



Neutral Citation Number: [2019] EWCA Civ 585

Case No: B3/2017/2810

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM QUEEN'S BENCH DIVISION
HHJ FREEDMAN (SITTING AS A JUDGE OF THE HIGH COURT)
[2017] EWHC 1495 (QB)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 08/04/2019

Before:

LORD JUSTICE McCOMBE
LORD JUSTICE FLOYD
and
LADY JUSTICE NICOLA DAVIES DBE

Between:

LUCY DIAMOND	<u>Appellant</u>
- and -	
ROYAL DEVON & EXETER NHS FOUNDATION TRUST	<u>Respondent</u>

Robert Kellar (instructed by **Enable Law**) for the **Appellant**
Lord Faulks QC and Laura Johnson (instructed by **DAC Beachcroft LLP**) for the
Respondent

Hearing date: 19 February 2019

Approved Judgment

Lady Justice Nicola Davies:

1. In this appeal the appellant pursues a claim for clinical negligence arising out of spinal fusion surgery performed on 6 December 2010 and subsequent identification and repair of a post-operative abdominal hernia on 28 June 2011. At the trial before HHJ Freedman, sitting as a High Court Judge, two allegations of negligence were pursued, namely:
 - i) The spinal surgeon, Mr Khan, failed to examine the appellant at a post-operative review consultation on 21 January 2011 causing a delay in the identification and treatment of her hernia. The claim succeeded and the appellant was awarded £7,500 for a delay of two months in respect of her hernia repair surgery.
 - ii) Mr Wajed, the surgeon who performed the abdominal repair, failed to obtain informed consent from the appellant prior to proceeding to a mesh repair of the hernia. The appellant succeeded in establishing that Mr Wajed had not provided appropriate information for the purpose of informed consent, however the judge concluded that had she been so informed the appellant would have chosen to proceed with the mesh repair which in fact took place.

This appeal is directed at the final ground, namely that of consent and any injury or damage caused thereby.

Background facts

2. The appellant was born on 11 September 1971 and was aged 39 at the time of the material events. On 9 May 2011 the appellant saw Mr Wajed who elected to repair the hernia by means of an open mesh based repair with abdominal wall reconstruction. Following the surgery the appellant continued to complain of abdominal swelling and pain. She was advised to undergo another surgical procedure. On 5 August 2014 surgery was performed which involved removing the mesh, the hernia was repaired and a full abdominoplasty was undertaken. HHJ Freedman found that the appellant's mental and physical wellbeing had been adversely affected, she has suffered depression and anxiety. Further, the appellant had subsequently established a relationship with a new partner. An evidential issue arose as to what discussion had taken place between the appellant and Mr Wajed in May 2011 as to any future pregnancy.
3. At trial it was common ground that at the May 2011 consultation Mr Wajed spoke only in terms of mesh repair of the hernia, he made no reference to the possibility of primary sutured repair. As to the issue of what, if any, discussion took place as to the appellant's intention to become pregnant in the future, the judge preferred the appellant's account, namely that she was not asked by Mr Wajed whether she planned to become pregnant in the future. However, the judge stated at [23]:

“In the end, however, this factual dispute is of little, if any, relevance because even on Mr Wajed's account, the Claimant had only said that she had no plans for a pregnancy in the foreseeable future which he took to mean within the next few months.”

4. At [24-28] the judge set out his reasoning as to the breach of duty in respect of obtaining consent for the mesh repair as follows:

“24. Mr Wajed agrees that he did not discuss at all with the Claimant the potential implications of a mesh repair in terms of a pregnancy in the future. On the basis of the expert evidence from both the Claimant's expert, Professor Winslet and the Defendant's expert, Mr Royston, there is general consensus that the Claimant should have been counselled about the potentially adverse effects of a mesh being present in pregnancy. Indeed Mr Wajed himself agrees that if there was a prospect of a pregnancy in the future, the risks associated with a mesh repair needed to be discussed.

25. In such circumstances, it is unsurprising that Mr Charles does not seek to argue against the preliminary view which I expressed to the effect that there was a lack of informed consent. Putting it shortly, on the basis (as I find) that Mr Wajed could not reasonably have excluded the prospect of a pregnancy in the future, to fail to mention the risks associated with the presence of a abdominal mesh amounted to a breach of duty.

26. Similarly, Mr Charles does not seek to dissuade me from the view that Mr Wajed was under an obligation to mention the possibility of a primary suture repair. On the totality of the expert evidence, it is agreed that the Claimant should have been told that this was an option and, a possible alternative to, a mesh repair.

