Risk disclosure, causation and the role of *Chester*

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Introduction: *Chester*,[1] *Montgomery*[2] *and Duce*[3]

Montgomery v Lanarkshire Health Board is now recognised as a landmark case, a decision which heralded a long overdue development in the law, the recognition of patient autonomy and the end of the much maligned 'doctors know best'[4] approach to information disclosure. Academics have largely focused on the breach of duty aspect of the decision,[5] the demise of the *Bolam*[6] test and the acceptance of the patient-driven standard espoused by *Montgomery* and its predecessors before it.[7] However, as with all claims in negligence, breach of duty is only one hurdle the claimant must overcome. Once established that the risk should have been disclosed, the claimant must then prove on a balance of probabilities that the absence of disclosure of the risk caused the injury complained of. The causation issue in *Montgomery* was similarly determined. Given the seriousness of the risk involved, and that if the claimant had known of the risks associated with natural delivery she would have elected to have a caesarean section,[8] causation was established on a factual causation[9] basis. Unusually, the Supreme Court preferred the evidence of Nadine Montgomery's consultant obstetrician, Dr McLellan, to Nadine Montgomery's own testimony in reaching this conclusion. Relying on the Lord Ordinary's previous assessment that Dr McLellan's evidence was both 'credible and reliable' the Supreme Court were convinced that

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1 [2004] UKHL 41; [2005] AC 134.

2 [2015] UKSC 11; [2015] AC 1430.

3 [2018] EWCA Civ 1307.

4 The term used to describe a paternalistic attitude of clinicians to information disclosure. Pre-*Montgomery* clinicians would decide what information they provide to patients. Post-*Montgomery* information disclosure takes its lead from what a reasonable patient would want to know.

5 See R Heywood 'R.I.P. Sidaway: Patient-Oriented Disclosure – A Standard Worth Waiting For? Montgomery v Lanarkshire Health Board [2015] UKSC 11' [2015] 23 Med L Rev 455; J Laing 'Delivering informed consent post-Montgomery: implications for medical practice and professionalism' (2017) PN 33(2) 128; C Foster 'The last word on consent?' (2 April 2015) NLJ.

6 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582; [1957] 2 All ER 118. In *Bolam*, McNair J gave the most cited direction to a jury at [122], a doctor was 'not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art'. Thus the amount of information to be disclosed to the patient was to be judged in accordance with medical accepted practice, effectively allowing the medical profession to decide what risks (if any) to disclose to the patient. Critics of the *Bolam* test (see for example A Maclean, 'From *Sidaway* to *Pearce* and beyond: is the legal regulation of consent any better following a quarter of a century of judicial scrutiny?' [2012] Med L Rev 20(1) 108) argued that risk disclosure merited a different approach from claims for negligent diagnosis or treatment, as risk disclosure involves no clinical skill.

7 See for example Lord Scarman's dissenting judgment in *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871 at p 882; *Smith v Tunbridge Wells Health Authority* [1994] 5 Med LR 343; *Rogers v Whitaker* [1992] 11 WLUK 288; [1993] 4 Med LR 79.

8 *Supra* n 2 at [18].

9 First limb of test for causation referred to as the 'but for' test and discussed further below.

Nadine Montgomery would have elected for a caesarean section.[10] This rendered it unnecessary 'to consider whether if, Mrs. Montgomery could not establish "but for" causation, she might nevertheless establish causation on some other basis in the light of *Chester v Afshar*'.[11] With this obiter comment, the Supreme Court seemingly acknowledged the existence of a potential alternative to the 'but for test',[12] the much-maligned '*Chester exception*';[13] however, they failed to give an insight as to how and when the *Chester* exception may be invoked, which is perhaps understandable given the application of the orthodox approach. The purpose of this article is to re-visit the decision of *Chester v Afshar*, labelled by many a doctrinal anomaly,[14] a blot on the causation landscape, but more recently making a comeback in a flurry of post- *Montgomery* decisions.[15] We will begin our discussion by providing a brief overview of the law of factual causation, before then moving on to consider causation in the context of a negligent failure to warn. An analysis of the case of *Chester* and a review of the role of *Chester* in the post-*Montgomery* jurisprudence will follow. Finally, we will address the residual uncertainties surrounding the scope and applicability of the *Chester* exception. The decisions in *Duce v Worcestershire Acute Hospitals NHS Trust* and *Diamond v Royal Devon & Exeter NHSFT*[16] will be instrumental in our conclusion that *Chester* is not after all an exception or even a viable alternative when the conventional route for proving factual causation fails, but it remains of potential significance for legal causation.

Causation – the legal tests

Having established breach of the duty of care the claimant must then establish causation which can be divided as follows:

- Stage 1 Factual causation: the '*but for*' test – the claimant must establish the damage suffered would not have arisen *but for* the defendant's breach of duty; and
- Stage 2 Legal causation: the scope of liability – at the very least the damage to the claimant must have been foreseeable and it also must not be merely coincidental.

10 *Supra* n 2 at [104]. The Supreme Court held that the Lord Ordinary and the Extra Division had failed to consider Dr McClellan's evidence in considering factual causation and had erroneously relied exclusively on Nadine Montgomery's evidence which they had subsequently determined as inherently unreliable and affected by hindsight. The Supreme Court noted that the Lord Ordinary 'had no such misgivings about Dr McLellan: she was found to be 'an impressive witness' in relation to the informed consent aspect of the case, and her evidence was 'credible and reliable'. Relying on Dr McClellan's evidence that if Nadine Montgomery had been made aware of the risk 'she would have no doubt requested a caesarean section, as would any diabetic today' (para 100) the Supreme Court concluded factual causation was established.

11 *Supra* n 2 at [105]. This approach contrasts with that taken by the Court of Session which after finding the but for test not satisfied then considered causation afresh applying *Chester v Afshar*, see *Montgomery v Lanarkshire Health Board* [2010] CSOH 104, at 268.

12 The test for factual causation discussed below.

13 *Supra* n 1. *Chester* has been considered as an alternative to the conventional causation test.

14 See for example, S Green *'Chester v Afshar [2004]'* in Herring and Wall (eds) '*Landmark Cases in Medical Law*' (Hart Publishing, 2015); T Clark and D Nolan 'A Critique of Chester v Afshar' (2014) 34(4) OJLS 659; C Foster 'It should be, therefore it is' (2004) 154 NLJ 1644.

15 *Supra* n 3. See also See *Shaw v Kovac and University Hospitals of Leicester NHS Trust* [2017] EWCA Civ 1028; *Correia v University Hospital of North Staffordshire NHS Trust* [2017] EWCA Civ 356; *Jones v Royal Devon & Exeter NHSFT* (unreported; judgment handed down 22/9/2015).

16 *Supra* n 3 and *Diamond v Royal Devon & Exeter Foundation Trust* [2019] EWCA Civ 585.

