not accept that the evidence before the judge clearly established the kind of stark illogicality on which he relied. On the contrary, the evidence of the relative benefits of sympathectomy and angioplasty was not clearly established by the evidence.

15. As to that, I take first the benefits for sympathectomy, Mr Preston pointed to a passage in the cross-examination of Mr Earnshaw which reads as follows:

> "Q. The effects of a lumbar sympathectomy on the large and medium-sized vessels is negligible, isn't it?
> A. Your Honour, it's, we're back to what's a large and what's a medial, medium-sized artery. The sympathectomy is not going to affect any of the named arteries that you have in this case, it's not going to affect the crural arteries, it's not going to affect the pedal arteries, it's going to affect the arterioles at a much lower level, yes. It's not going to have any effect on the larger arteries that we've been talking about.
> Q. Therefore when dealing with a foot like this which has got critical ischaemia, which has not significant vascular problems, doing the sympathectomy is not going to affect anything else significantly, save for these peripheral vessels, is it?
> A. That's true, your Honour, and that's why it doesn't make a huge difference to the circulation to the leg. When you are doing a sympathectomy, you're just trying to make a minor difference to just get someone who's just got critical ischaemia and you're trying to make a small difference that will just tip them over the edge so that any ulcers or gangrene or pain will heal up. And as you've seen in the indications, the gangrene's got to be relatively minor, it's not got to be a severely ischaemic or severely gangrenous foot.
> Q. So it's only going to make a small difference to the flow to this foot.
> A. That's correct."

Mr Preston said that that constituted an acceptance by Mr Earnshaw that sympathectomy would be of no benefit in the present case. He focused particularly on his statement at the end of the second of the two answers quoted "it's not got to be a severely ischaemic or severely gangrenous foot". He said that that constituted an acceptance that a sympathectomy would be of no benefit in the present case because the appellant's ischaemia was indeed severe. But it is not clear to me that Mr Earnshaw was accepting any such thing, which would indeed have been contrary to the main thrust of his evidence. If his answers are read as a whole, he appears to be saying that sympathectomy would only make a small difference but that in a case of critical ischaemia (such as was the appellant's

case) it could tip the balance. In any event, if there was ambiguity, it was for the appellant to tease it out. It was never squarely put to Mr Earnshaw that his evidence meant that the procedure had no chance whatever of benefiting Mr Williams. I would add that it was also the evidence of Mr Lewis himself that he had experience of sympathectomy being effective in cases like the appellant's.

16. As for angioplasty, Mr Preston points to a statement in the unchallenged report of Professor Gaines to the effect that he would have expected a 80% to 90% success rate for angioplasty to remove the occlusion in the peroneal artery. I have to say that it was only in his reply that he sought to rely on this statement, having initially accepted that it was inconsistent with a subsequent passage in which Professor Gaines said that he would not expect angioplasty of the tibial arteries to have prevented amputation. Mr Preston says on reconsideration, probably rightly, that Professor Gaines was distinguishing between angioplasty to the tibial arteries and the peroneal artery. However, Professor Gaines was not in the passage in question addressing the crucial question of whether the judgment made on 1 February, on the basis of the Doppler scan, was negligent. He does in fact address that question in a later answer, where he says:

> "The duplex scans performed prior to 28 January 2010 and clinical features of the patient indicates a high probability of tibial artery and pedal artery disease. An expert vascular surgeon should address whether it was appropriate to perform a sympathectomy before angioplasty. As stated above, I think the tibial artery disease was complex. Only the peritoneal occlusion had a good chance of being successfully treated by angioplasty and even then the probability of foot salvage was unlikely."

That is certainly not an unequivocal statement of negligence. In those circumstances, I do not think that Professor Gaines' report assists the appellant.

17. That brings us back to the evidence of the surgeons. Again, Mr Preston disavows any reliance on Professor Bell's evidence. He does however draw attention to the answer given in the joint experts' report to the question: "What are the risks and/or benefits associated with those treatment options in someone such as the claimant?", namely "A successful angioplasty or bypass has the biggest effect on the limb circulation." That is fine as far as it goes, but of course it depends on the operation being successful. The evidence of Mr Davies was that he did not believe it would be successful, not only on 1 February, when he had the benefit only of the Doppler scan, but also on the 19 February when he had the result of the angiogram. Logically perhaps only the former is relevant. But it was the unequivocal evidence of Mr Earnshaw that it was reasonable to make a judgment on which treatment to pursue on the basis of the information available on the 1 February. As to risks, the joint experts' report said this in response to the same question:

> "Tibial angioplasty has the lowest potential risks around 10% of chance of major complications.... Complication rates after lumbar sympathectomy are less well documented but include bleeding, infection and wound complications including late incisional hernia."

That is certainly a general statement that there is a lower chance of complications with angioplasty than with sympathectomy but it does not in any way quantify the extent of the difference. Of course, it is important not to overlook the reasonable view of Mr Davies at the time that an angioplasty would not be successful any way.

18. It is not necessary for me to reach a concluded view about precisely where the balance of all that evidence comes down. What is however in my view clear, and is sufficient for our purposes, is that none of it amounts to evidence which would have entitled the judge, on

his own assessment, unsupported by expert evidence, to hold that a decision made by the multi-disciplinary team, which was accepted as being one which a reasonable body of medical opinion would support, nevertheless lacked any rational basis. A decision in a difficult situation, where there are no easy solutions, to take a course which with hindsight might appear as a matter of strict logic less preferable than some other course is not necessarily negligent, at least where, as here, there is no stark difference between the risks and benefits of the two alternatives. It is important in a case of this kind to give appropriate respect to the assessment of the judge who had the benefit of hearing the evidence and the respective submissions in, so to speak, real time.

19. Mr Preston had a couple of minor criticisms of the judge's reasoning, but they were only relied on as showing how he might have been led into the substantive error alleged. Since I do not accept that there was any such substantive error, I need not consider them further.

20. For those reasons, I would dismiss this appeal.

LADY JUSTICE KING:

21. I agree.

LORD JUSTICE NEWEY:

22. I agree also.

proceedings or part thereof.

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