27. I am quite satisfied that the reason why Mr Wajed did not mention it was because he himself was convinced, or at least thought it highly likely, that a suture repair would fail with the result that the hernia would recur. Nevertheless, both Professor Winslet and Mr Royston maintain that the Claimant should have been informed that there was a possible alternative to a mesh repair.

28. Accordingly, in two respects, I find there was a breach of duty in relation to the counselling process for the mesh repair:

i) it should have been explained to the Claimant that there was attendant upon a mesh repair certain risks, should she become pregnant in the future; and

ii) the claimant should have been told a primary suture repair as opposed to mesh repair was possible even if there was a high risk of failure.”

5. As to the information which the appellant should have been given at the consultation the judge relied upon a letter written by Mr Wajed after his examination of the appellant on 3 December 2013 as a result of a referral by her GP following the appellant's

complaint of discomfort in the lower part of the wound. At the consultation the appellant asked Mr Wajed about becoming pregnant. In his letter Mr Wajed stated:

“She asked me about pregnancy today and I think, although not completely contraindicated, given her previous abdominal surgery there will have to be some cautions (sic) as the mesh may restrict the growth of the uterus causing possible early delivery. There is also the risk that if she requires an emergency caesarean section that access to her abdomen may be difficult in the presence of the mesh and certainly there is a possibility that after the pregnancy the mesh and abdominal wall may be disrupted...”

At [31] the judge found:

“It is therefore reasonable to infer that, at the consultation in May 2011, had Mr Wajed turned his mind to the issue of pregnancy, he would have told the Claimant that the mesh would not mean that she could not become pregnant. However, he would have been obliged to point out that there were certain risks namely:

- i) the mesh restricting growth of the uterus, possibly resulting in early delivery;
- ii) if a caesarean section was required, access to the abdomen could be difficult in the presence of the mesh;
- iii) after the pregnancy the mesh and abdomen wall could be disrupted.

It is also likely that he would have added in the event that if she was contemplating becoming pregnant, it would be prudent to consult a gynaecologist.”

6. Having considered the evidence of the expert witnesses the judge was satisfied that if Mr Wajed had informed the appellant of the matters set out in his letter he could not have been criticised. The judge stated that what Mr Wajed would have said:

“... would have been well within the range of the advice given by reasonably competent general surgeons. Accordingly, I find that what Mr Wajed would have said if asked about the risk of pregnancy was sufficient to allow the Claimant to give informed consent, subject of course to being offered the choice of a different surgical procedure.”

7. As to an alternative surgical procedure the judge described Mr Wajed as being “emphatic” that he considered that the primary suture repair would fail. In his supplementary witness statement Mr Wajed stated:

“Sutures alone would not have provided a sound and durable repair as the quality of her abdominal wall tissue was very poor. This was evident both clinically and on the scans... In my

opinion the risks of recurrent hernia from a simple suture repair were very high – in the region of 50% within two years and inevitable in the course of her natural life. Therefore, I did not consider this was a viable option for the Claimant.”

8. As to this advice the judge concluded:

“37. Returning then to Mr Wajed's assessment of matters, I conclude that if he had discussed the possibility of a suture repair with the Claimant, he would have told her that the rate of a recurrent hernia from such a repair was very high, in the order of 50% within two years and, highly likely, if not inevitable that a hernia would recur during her lifetime. In short, he would have very strongly recommended a mesh repair and counselled against a primary suture repair. I am satisfied that this is the advice which he would have given even if he had been made aware that the Claimant had not ruled out becoming pregnant in the future. He would have explained that a pregnancy would put additional strain on a suture repair with a real risk of recurrence of the hernia. He is likely to have added that the vast majority (in the order of 95%) of surgeons would elect to repair the Claimant's hernia with a mesh.

38. In the light of the expert evidence from Professor Winslet and Mr Royston, it seems to me that what, as I find, Mr Wajed would have said about the suture repair was entirely reasonable and well within the range of what a competent surgeon might say. It accords with what Mr Royston would have said, and Professor Winslet accepts it was reasonable for Mr Wajed to conclude that a suture repair stood little chance of success.”

9. At [39] and following the judge addressed what he described as the “critical question” as follows:

“39. The critical question is of course what the Claimant would have elected to do armed with the knowledge that a mesh repair carried certain risks in the event of a pregnancy and that a suture repair was a possibility, albeit likely to fail.

40. ... I should make it plain that it is not argued that the Claimant would have opted for no treatment: she was understandably desperate to have her hernia repaired.

41. Mr Kellar relies upon various passages in her evidence. By way of illustration, she said that if she had been advised about the risk of carrying a child, ‘that would have changed everything’. She went onto to (sic) say that she would not have elected to have a permanent repair ‘at the cost of [my] fertility’. She sought to emphasise that any risk to a baby would have overridden any concern she had for herself, saying words to the effect ‘it's not just yourself when you're told that there is an

inkling of risk to the baby, that is something you just don't think about risking'. She added that the ability to have children was 'just about everything I am'.