Causation is a difficult concept and there is a lack of consensus in relation to how the different elements of causation should be divided.[17] In relation to factual causation the but for test is the appropriate starting point. *Barnett* v *Chelsea and Kensington Hospital Management Committee*[18] confirms the nature of this test. In *Barnett*, the claimant attended hospital following an episode of vomiting. The doctor on duty did not see the patient but advised a nurse to tell the patient he should go home to rest. He died a few hours later from arsenic poisoning. An action in negligence against the hospital failed on the basis that by the time the claimant reached hospital, the arsenic poisoning was so far advanced that death would still have occurred even if treatment had been given. *The defendant causes a claimant's injury if the injury would not have happened but for the defendant's breach of duty.* The claimant must establish the causal connection between the breach and the loss sustained on the balance of probabilities, such that it is more likely than not that the breach of duty is a but for cause. The but for test does not always provide a solution to a complex scenario where for instance there are multiple factors at play or where there is an evidentiary gap.[19] Arguably, *Fairchild v Glenhaven Funeral Services Ltd and others*[20] is the most recognised example of a policy decision in the context of factual causation. The claimants developed mesothelioma as a direct consequence of asbestos exposure but had worked for various employers and the medical evidence was equivocal as to which period of exposure led to the injury.[21] The claimants succeeded on the basis that each period of exposure materially increased the risk of developing mesothelioma.[22]

However, the issues that arise in relation to risk disclosure do not fall into this 'complex' category of cases involving scientific uncertainty. In a risk disclosure case attention is focused on the effect of non-disclosure of risk or failure to discuss alternative treatments and the but for test is applied to determine this.

Even if the but for test is satisfied, further analysis is needed to determine whether the connection is sufficient to establish legal causation and whether the damage caused is within the scope of the defendant's liability. At this stage of the causation analysis, the enquiry is whether the defendant *should* be liable for the claimant's injury. Initially we consider whether the harm is of a foreseeable type[23] but even if it is, the enquiry does not end there as a defendant will not necessarily be liable for all foreseeable harm. In terms of scope of liability this will be limited 'to those consequences which are attributable to that which made the act wrongful'.[24] Clark and Nolan argue that 'what makes the

17 J Stapleton 'Occam's razor reveals an orthodox basis for Chester v Afshar' (2006) LQR 426, 426. Stapleton considers the three- step approach advocated by Hart and Honore (in *Causation in the Law* (OUP, 1985) to be 'both inconvenient and obfuscatory'. She advocates focus on 'a two-step analysis consisting of the factual issue of historical involvement and the normative question of whether a particular consequence of breach should be judged to be within the scope of liability for the breach'.

18 [1969] 1 QB 428.

19 See *Bonnington Castings Ltd v Wardlaw* [1956] AC 613, *McGhee v National Coal Board* [1973] 1 WLR 1 and *Fairchild v Glenhaven Funeral Services* [2002] UKHL 22 instances where there was an evidentiary gap.

20 [2002] UKHL 22.

21 Mesothelioma is triggered by a single incident of exposure and by the inhalation or ingestion of a single fibre.

22 Supra n 20. Lord Bingham observed at [33], 'there is a strong policy argument in favour of compensating those who have suffered grave harm, at the expense of their employers who owed them a duty to protect them against that very harm and failed to do so, when the harm can only have been caused by breach of that duty and when science does not permit the victim accurately to attribute, as between several employers, the precise responsibility for the harm'.

23 Test for remoteness of damage as set out in The Wagon Mound *Overseas Tankship (UK) Ltd v Miller Steamship Pty Ltd* [1966] 2 All ER 709, [1967] 1 AC 617.

24 South Australia Asset Management Corp v York Montague [1997] AC191 (commonly known as 'SAAMCO').

defendant's act wrongful is the fact that it creates unreasonable risks, … and liability is imposed only where the consequence in question was the materialisation of one of the risks that made the defendant's conduct wrongful in the first place'.[25] An outcome that is merely coincidental would not be sufficient to attract liability – although, as argued by Turton, it is difficult to identify what will constitute a coincidental outcome to negate liability and there is a lack of clarity as to what is meant by 'coincidence'.[26] This stage of the causation enquiry has an inherent policy dimension as a decision must be taken as to how far liability *should* extend.[27]

We will now consider causation in the context of a failure to warn.

Causation: the special case of failure to warn

Usually in a risk disclosure claim the focus is exclusively on factual causation, the courts formulating the question as to what a person in the claimant's position would have done had the risk been disclosed: put simply, a 'would they or wouldn't they' approach. In this jurisdiction the courts have adopted a subjective test for causation: what would the claimant herself have chosen to do had the risk been disclosed, the *particular patient* test.[28] This contrasts with an objective test that asks what a *reasonable patient* in the claimant's position would have done, an approach favoured by the Canadian Supreme Court in an attempt to counteract the risk of self-serving evidence from patients giving evidence with the benefit of hindsight.[29] The objective test can be criticised for its failure to consider the individual patient, for if the success of the claimant action is wholly dependent on what a reasonable patient would have done this precludes a claimant refusing treatment for reasons that are considered irrational or for no reason at all. In *Smith v Barking, Havering and Brentwood Health Authority* the defendant failed to disclose to the claimant the risk that she would be immediately and permanently tetraplegic following an operation on her spinal cord.[30] Finding the defendant to have breached their duty in failing to inform the claimant of the risk, the court then addressed what was correct approach to the issue of factual causation.[31] Hutchinson J stated the question was whether this particular patient if she had been made aware of the risk would have decided to undergo the operation. He favoured a subjective test but elected to evaluate the evidence on an objective basis, contending that everything pointed to the claimant acting as a reasonable patient and consenting to the operation if she had been properly informed.[32] Hutchinson J observed that there was

25 T Clark and D Nolan, 'A Critique of Chester v Afshar' (2014) 34(4) OJLS 659, 664.

26 See G Turton 'Informed Consent to Medical Treatment Post-Montgomery: Causation and Coincidence' (2018) Med L Rev 27(1) 108, 121. Turton argues 'inconsistency in the use of the notion of coincidence is accompanied in general by a failure to define what is meant by the term 'coincidence'.

27 *Supra* n 17, at 437 Stapleton notes 'the *normative* concerns that influence courts' decisions on scope are … ones on which reasonable minds might differ for a variety of moral as well as policy reasons'.

28 Although in *Hills v Potter* [1984] 1 WLR 641 Hirst J held that the claimant's action failed whether the test was objective or subjective.

29 See for example *Reibl v Hughes* (1980) 114 DLR. (3d) 1; [1980] 2 SCR 880.

30 [1994] 5 Med LR 285. The claimant when aged nine, had undergone a successful operation to drain a cyst on her spinal cord but some nine years later she began to experience symptoms of paralysis and was advised by her surgeon, Mr Fairburn (who died before the trial) to have further surgery in an attempt to alleviate her symptoms. Mr Fairburn however failed to inform the claimant that (1) if nothing was done she was likely to be tetraplegic within nine months; and (2) that if the operation was performed this may delay the onset of paralysis for some years but there was a "real risk" that the paralysis would be immediate.

31 *Ibid* at [298].