42. In her third witness statement at paragraph 7 she said:

'If I had been told in May 2011 that prolene mesh repair might compromise a future pregnancy I would never have agreed to have this procedure. The ability to have children has always been very important to me and I would not have wanted to be stripped of my womanhood in this way. This is especially as I witnessed what damage a hysterectomy has done to the psyche, self-esteem and consequent relationships experienced by my mother when she was 43 and my cousin (who is like a sister to me) at least 10 years ago.'

43. Mr Kellar also urges me to accept that the risk of recurrence would not have deterred the Claimant from opting for a sutured repair. He says that such would be consistent with the fact that she opted to undergo spinal surgery notwithstanding the serious risks of the procedure and the very high chance of failure.

44. Mr Kellar also relies upon the fact that the risks of pregnancy posed by the mesh repair were both objectively serious and subjectively serious. As to the latter, he points to the fact that once the Claimant was made aware of the risks of a pregnancy, she chose to abandon her plans of having another child. It is right to observe, however, that she was told, in fairly clear terms by Mr Peter Jones that it would be inadvisable to become pregnant in the presence of a mesh.

45. I pause to observe that I unhesitatingly find the Claimant to be a credible and a truthful witness. Earlier in this judgment, I have found her evidence to be reliable in two material respects: telling Mr Khan about her stomach problems on 21st January 2011 and in relation to the lack of any discussion about pregnancy with Mr Wajed.

46. But recalling specific events or conversations is markedly different from attempting to reconstruct what her response would or might have been if given certain information. Expert witnesses, lawyers and others are trained not to use the benefit of hindsight to inform their opinion of what might or should have happened. It is, however, human nature for people to permit that which eventuated to influence their thinking on what they might have done if warned about a particular risk. To my mind, it would be quite impossible for the Claimant to divorce from her thinking, the fact that she was subsequently told by Mr Jones that it would be inadvisable for her to become pregnant because of the mesh and that, in the event, she has not had another child. Unquestionably, in my view, this sad outcome colours and

informs her view of what she would have done if she had been appropriately warned.

47. I conclude that the Claimant genuinely believes and has convinced herself that she would have opted for a suture repair, if she had been provided with all the relevant information. Accordingly, what she said to me in evidence accords with her honestly held belief. But it does not of course, automatically follow that what she now believes to be the case would in fact have been the position at the material time.

48. I have weighed up, as I must, all the available evidence (both objective and subjective) on this issue and I have come to the conclusion, on the balance of probabilities that even if she had been in a position to give informed consent, exactly the same procedure would have been undertaken.

49. Having heard and seen the Claimant, my reasons for coming to this view are as follows:

i) She would have been told that a primary suture repair was almost certain to fail ultimately and likely to fail within 2 years.

ii) She would have been told that a mesh repair stood a very high chance of success.

iii) She would have been told that virtually all surgeons would do a mesh repair in these circumstances.

iv) Mr Wajed would have given her the strongest possible advice that she should have a mesh repair.

v) Mr Wajed would have expressed enormous reluctance to do a suture repair.

vi) She would not have been told that she could not have children in the future – only that there were certain risks. (That to my mind is a crucial distinction.)

vii) She was single at the time. A pregnancy was not within her immediate contemplation albeit that she had thought about having a child two years earlier with her ex-partner.

viii) Overall, in the face of this information, looking at the matter both objectively and subjectively in the face of the advice which would have been given to her, it would have been irrational for her to opt for a suture repair; and I find that she is not a person who would act irrationally.

I stress that, in my judgment, even if the operation had been performed two months' earlier when the lesion may have been a little smaller, a mesh repair would still have been the outcome.”

10. The judge, having dealt with the primary argument on the issue of consent, addressed two further arguments advanced by counsel on behalf of the appellant, which he claimed gave rise to an entitlement to damages for the failure to provide informed consent. The first was identified and addressed by the judge at [50-53] as follows:

“50. ... First, he argues that the Claimant should be entitled to compensation for the ‘shock’ of discovering that she could not have children. The Claimant told Dr Wright, ‘being told I wouldn't have children was a major slap in the face’. It is contended that being told that she could not have children exacerbated her psychiatric condition.

51. It should be observed that this somewhat ingenious argument featured for the first time in Mr Kellar's closing submissions. The whole thrust of the Claimant's case has been that had she been adequately counselled, she would not have had the mesh repair and, in that event, she would have been able to child-bear. This ‘secondary’ case is only propounded in the event of a finding that the Claimant would still have had a mesh repair, even if appropriately warned and counselled.

52. As it seems to me, it is not surprising that Mr Kellar did not, at any earlier time, put forward this argument. The reason why I express that view is because, in my judgment, it has neither factual or legal validity. The breach of duty on the part of Mr Wajed was to fail to warn the Claimant about possible complications in pregnancy. That is wholly different from being under a duty to tell a patient that if she undergoes a certain procedure, she would not be able to child-bear in the future. It cannot conceivably be said that it was a foreseeable consequence of the failure to warn about certain risks that another doctor (Mr Jones), nearly three years later would tell the Claimant that it was inadvisable to become pregnant. That such advice was given is, to my mind, unconnected to the breach of duty of the part of Mr Wajed or, at the very least, far too remote a consequence.

53. Furthermore, it is the Claimant's case that by the time she was given advice by Mr Jones, she was already suffering depression and anxiety. It seems to me that it would be very difficult to measure, in any meaningful way, the extent to which the advice given by Mr Jones rendered her depression/anxiety more severe. Additionally, it is, of course, trite law that ‘shock’ on its own does not sound in damages.”

11. The appellant’s second submission was that a negligent non-disclosure of information by a doctor of itself creates a right for the patient to claim damages. Mr Kellar based that assertion on the decision of the Supreme Court in *Montgomery v Lanarkshire*

Health Board [2015] 2 WLR 162 and the decision of the House of Lords in *Chester v Afshar* [2005] 1 AC 134. The judge found that *Montgomery* did not lend any support to the proposition that a mere failure to warn of risks, without more, gives rise to a free-standing claim in damages. He also found that *Chester* is not authority for the proposition that a claimant does not have to prove causation, in the conventional sense, as a result of a failure to provide informed consent. In so doing he took account of the decision in *Correia v University Hospital of North Staffordshire NHS Trust* [2017] EWCA Civ 356. The judge rejected the appellant's further submission.

Grounds of appeal

12. The grounds of appeal, in particular ground 3, have been amended since permission to appeal was granted. The grounds now relied upon are:
 - Ground 1: In considering the issue of causation the judge was wrong to apply a test of "rationality". Alternatively, having held that the respondent was under a duty to offer a sutured repair by way of alternative, the judge erred in holding that it would have been "objectively and subjectively... irrational" for the appellant to have accepted that offer.
 - Ground 2: Alternatively, the judge was wrong to reject the claim for psychiatric injury. The appellant's case was that she was shocked and upset to learn, at a time when she had entered into a new relationship, of pregnancy related risks to which she had never before been properly consented. It was foreseeable that the appellant may suffer shock, distress and consequential depression in such circumstances.
 - Ground 3: Alternatively, if (which is denied) the claim for psychiatric injury could not succeed on conventional causation/foreseeability principles the appellant was entitled to succeed on the principle described in *Correia v University Hospital of North Staffordshire NHS Trust* [2017] EWCA Civ 356. The appellant's shock, distress and consequential depression was, at least, "intimately connected" to the failure to obtain properly informed consent.

Ground 1

13. The judge's wrongful application of a "rationality" test at the causation stage of the analysis is said to be demonstrated by the express language used at [49(viii)] of the judgment and by the decisive objective factors relied upon by the judge to justify his conclusion at [49(ii)-(vi)]. Reliance is placed upon the "compelling" evidence of the appellant identified at [41] of the judgment and to the judge's finding that the appellant was a credible and truthful witness. Given such findings the judge should not have rejected the appellant's evidence as to the choice she would have made on the basis that this was deemed by the court to be "irrational". Reliance is placed upon the authorities of *Chester* and *Montgomery* (above) in support of the proposition that a fundamental purpose of the requirement for properly informed consent is to ensure that respect is given to a patient's autonomy, dignity and right to self-determination. Such a right includes the choice to make decisions that others, including the court, might regard as unwise, irrational or harmful to their own interests.
14. It is the respondent's case that the judge did not apply a rationality test in the sense of imposing on the appellant the actions of a hypothetical rational person. The judge

weighed the evidence appropriately and reached a finding of fact about the decision which the appellant would have made as to her preferred method of surgery if properly advised. This was a finding with which an appellate court should not interfere unless it was reached on an erroneous basis.