32 *Ibid*.

a danger in considering the evidence of the claimant given in the witness box 'in a wholly artificial situation'.[33] Only if there were additional factors to substantiate the claimant's position,[34] would the court accept that the claimant had good reason for not following the reasonable patient approach.[35] In *Smith* Hutchinson J found nothing to differentiate the claimant from the ordinary reasonable patient. The claimant's own assertion that she would have refused the surgery in the knowledge that the success of her case depended on it therefore carried very little weight.

In a '*what if*' situation in a risk disclosure case factual causation may be more speculative as the claimant is unlikely to have a track record of provable statements about what they would do had they been in possession of all the facts. However, whether the factual causation test is subjective or objective, the courts will test the credibility of the claimant's evidence, and if the hypothetical reasonable patient would have accepted the treatment then this may cast doubt on a claimant who maintains they would have acted differently. In *Smith*, it was likely that the claimant would have run the risk knowing that it was her only hope of avoiding an inevitable paralysis, other situations however may not be as clear-cut.

Smith's importance is perhaps now only as an illustration of the court's approach to factual causation pre-*Montgomery* jurisprudence. Any dispute regarding causation was at the factual causation stage; disputes regarding legal causation did not arise. That is until the decision in *Chester v Afshar*.

Chester v Afshar: a causation solution for a special causation problem

Carole Chester suffered recurrent back pain for a number of years and had tried a number of treatments with mixed success. As a last resort, she agreed to elective back surgery. The surgery was performed without negligence but the claimant succumbed to an inherent risk in the surgery, a 1–2 per cent risk of cauda equina syndrome, leaving her partially paralysed. Mr Afshar was found to have breached his duty of care by failing to warn her of the risk. However, Carole Chester then presented a causation dilemma. Her argument was not:

(i) that had she been warned of the risk she would never have had the operation; or
(ii) that she would have searched for another surgeon to perform the operation (so creating a different set of circumstances).[36]

33 *Ibid*.
34 *Ibid*. Hutchinson J gives examples of religious convictions or particular social or domestic considerations.
35 *Supra* n 29.
36 In *Chester* all of their Lordships (with the exception of Lord Hoffman) referred to the Australian case of *Chappel v Hart* (1998) 195 CLR 232; [1998] 9 WLUK 26. *Chappel* is factually similar to *Chester* – Mrs Hart's surgery was elective (in this instance on the oesophagus) and was performed competently. Like Carole Chester, Mrs Hart succumbed to an inherent risk in the operation resulting in paralysis (in Mrs Hart's case the paralysis was to her vocal cord). However, unlike Carole Chester, Mrs Hart alleged that had she been informed of the risk, she would have delayed her operation in order to research and locate the most experienced surgeon to perform the procedure, thus creating a different set of circumstances and arguably reducing the risk of injury. By a majority, the High Court found for Mrs Hart on conventional causation principles. Carole Chester however could not rely on a similar argument, there was no indication she would have sought a different surgeon and she could not definitively say what course of action she would have followed had she been aware of the risk.

Carole Chester argued that if she had known of the risk of cauda equina syndrome, she would not have undergone the surgery within three days of her first consultation, and she instead would have sought advice on the alternatives. There was no finding that Carole Chester would never have had the operation had she been made aware of the risk of cauda equina syndrome.[37]

In the House of Lords, the majority found the test for factual causation satisfied; Carole Chester would not have suffered her injury *but for* the defendant's breach of duty. Lord Steyn commented, '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'.[38] Lord Hope asserted 'The "but for" test is easily satisfied … she would not have had the operation on 21 November 1994 if the warning had been given'.[39] Lord Walker, agreeing with the judgments of both Lord Steyn and Lord Hope, found 'Bare "but for" causation was 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'.[40] The fact that the injury sustained by Carole Chester was the very risk of injury of which Mr Afshar was under a duty to warn her, was also reason to find the 'but for' test satisfied.

The dissenting judgments adopted a different view and found that the claimant had not satisfied the test for factual causation. Lord Hoffman stated bluntly, the burden was on the claimant to prove that she would never have undergone the operation.[41] Dismissing the claimant's case that she need only prove she would not have had the operation on that day, Lord Hoffmann responded that the question was, 'whether one would have taken the opportunity to avoid or reduce the risk, not whether one would have changed the scenario in some irrelevant detail'.[42] Lord Bingham agreed that the but for test was not satisfied as 'Miss Chester has not established that but for the failure to warn she would not have undergone the surgery'.[43] Carole Chester had proven that she would not have consented to the surgery when she did if she had been aware of the risk. However, Lord Bingham opined that the timing of the operation was irrelevant to the injury she suffered.[44]

Although perhaps some of the arguments of the minority are persuasive, as Miss Chester had failed to establish that she would never have had the operation and thus

37 *Supra* n 1 at [7].
38 *Ibid* at [19].
39 *Ibid* at [81].
40 *Ibid* at [94]. In his deliberations on factual causation Lord Walker considered it important that Carole Chester had sustained the very injury which Mr Afshar had neglected to warn her of and not some 'wholly unforeseeable accident of anaesthesia' or an injury that could be 'described as coincidental'. He referred to the example of passenger of a speeding taxi cab who was injured when a falling tree hit the cab. Lord Walker opined that this was an example of 'sheer coincidence'. Whether Miss Chester's injury is labelled as a coincidence appears wholly dependent on whether we consider the risk would have been the same whenever she had the operation a point on which the House of Lords took very differing views. For further discussion on the concept of coincidence see *supra* n 26, G Turton, 'Informed Consent to Medical Treatment Post-Montgomery: Causation and Coincidence' (2018) Med Law Rev 27(1) 108.
41 *Ibid* at [29].
42 *Ibid* at [31].
43 *Ibid* at [8].
44 *Ibid* at [9] per Lord Bingham, 'But the timing of the operation is irrelevant to the injury she suffered, for which she claims to be compensated. That injury would have been as liable to occur whenever the surgery was performed and whoever performed it'.

she could be exposed to the risk of injury at a later date,[45] in reality *Chester* is simply a very ordinary application of but for causation. *But for* the non-disclosure of risk Miss Chester would not have had the operation on *that* day. The court accepted that had Carole Chester been informed of the risk she would not have had the surgery at that time; she would have taken further advice. Whether the risk would have materialised on a different day is an entirely different question and it should not detract from acknowledging that Carole Chester's injury was intrinsically linked to the failure of Mr Afshar to disclose the risk. The risk of cauda equina syndrome occurring was in the region of 1–2 per cent; this made it extremely unlikely that the risk would also have occurred on a different day if the risk was as random as spinning a roulette wheel as Lord Hoffman contended.[46] Mr Afshar was not to blame for the cauda equina syndrome, as the operation was performed with reasonable care and skill, but he was at fault for Carole Chester being on the operating table three days after her consultation.[47]

The court then entered uncharted territory in a risk disclosure case and had to address the test for legal causation. It is worth reiterating that in a risk disclosure claim once factual causation is established the court must then be satisfied that the risk that materialised would have been avoided in the absence of the defendant's breach of duty. Carole Chester presented a unique problem. She could not unequivocally state that she would never have undergone the operation and consequently avoided the risk. Lord Bingham, who had previously found the test for factual causation not met,[48] opined that to find for a claimant who had not established that the defendant's breach had caused her any injury would be a step too far and would be 'a substantial and unjustified departure from sound and established principle'.[49] Lord Hoffmann contended that Carole Chester had failed to prove the non-disclosure had caused her any loss, as she would have been exposed to precisely the same risk in any event, albeit on a different day.[50] In short, the minority in *Chester* maintained that Miss Chester's risk of injury was unaffected by the negligent non-disclosure.

The minority then considered whether Miss Chester might still be entitled to compensation even though she had, in their view, failed to prove the non-disclosure was a cause of her loss. Lord Bingham acknowledged that Carole Chester's right to be informed had been violated but contended that this alone was insufficient reason to award damages when 'violation of that right is not shown to have worsened the physical condition of the claimant.'[51] For Lord Bingham there could be no compensation for 'damage not caused by

45 See M Hogg 'Duties of Care, Causation, and the Implications of *Chester v Afshar*' (2005) 9 Edin L Rev 156, 163 who also contends that, 'None of the classic common law formulations of factual causation (whether but for, material contribution, or material increase in risk) give us a satisfactory answer in this [*Chester*] case'. (163). For a different view see T Clark and D Nolan 'A Critique of Chester v Afshar' (2014) OJLS 34(4) 659 and J O'Sullivan 'Causation and non-disclosure of medical risks – reflections on Chester v Afshar' (2003) PN 19(2) 370.

46 Following up Lord Hoffman's roulette analogy T Clark and D Nolan *ibid*, at [662] comment on the likelihood of the risk of cauda equina syndrome occurring on a different day and observe that, 'the fact that a six comes up when you throw a die does not make it any more likely that you would have thrown a six had you waited and thrown the die later on'.

47 [2002] EWCA Civ 724, at 44. As Sir Denis Henry observed Miss Chester's injury was a, 'consequence about which the claimant had expressed her concern to the doctor and had been wrongly reassured'.

48 *Supra* n 1 at [8].

49 *Ibid* at [9].

50 *Ibid* at [31].

51 *Ibid* at [9].

the negligence complained of.'[52] Lord Hoffmann emphasised that the claimant had failed to prove that the non-disclosure had caused her any loss and then, like Lord Bingham, speculated whether a 'special rule should be created by which doctors who fail to warn patients of risks should be made insurers against those risks'.[53] Such an award may be appropriate to 'vindicate a violation of a patient's right to choose'.[54] However, he surmised that the difficulties in calculating a figure together with the costs of litigation precluded a conventional award.[55] Lord Hoffmann was also unmoved by any moral argument of making a doctor an insurer of the risk.[56]

The majority, having already found factual causation to have been established, were not so reticent in seeking a solution to a case that could not neatly be accommodated within conventional legal causation principles. Lord Steyn argued that, **'**a narrow and modest departure from traditional causation principles' was justified and 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'.[57] Lord Hope boldly declared that 'justice requires Miss Chester be afforded the remedy 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'.[58] Lord Walker emphasised the significance of the duty breached before he concluded Carole Chester 'ought not to be without a remedy, even if it involves some extension of existing principle … Otherwise the surgeon's important duty would in many cases be drained of its content'.[59] The majority were in unison that the violation of Carole Chester's dignity and autonomy was a wrong that the law should compensate. To follow conventional causation principles would, in the words of Lord Hope, 'discriminate against those who cannot honestly say that they would have declined the operation once and for all if they had been warned'. Such a result would, in Lord Hope's view, be 'unacceptable'.[60] Lords Steyn and Walker were similarly minded.[61]

The rights and wrongs of this decision have attracted intense academic scrutiny.[62] Much of the debate has centred on whether *Chester* offered a solution or even an alternative to difficulties with the conventional approach to legal causation. Carole Chester established that but for the non-disclosure she would not have been operated on that day (factual causation) *but* she agreed that she may have exposed herself to the risk of cauda equina syndrome at a later date.[63] This posed a problem for the conventional legal causation test where recovery is permitted only if the risk that materialised was increased by the

52 *Ibid*.
53 *Ibid* at [32].
54 *Ibid* at [33].
55 *Ibid* at [34].
56 *Ibid* at [35].
57 *Ibid* at [24].
58 *Ibid* at [88].
59 *Ibid* at [101].
60 *Ibid* at [87].
61 *Ibid*. Lord Steyn at [24] commented 'Her right of autonomy and dignity can and ought to be vindicated by a narrow and modest departure from traditional causation principles'. At [101] Lord Walker stated, 'I agree with Lord Steyn and Lord Hope that such a claimant ought not to be without a remedy, even if it involves some extension of existing principle, as in *Fairchild v Glenhaven Funeral Services Ltd [2003] 1 AC 32* (see especially the speech of my noble and learned friend Lord Bingham of Cornhill at paras 8–13). Otherwise the surgeon's important duty would in many cases be drained of its content'.
62 *Supra* n 14. See also J Stapleton, *supra* n 17.
63 *Supra* n 1 at [7].

defendant's breach of duty. Carole Chester may still have been exposed to the same risk in any event. Clark and Nolan, commenting on legal causation and risk disclosure, argue that what makes the non-disclosure negligent 'is not the risk of the complication in question coming about *per se*, but the risk of the complication in question coming about *when the patient was unwilling to subject herself to that risk*'.[64] However, as Clark and Nolan point out, this argument was not open to Miss Chester.[65] Carole Chester was willing to run the risk; her complaint was that she had been denied an opportunity to delay it.

Stauch argues that the belief that *Chester* involved a special departure from the ordinary rules of causation was the direct consequence of the failure of the House of Lords always to distinguish clearly between factual and legal causation.[66] Stauch concludes that had their Lordships been more scrupulous in differentiating between factual and legal causation, 'it would have been clearer that no radically new principle was involved. There was merely a modest (and justifiable) relaxation of legal causation'.[67]

Chester v Afshar: the aftermath

The immediate aftermath after *Chester* was marked by the courts' misunderstanding of *Chester* and a characterisation of *Chester* as, at best, an unusual policy decision. The mood of the courts was summed up by Lady Justice Arden in *White v Paul Davidson & Taylor* who emphasised that *Chester* did not establish a general causation rule:[68]

> 'I would like to add a few observations on Mr White's supplementary written submissions in which he places reliance on the recent decision of the House of Lords in *Chester v Afshar* [2004] WLR 927. In my judgment, this case does not establish a general rule in causation. It is an application of the principle established in *Fairchild v Glenhaven Funeral Services* [2003] 1 AC 32 that, in exceptional circumstances, rules as to causation may be modified on policy grounds.'

Chester's impact seemed to be restricted to risk disclosure causation disputes. It was the flagship case of patient autonomy, *Montgomery*, that suggested causation and *Chester* were not over and done with quite yet.

Nadine Montgomery was diabetic, of small stature and pregnant with a large baby. During the course of the delivery of her baby, shoulder dystocia[69] occurred and her son was born with severe disabilities. She maintained that the defendant acted negligently in failing to inform her of a 9–10 per cent risk of shoulder dystocia associated with a vaginal birth and had she been made aware of the risk she would have opted for a caesarean section. The Supreme Court handed down a judgment that effectively brought the law

64 *Supra* n 25 at [666]–[667], emphasis added.