Discussion

15. It is common ground that the conventional “but for” test for causation applies to consent cases in that it is for the patient to prove that had he or she been warned of the risks, the patient would not have consented to the treatment. In *Montgomery* (above) the duty of the doctor to inform of material risks was considered in the judgment of Lord Kerr and Lord Reed JJSC as follows:

“86. ... the analysis of the law by the majority in *Sidaway* is unsatisfactory, in so far as it treated the doctor's duty to advise her patient of the risks of proposed treatment as falling within the scope of the *Bolam* test, subject to two qualifications of that general principle, neither of which is fundamentally consistent with that test. It is unsurprising that courts have found difficulty in the subsequent application of *Sidaway*, and that the courts in England and Wales have in reality departed from it; a position which was effectively endorsed, particularly by Lord Steyn, in *Chester v Afshar*. There is no reason to perpetuate the application of the *Bolam* test in this context any longer.

87. The correct position, in relation to the risks of injury involved in treatment, can now be seen to be substantially that adopted in *Sidaway* by Lord Scarman, and by Lord Woolf MR in *Pearce*, subject to the refinement made by the High Court of Australia in *Rogers v Whitaker*, which we have discussed at paras 77-73. An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under 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. 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.

...

89. Three further points should be made. First, it follows from this approach that the assessment of whether a risk is material cannot be reduced to percentages. The significance of a given risk is likely to reflect a variety of factors besides its magnitude: for example, the nature of the risk, the effect which its occurrence would have upon 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 involved in those alternatives. The assessment is therefore fact-sensitive, and sensitive also to the characteristics of the patient.”

16. As to the approach of the appellate courts to reversing findings of fact made at first instance Lord Kerr and Lord Reed JJSC at [97-98] stated:

“97. This court has reiterated in a number of recent cases, including *McGraddie v McGraddie* [2013] UKSC 58; 2014 SC (UKSC) 12; [2013] 1 WLR 2477 and *Henderson v Foxworth Investments Ltd* [2014] UKSC 41; 2014 SLT 775; [2014] 1 WLR 2600, that appellate courts should exercise restraint in reversing findings of fact made at first instance. As was said in *Henderson's* case at para 67,

‘in the absence of some other identifiable error, such as (without attempting an exhaustive account) a material error of law, or the making of a critical finding of fact which has no basis in the evidence, or a demonstrable misunderstanding of relevant evidence, or a demonstrable failure to consider relevant evidence, an appellate court will interfere with the findings of fact made by a trial judge only if it is satisfied that his decision cannot reasonably be explained or justified.’

It is in addition only in comparatively rare cases that this court interferes with concurrent findings of fact by lower courts. As Lord Jauncey of Tullichettle explained in *Higgins v J & C M Smith (Whiteinch) Ltd* 1990 SC (HL) 63, 82:

‘Where there are concurrent findings of fact in the courts below generally this House will interfere with those findings only where it can be shown that both courts were clearly wrong.’

98. As has been observed in the Australian case law, the issue of causation, where an undisclosed risk has materialised, is closely tied to the identification of the particular risk which ought to have been disclosed...”

17. The appellant accepts that the “critical” question which the judge posed at [39] of his judgment is correct. The appellant filed three witness statements comprising 41 pages, she also gave oral evidence to the court. The judge had the considerable advantage of not only reading her detailed written evidence but of seeing and hearing the appellant give evidence.
18. The judge’s approach is identified at [48], at [49] his reasoning is set out. The facts which are identified at [49(i)-(vi)] reflect the evidence. There is no challenge as to their clinical validity nor to the fact that it was the evidence before the judge. As to the fact at [49(vii)], namely that a pregnancy was not within the appellant’s immediate contemplation, albeit she had thought about having a child two years earlier with her

ex-partner, that was factually correct. As at the date of the May 2011 consultation the appellant was single, she was not in a relationship and thus a pregnancy was not within her “immediate contemplation”.