65 In support of their analysis Clark and Nolan rely on the decision of the High Court of Australia in *Wallace v Kam* [2013] HCA 19. See further n 127.

66 M Stauch and K Wheat, *Text, Cases and Materials on Medical Law* (Routledge, 2018) 137. See also M Stauch, 'Causation and confusion in respect of medical non-disclosure: *Chester v Afshar*' (2005) 14 Nott LJ 66.

67 *Ibid*.

68 [2005] PNLR 15, [2004] EWCA 1511, at [40].

69 Shoulder dystocia is a complication that occurs during vaginal delivery when a baby's shoulders are impacted in the mother's pelvis, often because the baby is too big to pass through the birth canal.

into line with professional and ethical guidance,[70] explicitly ruling that a doctor's duty is to ensure that a patient is aware of any material risks involved in the treatment and of any alternative or variant treatment. Lords Kerr and Reed pronounced:

> '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.'[71]

Montgomery signalled the death knell for 'doctors know best'[72] and the *Bolam*[73] era for the legal standard for disclosure. Was the *Montgomery* decision equally as momentous for causation? Adopting the accepted two-stage approach to causation, although expressing doubts as to whether Nadine Montgomery's evidence was 'affected by hindsight',[74] the court had no such reservations about the evidence of Dr McLellan, Nadine Montgomery's consultant. She was unequivocal that Mrs Montgomery would have elected to have a caesarean section if advised of the risk of shoulder dystocia associated with a vaginal delivery.[75] There was therefore no need to consider legal causation, the injury was clearly within the scope of liability. In *Montgomery* both factual and legal causation were uncontentious; it is therefore unclear why Lords Kerr and Reid then added, 'It is unnecessary in these circumstances to consider whether, if Mrs. Montgomery could not establish "but for" causation, she might nevertheless establish causation on some other basis in the light of *Chester v Afshar*.'[76]

This comment suggested the application of the *Chester* exception as an alternative to factual causation. This is, with respect, an incorrect understanding of the role of *Chester.* In *Chester* the claimant succeeded on factual causation using ordinary principles. The reality is that had Nadine Montgomery been unable to establish factual causation with reference to the but for test, she would have failed. *Chester* could not have been invoked as a special solution to a factual causation problem. If a *Chester* 'exception' exists, this applies to the legal causation stage, but the claimant must first survive the factual causation filter.[77] In *Montgomery* once factual causation was established, legal causation inevitably followed without recourse to a policy-based analysis or a special *Chester*-style solution because it was simply not required. The reference to *Chester* was misplaced, on the facts and the law.

Chester and *Montgomery* involved two very different risks, two very different scenarios, and only *Chester* presented a causation problem. Carole Chester was not informed of a 1–2 per cent risk with her spinal surgery. This risk was inherent; it could not have been avoided unless Carole Chester had decided not to undergo the operation at all. Carole Chester's surgery was elective; she had a choice whether to proceed with surgery; the failure to warn her of the risk deprived her of the opportunity to think things over, the

70 See GMC Guidance, Consent: patients and doctors making decisions together (2008), paras 28–36.
71 *Supra* n 2 at [87].
72 *Supra* n 4.
73 *Supra* n 6.
74 *Supra* n 2 at [104].
75 *Ibid*. See also the judgment of Lady Justice Hale who observed at [113], 'What could be the benefits of vaginal delivery which would outweigh avoiding the risks to both mother and child.'
76 *Ibid* at [105].
77 *Supra* n 1, at [19], [81] and [94]. In *Chester* the majority all found the factual causation test satisfied.

ability to make a different choice, a violation of her right to autonomy. Had Carole Chester been made aware of the risk she would not have consented to the operation on that day (factual causation established) but she may have exposed herself to the same risk at a late date (posing a potential problem regarding the scope of liability). Nadine Montgomery was not warned of a 9–10 per cent risk of injury to her unborn son if she proceeded with a vaginal delivery. Nadine Montgomery could have avoided the risk by opting for a caesarean section. Unlike Carole Chester, Nadine Montgomery had no choice but to expose herself to the risk of injury to herself and her unborn son; the delivery of her baby was inevitable. The failure to disclose the risk of shoulder dystocia deprived Nadine Montgomery of the opportunity to reduce the risk to her unborn child. Had Nadine Montgomery been made aware of the risk with a vaginal delivery, she would have proceeded differently (factual causation established) *and* her son would have avoided injury (the risk that materialised could have been avoided).

Chester has been overused in situations where it simply does not fit or apply.[78] Care must be taken to ensure that *Chester* is not raised in argument by the claimant to make the causation analysis in any new case more complicated than it needs to be. The claimant cannot simply invoke it whenever a causation challenge is anticipated, as *Duce v Worcestershire Acute Hospitals NHS Trust*[79] will show.

Duce v Worcestershire Acute Hospitals NHS Trust – back where we started?

Like *Chester*, *Duce*[80] was a surgical consent case and the surgery was performed competently. Unfortunately, the claimant suffered chronic post-surgical pain and alleged that the defendant had failed to warn her of this possible outcome. The trial judge found that, applying *Montgomery*, there was no duty to warn the claimant of the risk of chronic or neuropathic pain and in any event, the claimant had been warned of the risk of pain although the words '*chronic*' or '*neuropathic*' had not been specifically used. Additionally, the claimant was informed of an alternative treatment. At first instance, the court determined that the claimant would still have proceeded with the operation immediately regardless of whether or not she was warned of the risk of pain.

The claimant appealed on several grounds, though our focus is causation. The claimant contended that in risk disclosure cases, legal causation is established by satisfying the following test:

(i) The injury suffered was intimately involved with the duty to warn and the duty was owed by the doctor who performed the surgery on the patient; and

78 *Supra* n 3. In *Shaw v Kovac and University Hospitals of Leicester NHS* Trust [2017] EWCA Civ 1028. LJ Davis in his judgment noted causation was established, thus there was no need to invoke *Chester*. In *Correia v University Hospital of North Staffordshire NHS Trust* [2017] EWCA Civ 356 the claimant argued that the failure to warn her of the risks meant she did not need to establish causation in the traditional sense. It was sufficient to show the injury was within the scope of the surgeon's duty to warn. The Court of Appeal unanimously dismissed the argument. There was no evidence to justify a complaint against the consent procedure in this case. The claimant unlike Carole Chester had never argued that, had she been so warned, she would have deferred it or gone to another surgeon.

79 *Supra* n 3.

80 *Supra* n 3 at [51].

(ii) The injury was the product of the very risk that the patient should have been warned about when they gave their consent.[81]

The claimant, relying on *Chester*, argued that damages should be awarded in any situation where there is a duty to warn of a risk, the patient is not warned and the risk materialised. In other words, a denial of the patient's right to make an informed choice gives rise to a right to compensation. This claimant also implied that the *Chester* exception applied to both factual and legal causation. Previously, the trial judge had dismissed the claimant's argument on factual causation and found that even if a warning had been given she would have proceeded with surgery on the same day.[82] Relying on Lord Hope's judgment in *Chester* the claimant contended that there was no need to establish factual causation.[83] By any stretch of the imagination this was an incorrect interpretation of *Chester.* In *Chester*, the House of Lords found the but for test was clearly satisfied.[84] *Chester* is not an authority to dispense with factual causation. This is not the ratio in *Chester. Chester's* importance is with regard to legal causation *only.* Lord Justice Hamblen seized the opportunity to confirm the ratio in *Chester*. Fifteen years on from *Chester*, his words have a resonance that is long overdue. Perhaps at last he has put the genie back in the bottle. First, he poured cold water on the notion of a free-standing test: Lord Hope in *Chester* had merely set out 'the circumstances which justify the normal approach to causation being modified' nothing more.[85] Secondly, he explained that the modification in *Chester* was simply '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'.[86] In other words, although Carole Chester could establish that the failure to disclose the risk denied her chance to avoid the risk, she could not establish that she would have acted differently; on the contrary, she might have still elected to run the risk if properly informed and suffered the resultant injury.

Chester is fact specific, there is no general exception and fundamentally:

> '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.'[87]

Chester was never an authority that, in consent cases, factual causation can be dispensed with. Therefore, *Chester* was of no help to the claimant in *Duce*, since the trial judge had previously determined that, even with additional advice, the same surgery would always have taken place when it did.

The *Chester* exception is viable only when a claimant proves that with full disclosure of the risk, she would have delayed the treatment to a later time, with an identical risk

81 *Ibid*.
82 Referred to by the Court of Appeal at [28].
83 *Supra* n 3 at [50].
84 *Supra* n 1 at [7], [19] and [81].
85 *Supra*, n 3 at [84].
86 *Ibid* at [66].
87 *Ibid* at [69].

of harm.[88] *Duce* confirms that if she would have had the treatment at the same time, the claim fails. If she would never have had the treatment at all then on the conventional but for approach the claim succeeds; there is no need for recourse to *Chester*.

Chester is an ordinary case which has now run out of steam in relation to factual causation. *Duce* stands as the final nail in its coffin. *Chester* is and never was an alternative to the factual causation test. Rather, it is an example of the very application of it. Its significance (if any) lies at the legal causation stage. If a claimant falls at the factual causation stage, *Chester* cannot come to the rescue.

In the final part of this article, we summarise the arguments on the applicability of the *Chester* exception that can now be laid to rest and the issues that remain outstanding.

Factual causation: a settled outlook but with clouds on the horizon

Have we finally achieved clarity regarding factual causation in the aftermath of Chester?

Chester had been wrongly labelled as a radical case which took an unconventional approach to factual causation.[89] This misunderstanding may be, at least in part, attributable to the reference to *Fairchild*[90] in the House of Lords when in fact no such recourse to policy was required at the factual causation stage. In clinical negligence cases the factual causation stage has consistently been a necessary and accessible filter to identify factors which lack the necessary causal connection. In other areas of tort, the courts can and have invoked policy at the factual causation stage but only where there are multiple potential causal factors in play.[91] In clinical negligence however we witness a much more restrictive, more orthodox approach.[92] It would be surprising if steps were taken in future risk disclosure cases to provide a solution to problematic factual causation situations that would represent a wholesale rejection of the principles of factual causation.[93] *Chester* certainly would not provide authority to do so; the but for test was satisfied.

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88 *Crossman v St George's Healthcare NHST* [2016] EWHC 2878 is case in point although the case succeeded using conventional causation principles. At [53] the trial judge stressed that 'it is important to keep in mind the exceptional and limited nature of the extension to conventional causation principles that the majority in the House of Lords intended to make in *Chester v Afshar*'.

89 See for example R Stevens, 'An Opportunity to Reflect' (2005) 121 LQR 189; S Green, 'Coherence of Medical Negligence Cases: A Game of Doctors and Purses' (2006) 14 Med L Rev 1; and K Zoltan von Csefalvay Bartal, 'On Good Intentions and Poor Outcomes: A Critical Retrospective on Chester v Afshar' (2009) 9 UCD L Rev 46.

90 *Supra* n 20.

91 *Ibid*.

92 In *Wilsher v Essex Area. Health. Authority* [1988] A.C. 1074 a baby had been negligently given excess oxygen. The baby developed retrolental fibroplasia which led to near total blindness. The negligence however was only one of five possible causes. The House of Lords declined to apply the 'materially increased the risk' test from *McGhee*, (*supra* n 19) Lord Bridge at [1090] stating that *McGhee* had simply taken 'a robust and pragmatic approach to the undisputed primary facts'.

93 In relation to clinical negligence we see a robust, orthodox approach regarding factual causation. For instance, in *Gregg v Scott* [2005] UKHL 2. The House of Lords took a rigid approach notwithstanding the apparent unfairness of this for the claimant. The delay in referring the Mr Gregg to hospital resulted in a reduction of his chance of survival (falling from 42% to 25%). His claim failed on the basis that at the time of the breach his prospect of survival was already less than 50% In dismissing the claimant's appeal Lord Hoffman at [79] held 'There is no inherent uncertainty about what caused something to happen in the past or about whether something which happened in the past will cause something to happen in the future. Everything is determined by causality. What we lack is knowledge and the law deals with lack of knowledge by the concept of the burden of proof'.

The position regarding factual causation appears to be settled. Thus the 'acquiescent patient' who would have still taken the same path had they been told of the risks will fail to satisfy the but for test and the case of *Duce*[94] is unequivocal: the ratio of *Chester* provides no alternative solution for the patient.

The 'unsure patient' who simply says 'I don't know what I would have done' may pose greater problems in determining causation, but this is still addressed on a conventional basis. Let us suppose that a doctor was in breach of the duty of care owed to a patient due to failure to disclose an important risk associated with complex spinal surgery. At the time of the surgery the patient was suffering from severe depression and it was only once the depression had alleviated that the patient decided to pursue a claim. Now the patient finds it genuinely difficult to provide evidence as to what they would have decided at the time of the surgery. After recovering from depression the patient finds it difficult to return to that frame of mind and contemplate what decision would have been made. It is still possible for external evidence to be adduced to establish causation.[95] Indeed, in relation to the causation issue in *Montgomery*, the claimant benefited from the doctor's evidence which indicated that it was likely that a patient would opt for a caesarean section where risks associated with natural delivery were explained.[96] This is not evidence of 'manipulating' causation or invocation of policy, it is simply an alternative way to establish causation on the balance of probabilities by relying on evidence other than the claimant's own assertion of what the likely decision would have been.

So does this mean factual causation is finally settled? Perhaps there is one further issue to address.

*The particular patient: an alternative approach to the evidential standard is required post-*Montgomery

Could we see *Montgomery*, a pioneering case in respect of breach of duty, as the new platform for a fresh approach to the evidential standard applied to causation arguments? We argue that it has the potential to shake up the aspect of causation that had until now been relatively settled, namely how we test the claimant's evidence that they would have changed their behaviour if they had known of the unexplained risk or alternative procedure.