19. In addition to the primary argument that the judge applied a rationality approach, which represents the hypothetical rational person rather than the real person who was before the court, particular criticism is levelled at the reasoning set out at [49(viii)], namely that it would have been “irrational” for the appellant to opt for a suture repair, the judge finding that she is not a person who would act irrationally. The appellant contends that the judge’s assessment of objective rationality is not a reliable basis to infer what she would have done.
20. Reliance is placed upon the test of materiality identified in the final sentence of [87] in *Montgomery*. I understand that test to mean that in considering what a reasonable person in the patient’s position would attach significance to, account must be taken of the particular patient. The appellant contends that applying a test of objective rationality is placing too much weight on the doctor’s view of what is best for an individual patient. The appellant accepts that the judge was entitled to have some regard to rationality but the point is made that the more irrational an account is found to be the more carefully it must be scrutinised.
21. In my opinion the judge was scrupulous in his assessment of the appellant and her evidence. He found that she was a reliable and honest person, he took account of the personal and social considerations particular to the appellant. The judge considered the clinical facts in the context of the appellant’s character and circumstances. He made the valid observation that recalling specific events or conversations is markedly different from attempting to reconstruct what a person’s response would or might have been had that person been given certain information. Hindsight was acknowledged to be a factor in such a consideration and the judge found that it would be “quite impossible” for the appellant to divorce from her thinking “the fact that she was subsequently told by Mr Jones that it would be inadvisable for her to become pregnant because of the mesh and that, in the event, she has not had another child.” He found that the “sad outcome” coloured and informed her view of what she would have done had she been appropriately warned. The judge did not leave the matter there; he went on to conclude that the appellant genuinely believes and has convinced herself that she would have opted for the suture repair had she been provided with all the relevant information. Critically he held that her evidence accorded with her honestly held belief, however it did not follow that what she now believes would in fact have been the position at the material time.
22. The judge’s approach, coupled with his assessment of the appellant and her evidence, was detailed, nuanced and insightful. It was an assessment that was properly open to him to make on the evidence before the court. The judge met the requirement set out in *Montgomery* in that he took account of the reasonable person in the patient’s position but also gave weight to the characteristics of the appellant herself. He did not apply a single test of “rationality” without more to the issue of causation. No valid criticism of the judge’s approach, still less his assessment of the factual evidence can be made. There is no basis for this court to find that there was a material error of law or that a critical finding of fact was made for which there is no evidential basis. This limb of ground of appeal 1 is dismissed.

23. The second submission of the appellant in respect of ground 1 is that assuming in the respondent's favour that no error of principle can be identified, the judge was not entitled to conclude on the evidence that it was irrational for the appellant to refuse the suture repair. It is said that is difficult to reconcile with the expert evidence. I do not agree. There was an only limited divergence of opinion as between the surgical experts as to whether a suture repair was a viable option, as set out at [37] and [38] of the judgment (paragraph 8 above). Mr Wajed would not have favoured such a repair because of the high recurrence rate. That accorded with the view of the respondent's expert and was considered reasonable by the appellant's expert. Mr Wajed would have been the surgeon seen by the appellant and who would have advised her. Given his clear opinion as to the non-viability of a suture repair and the reasons for it, which are directly related to the appellant, the evidence before the judge provided a proper basis for the finding of fact which he made. It follows that this submission also fails.

Ground 2

24. The judge dealt with the submission which founds this ground of appeal at [50-53] of the judgment (paragraph 10 above). It is clear that the evidence before the judge identified at [44] and [46] of the judgment was to the effect that it was another surgeon, Mr Peter Jones, who informed the appellant that it would be inadvisable for her to become pregnant because of the presence of the mesh. The appellant saw Mr Jones in 2014. In evidence the appellant stated that in an email from Mr Jones he stated that "on balance of probabilities no you can't carry a child". The email is dated 2 June 2015 and was sent in response to an enquiry from the appellant on the day before the trial was to commence. In her email the appellant asked Mr Jones for his "opinion on having a pregnancy at this stage of my recovery, if at all, I will be 44 years old in four months." In reply Mr Jones stated "there is no yes or no answer but on balance I would say not".
25. The re-amended Particulars of Claim dated 17 October 2014 include no claim for psychiatric injury allegedly caused by a failure to advise of an inability to carry a child in the presence of the mesh repair. Evidence from psychiatric experts on behalf of both parties was before the court. It was the evidence of the appellant's psychiatrist that she had suffered previous episodes of depression in 2002 and 2009. In a report dated 26 August 2015 he stated that:

"The onset of lumbar disc prolapse, subsequent development of the abdominal hernia, chronic pain, disfigurement and disability resulting from the hernia are factors that caused onset of the third episode in 2011. This episode was then subsequently worsened substantially following uncontrolled post-operative pain and infection following the third operation in 2014 and the realisation that, as a result of the series of operations to her abdomen, that she may not be able to have further successful pregnancies with her new partner."

In the same report the psychiatrist recorded the appellant as informing him that:

"In 2014, she underwent further surgery to remove the previously inserted mesh and further repair of the hernia and abdominoplasty. While she was satisfied with the cosmetic result, she experienced severe pain post-operatively which

proved difficult to control thereafter. She also suffered post-operative infection over a period of three months.

... In 2014, she became aware that she may not be able to have children, as a result of the abdominal surgery. This came at a time when she had entered her current relationship with her partner who did not himself have children, but who wished to start a family in the future. She described feeling ‘... a failure ... useless to him ... wanted to end the relationship...’”

26. In a joint psychiatric statement dated 11 October 2016 the appellant’s psychiatrist gave an opinion which was “based on the Claimant’s account at interview”, it included the following:

“She suffered from a number of psychiatric symptoms ... consistent with a mild Major Depressive Episode from 2011 onwards

These symptoms worsened from 2014, when she became aware that her surgery meant that she would be unable to have children and she then sought treatment from her General Practitioner ...”