The court must determine factual causation using a subjective test to decide whether or not *this* patient would have agreed to treatment if the relevant risk or alternative procedure had been explained.[97] Factual causation has turned on whether the trial judge believed the claimant's evidence that treatment would have been declined. As we have seen in *Smith* there is an objective element to this assessment: what would the *reasonable* person in the claimant's position have done had the risk been disclosed?[98] If it appears that

94 *Supra* n 3.

95 See for example McAllister v Lewisham and North Southwark Health Authority [1994] 5 Med LR 343. Rougier J at [353] confirmed 'The fact that the plaintiff herself … is reluctant to hypothesise, should not of itself preclude a judge from the attempt, provided there exists sufficient material upon which he can properly act'.

96 *Supra* n 9.

97 *Supra* n 28.

98 *Supra* n 30 at [289]. In *Smith*, Hutchinson J referred to 'the importance of giving proper weight to an objective assessment of what a reasonable patient could be expected to decide in the light of such proper advice as should have been given'.

the reasonable person would have agreed to the procedure in any event, then the court will consider whether there are 'extraneous or additional factors' to support the claimant's assertion that treatment would have been refused.[99]

In the post *Montgomery* era of patient autonomy is an alternative approach needed? In the recent decision of *Diamond v Royal Devon & Exeter NHS Foundation Trust*[100] the Court of Appeal considered the appellant's argument that the trial judge had taken the wrong approach at the causation stage when determining how she would have behaved had she been aware of the risks associated with the planned procedure.

In *Diamond*, a patient required a hernia repair.[101] Freedman J found that the risks associated with mesh repair (should the claimant become pregnant) and an alternative to mesh repair (albeit with a higher risk of failure) should have been explained to the claimant.

The claimant argued she would not have had the mesh repair if she had been told of the risks. Despite finding the claimant to be 'a credible and truthful witness', Freedman J decided that she would still have agreed to the mesh repair even if the information regarding risks and alternatives had been provided.[102] Although acknowledging that the claimant 'genuinely believes and has convinced herself' that she would have opted for the alternative treatment, the judge noted that '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'.[103] The claimant appealed and challenged the trial judge's approach to the causation issue.

The Court of Appeal rightly noted that the but for test determines factual causation and, 'it is for the patient to prove that had he or she been warned of the risks, the patient would not have consented to treatment'.[104] The trial judge correctly identified that: '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'.[105] The appellant accepted this was the issue to be addressed, but questioned the trial judge's approach in determining the answer.

The appellant argued that post *Chester* and *Montgomery* she had the 'choice to make decisions that others, including the court, might regard as unwise, irrational or harmful to their own interests'.[106] The trial judge had decided opting for suture repair would have been irrational, that the appellant was not a person who would act irrationally and consequently she would have agreed to the mesh repair in any event. She therefore argued the trial judge had erred by applying 'a rationality approach, which represents the hypothetical rational person rather than the real person before the court' and that

99 *Ibid*.
100 *Supra* n 16.
101 The claimant had undergone spinal fusion surgery. Subsequently she was diagnosed with a post-operative incisional hernia. Surgery was performed to repair the hernia using an open mesh-based repair. The claimant contended that she should have been informed of the adverse risks associated with mesh repair, (the mesh could restrict the growth of the uterus and there could be post pregnancy complications) should she become pregnant.
102 *Diamond v Royal Devon & Exeter NHS Foundation Trust* [2017] EWHC 1495 (QB) at [45].
103 *Ibid* at [47].
104 *Supra* n 16 at [15].
105 *Ibid* per Freedman J, referred to by the Court of Appeal at [9].
106 *Supra* n 16 at [13].

'the judge's assessment of objective rationality is not a reliable basis to infer what she would have done'.[107] Lady Justice Davies however disagreed and considered the trial judge's approach had been 'detailed, nuanced and insightful' and that a *Montgomery*-compliant approach had been adopted as 'he took account of the reasonable person in the patient's position but also gave weight to the characteristics of the appellant herself.'[108]

On the facts of this particular case this may well have been the appropriate causal enquiry, ie where the breach can be established because the reasonable person in the patient's position would have wanted the information, then it may be acceptable for the causation test to be similarly aligned. We can question though whether giving 'weight to the characteristics of the appellant herself'[109] will always suffice. Will there be occasions which demand an exclusively subjective approach without reference to the reasonable person?

When considering the 'test of materiality' Davies LJ stated that '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'.[110] Yet this comment appears to result in a fusion of the reasonable person in the patient's position and the particular patient. In stark contrast, *Montgomery* identified the two '*patients*' as distinct personalities.[111]

In the *Montgomery* judgment, the notion of the particular patient, (patient X), appears as an alternate route to establish breach of duty where breach may not be established on a 'reasonable patient' basis. There may be something unique about X, which obliges a doctor to disclose information about risks that may have not been provided to the reasonable patient (Y). *Montgomery* confirmed that a risk was material and should be disclosed where:

> '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.'[112]

This alternative identified in the *Montgomery* test is important. It is inherent in *Montgomery* that there is an understanding the particular patient may have wanted information that a reasonable person in the patient's position would not. This crucial distinction was not made clear by the Court of Appeal in *Diamond*.

Following *Montgomery*, if the doctor does not comply with the duty and disclose the material risk that patient X would want to know, then the court still needs to assess how patient X would have behaved had he/she been provided with the information. Patient X must establish the causal link between the failure to warn and the damage sustained. Bear in mind the hypothetical reasonable person in the patient's position (reasonable patient Y) may well not have been *entitled* to the information in the first place because it would not have been significant to them; it is patient X's special status as the *particular patient* which resulted in the need for disclosure.

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107 *Ibid* at [19].
108 *Ibid* at [22].
109 *Ibid*.
110 *Ibid* at [20].
111 *Supra* n 2 at [87].
112 *Ibid* [emphasis added].

The but for test should be constructed accordingly and a purely subjective approach should be taken when 'testing' the claimant's evidence to determine *what would the particular patient X have done on the balance of probabilities?* There is an inherent risk of self-serving evidence, but it is the function of the court to test and evaluate this evidence. Indeed, particular patient X's evidence is more likely to be convincing if there was something unique about them that meant information should have been disclosed on a particular patient basis because it was clearly important to patient X. If it *is* so important, it is more likely than not that patient X would have acted on it. The particular patient in *Montgomery* is not the objectively reasonable patient, so why should the evidence of particular patient X be tested against the 'reasonable patient' at causation? Where breach is established on a particular patient basis (where it could not be established on a reasonable patient basis) surely it is counter-intuitive to revert to the objective reasonable patient standard at the causation stage to 'test' the particular patient's evidence. If the information is important to patient X, then patient X is entitled to have it *and* should be entitled to do with it whatever patient X wants.

Critics who advocate that the status quo should be maintained may argue that removal of the need to consider, at least initially, the claimant's evidence against the objective 'reasonable patient', would eliminate a key method to assess credibility and result in simple acceptance of self-serving evidence. Yet the claimant's evidence can be tested without the objective 'reasonable patient' comparator. Evidence of the patient's own consistency of approach and whether past decision-making was indicative of a particular or likely cautious approach should have to be considered at this stage in framing the approach to the causation question. Indeed, such evidence may already have been adduced in relation to breach, since if a patient had behaved very cautiously in the past this would be a factor raised in evidence to establish that this particular patient would have wanted information on this occasion.