27. In a detailed report prepared by the psychiatric expert on behalf of the respondent, the appellant’s general practitioner records between 1976 and September 2015 are reviewed. It is of note that between 2013 and 2015 there is no entry relating to anxiety or stress which is attributed to any advice given by a surgeon.
28. The account which the appellant gave to the psychiatrist instructed on her behalf, namely that it was advice in 2014 as to the inadvisability of becoming pregnant, which exacerbated her pre-existing depressive condition, was consistent with the evidence which the appellant gave to the court as to seeing Mr Jones in that year, albeit the email detailing his opinion was not sent until 2015. That was the case before the judge and it was on that basis that he determined the submission which now gives rise to ground of appeal 2.
29. There is no ground of appeal challenging the judge’s factual finding that it was the advice of Mr Jones which caused her distress on learning that it would be inadvisable for her to become pregnant by reason of the presence of the mesh. Undaunted by this, counsel on behalf of the appellant now seeks to shift the factual basis of this ground of appeal to encompass what was allegedly said by Mr Wajed at the consultation in 2013. Pressed by the court as to how he was putting the appellant’s case, Mr Kellar stated that it was the appellant’s interpretation of Mr Wajed’s advice. This is no part of the appellant’s pleaded case, nor was it her case before the trial judge. Critically, there is nothing in the medical records nor within the psychiatric evidence before the court to provide any factual support for a submission that it was the meeting with Mr Wajed in 2013 and any advice given which triggered or exacerbated pre-existing depressive symptoms.
30. It now appears to be the appellant’s case that she interpreted the advice given by Mr Wajed in 2013 as being that she should not proceed with a further pregnancy because of the presence of the mesh. This was not the advice given. The advice given by Mr

Wajed in 2013 is reflected in a letter which he wrote on 3 September 2013, the terms of which are set out in paragraph 5 above. The judge's findings as to that advice, namely that it was reasonable, are identified at paragraphs 5 and 6 above. Thus, whatever interpretation the appellant now seeks to place upon such advice, the same was not negligent which raises the question as to whether the advice given in 2014/2015 by Mr Jones was reasonable or correct.

31. The appellant's case as it was factually presented to the judge was properly dealt with, in particular when the judge found at [52] that it cannot conceivably be said that there was a foreseeable consequence of the alleged failure to warn about certain risks that another doctor, Mr Jones, nearly three years later would tell the appellant that it was inadvisable to become pregnant.
32. This ground of appeal, as now formulated, is without any factual or causal foundation.

Ground 3

33. The judge recorded the submission which finds this ground of appeal at [54] of the judgment as follows:

“... where there has been a negligent non-disclosure of information by a doctor then, that of itself, can create a right for the patient to claim damages.”
34. The appellant no longer seeks to challenge the judge's finding that there is no self-standing right to claim damages to compensate her for the invasion of her right to personal autonomy/choice. It is accepted that the issue has now been determined in *Shaw v Kovac* [2017] EWCA Civ 1028 and *Duce v Worcestershire Acute Hospitals NHS Trust* [2018] EWCA Civ 1307. The appellant must show that the breach of duty has caused her to suffer injury. However, the appellant now contends that if the claim for psychiatric injury could not succeed on conventional foreseeability principles the appellant was entitled to succeed on the principle identified in *Correia v University Hospital of North Staffordshire NHS Trust* [2017] EWCA Civ 356, which is said to be that the appellant's shock, distress and consequential depression was, at least, “intimately connected” to the failure to obtain properly informed consent.
35. The appellant's original argument before the trial judge was based upon the decision of *Chester* (above) and *Montgomery* (above). *Montgomery* lends no support for the proposition that a failure to warn of a risk or risks, without more, gives rise to a free-standing claim in damages. The importance of *Montgomery*, as identified at [87] of the authority, is that it departs from the view taken by the majority in *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871, namely that the doctor's duty to advise a patient of the risks of the proposed treatment falls within the scope of the *Bolam* test. *Montgomery* develops the concept of the autonomy of the patient and consistent with it the patient's awareness of material risks of the treatment, and of any alternative treatment. These are now recognised as being within the doctor's duty to take reasonable care in so advising.
36. The authority of *Chester* has subsequently been analysed in *Correia*, *Shaw* and *Duce*. In *Correia* Simon LJ set out the unusual facts of *Chester* at [13] as follows:

“On any view the facts of *Chester v. Afshar* were unusual. The defendant neurosurgeon advised the claimant to undergo an operation on her spine but failed to explain that, if performed without negligence, the procedure carried a small (1-2%) unavoidable risk of a neurological damage leading to a disabling condition. The claimant agreed to the procedure on a Friday and the operation was performed on the following Monday. She subsequently developed the disabling condition which left her partially paralysed, and sued the surgeon for negligence. In these circumstances, claimants had needed to show that, if a relevant warning had been given, they would not have undergone the procedure. That finding was not made in *Chester v. Afshar*. The trial judge held that the defendant had not performed the operation negligently, but that he had negligently failed to warn the claimant of the risks of developing the disabling condition and that, if she had been aware of the risks, the claimant would have sought advice on alternatives to surgery and the operation would not have taken place when it did. The judge held that there was a sufficient causal connection between the failure to warn of the inherent risks of the operation and the damage sustained by the claimant, and that the link was not broken by the possibility that the claimant might have consented to the surgery in the future. The Court of Appeal dismissed the defendant's appeal and he appealed to the House of Lords.”

At [22] he identified the concluding passages in the judgment of Lord Hope:

“... ”

‘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.

88. The reasoning of Kirby J in *Chappel v Hart*, 195 CLR 232, para 95, which I would respectfully endorse, supports this approach. I am encouraged too by the answer which Professor Honoré gave to the question which he posed for himself in his case note on that case at p 8: “is this a case where courts are entitled to see to it that justice is done despite the absence of causal connection?” I would hold that justice requires that Miss Chester be afforded the remedy which she seeks, as the injury which she suffered at the hands of Mr Afshar was within the scope of the very risk which he should have warned her about when he was obtaining her consent to the operation which resulted in that injury.”

At [24] Simon LJ identified the ratio of the decision in *Chester* as contained in [87] of Lord Hope’s opinion as being:

“... If there has been a negligent failure to warn of a particular risk from an operation and the injury is intimately connected to the duty to warn, then the injury is to be regarded as being caused by the breach of the duty to warn; and this to be regarded as a modest departure from established principle of causation.”

He added the following at [28]:

“... The crucial finding in *Chester v. Afshar* was that, if warned of the risk, the claimant would have deferred the operation. In contrast, in the present case, it was not the appellant's case that she would not have had the operation, or would have deferred it or have gone to another surgeon... Nevertheless, it seems to me that if a claimant is to rely on the exceptional principle of causation established by *Chester v. Afshar*, it is necessary to plead the point and support it by evidence. ...”

37. In *Shaw v Kovac* (above) Davis LJ at [61] in considering the authority of *Chester* stated:

“... Moreover, there is nothing in the actual majority decision in *Chester* which indicates the availability of a further, free-standing, award of the kind proposed in the present case. On the contrary, the damages awarded were (by reason of the majority conclusion on causation) of what I might call the conventional kind...”

38. Davis LJ dismissed a submission that *Montgomery* provided any support for an argument that there was a self-standing right to damages for a failure to warn at [64] and [65] in referencing *Montgomery* as follows:

“64. ... The true importance and significance of that decision is that, putting it shortly, it removes (contrary to the previous general understanding) the application of the principles of *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 from the assessment of the standard to be expected from a doctor in obtaining a patient's consent to a recommended medical procedure. ...

65. ... The duty and standard of care in providing proper information thus was not to be governed by a generalised view held by the medical profession as to a generalised norm of what was acceptable as to the provision of information in certain kinds of case. Rather, the standard required as to the proper provision of information had to be geared to the individual patient and the individual case: precisely because of the right of autonomy involved But nowhere does such decision suggest or provide support for the proposition that an additional, free standing, award of damages is available for the infringement of the patient's right of autonomy or interference with the patient's bodily integrity.”

39. In *Duce Hamblen* LJ, in addressing the appellant's case on causation, analysed the authority of *Chester* and concluded at [66-69]:

“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.”

At [70] he referred to the authority of *Correia* and noted that:

“... 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.”

40. At [92] Leggatt LJ stated that:

“... 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.”

41. The appellant’s argument in respect of ground 3 is without merit. The judge determined that even if the appellant had been warned of the relevant risk she would have still proceeded with the mesh repair. The judge’s finding has been upheld by this court. Thus, upon this premise, there is no factual basis upon which to argue ground 3. Further, given the shifting factual basis of the appellant’s case, namely that it was the advice given by Mr Wajed in 2013 which caused the relevant injury, any argument in respect of ground 3 also founders as there is no medical evidence to support such a submission. Finally, a contention that a failure to warn in 2011 is intimately connected with advice given in 2014/2015, in respect of which there is an issue as to whether in fact such advice is correct, is without any sound factual basis.

Conclusion

42. Accordingly, for these reasons, I would dismiss the appeal.

Lord Justice Floyd:

43. I agree.

Lord Justice McCombe:

44. I also agree.