Critics may also point out that the additional subjective element when testing the claimant's evidence should allay any concerns regarding the initial objective test. If the reasonable patient would have agreed to the procedure the court will then consider 'extraneous or additional factors'[113] or, as stated by the Court of Appeal in *Diamond*, the court will give 'weight to the characteristics' of the patient to test the patient's assertion they would have refused.[114] However, it can be argued that the subjective approach should be the primary consideration and not simply be employed as a possible rescue bid when the claimant potentially falls at the objective hurdle. It would be helpful if there were clarity as to what 'weight' will be given to the patient's characteristics, as those should surely dominate the assessment in relation to this causation issue when we are considering the particular patient.

In the wake of *Montgomery*, we cannot allow the particular patient the information they seek then expect them to behave as a reasonable person with that information and question their evidence where they insist they would have reached a different decision

113 *Supra* n 30.
114 *Supra* n 108.

compared to the reasonable person armed with that information. For example, it may be that a risk averse patient would have chosen to avoid a risk that a reasonable person in the claimant's position would have willingly taken. To impose an inappropriate hurdle when testing the claimant's evidence at the causation stage would then make the *Montgomery* obligations regarding risk disclosure the 'hollow duty' that the House of Lords in *Chester*[115] were so keen to avoid.

The courts, in their assessment of the evidence, have previously considered extraneous factors in assessing how the claimant would have acted had he/she been aware of the risks. In *Webster v Burton Hospitals NHSFT*,[116] a case factually similar to *Montgomery*, the evidence clearly indicated that the claimant would have opted for an induction of her labour if she had been aware of the risks of continuing with her pregnancy beyond her due date. Simon LJ referred to the findings of Inglis J at first instance who opined:

> 'I think that had the mother been advised that she should proceed to induction or that there were increased risks in waiting until 6 or 7 January, she would have wanted to be delivered. I think she was fed up with the pregnancy and with the lack of well-being and it was the due date that she had in mind. She would not have wanted it to be put off, since the prospect of induction was looming in any event'.[117]

Webster is an example of a reasonable patient, a patient shown from previous actions to be unwilling to run an unnecessary risk. In *Less v Hussain* the High Court found that although the defendant had breached her duty of care in failing to advise the claimant of the risks of a further pregnancy, the claimant would have still have fallen pregnant even if properly advised.[118] Cotter J noted the claimant was a 'stoic and strong willed individual'.[119] She had embarked on a second pregnancy in spite of suffering from severe morning sickness during her first pregnancy and she had seriously contemplated a further pregnancy following a stillbirth. Post-*Montgomery*, *Less* should perhaps now be viewed as an example of the 'particular patient',[120] a claimant who is resolute, unwavering in her approach, perhaps coming to a decision which 'no one in their right mind' would have made. In *Jones v North West SHA*,[121] the claimant, like Nadine Montgomery, also alleged that if she had been made aware of the risk of shoulder dystocia she would not have proceeded with a vaginal delivery for the birth of her son. The claimant's religious convictions however were sufficient for the court to find that she would not have elected

115 *Supra* n 1 at [87].

116 [2017] EWCA Civ 62. Sebastian Webster was born with cerebral palsy. It was accepted that his injuries would have been avoided if he had been delivered earlier. On appeal the court held that the claimant would have elected for a caesarean section had she been informed of the risks. Simon Brown LJ relied on the fact that the claimant had a degree in nursing, that previously she had demonstrated a willingness to take responsibility for her pregnancy and in her evidence she had expressly stated that if there had been 'any suggestion of risk I would have wanted him delivered' at [41].

117 *Ibid* at [20].

118 [2012] EWHC 3513.

119 *Ibid* at [141].

120 *Ibid* at [141], [149] and [150]. At [153] Cotter J opined that 'even if the consultant had, after properly setting out the risks, sought to actively discourage Ms Less from trying to conceive with the reasoning advanced that she already had been blessed with two children, that this would not have stopped her'.

121 [2010] EWHC 178.

for a caesarean section had the risks been disclosed.[122] The court noted that in 1992 for the claimant to have elected for a caesarean section 'would mean that she was one of those unusual patients who would not have followed her doctor's advice as to the manner in which she should give birth'.[123] With the advent of *Montgomery*, Mrs Jones would not now be labelled unusual, but simply an example of a particular patient. We are now done with the patient who is categorised as 'mainstream.'[124]

Webster, *Less* and *Jones* are three instances of the courts drawing on the evidence of past behaviour of a claimant and then assessing what route each would have followed had they been fully informed of the risks. If the courts can do this, then the courts can also evaluate if our particular patient X would have deviated from what the reasonable patient Y would have done *and* that X's course of conduct was reasonable and nothing more than expected.

Legal causation: pushing boundaries and brewing storms

Causation consists of two stages, factual causation and legal causation. Our attention here has largely concentrated on factual causation arguments. The *Chester* exception, however, applies *only* at the legal causation stage. We close with a brief deliberation on the possible development of legal causation arguments in light of this.

Although *Chester* does indeed offer some flexibility in relation to legal causation, this should cause less disquiet in the light of the inherent policy dimension of the legal causation stage. The risk about which the claimant should have been warned was the very risk which materialised. The approach taken in *Chester* is not entirely inconsistent with the normal application of remoteness and policy. We can envisage situations where it would have been a step too far for remoteness to succeed and legal causation would have been rejected on an entirely conventional basis.[125] Perhaps *Chester* offers limited scope for application into other remoteness conundrums when in unfamiliar territory.

In terms of the application of *Chester*, we do not yet seem to have encountered a case which has benefited from its possible legal causation flexibility (once factual causation has been established).

What if there was a materialisation of a different risk? What if a patient X were to establish that her doctor was negligent for failing to warn her of a risk of a complication associated with the medication she was taking? Fortunately for patient X, the said risk does not materialise, but unfortunately she suffers injury due to a different risk, a risk which the doctor is not negligent for failing to disclose. Knowledge of the risk that her doctor should have disclosed would have made no difference to patient X; she will still suffer injury due to a different risk.

Her claim will fail. In *Chester* it was made clear that it was significant that it was the risk about which she should have been warned that materialised.

122 *Ibid* at [66]. Her evidence indicated that the claimant had an antipathy to her newly born son receiving blood products. Although she argued that she was a non-practising Jehovah's Witness, the court found she would not have consented to a caesarean procedure with 'its added risk of bleeding and the possible need for a transfusion'.

123 *Ibid* at [67]. The claimant had stated in evidence that, 'she put her trust in the doctor. They did lots of caesareans'.

124 *Ibid* at [66].

125 *Supra* n 47 at [43]. Consider, for instance the examples given by the Court of Appeal in Chester v Afshar at [43], 'the defendant is not liable for coincidences which have nothing to do with him, such as the anaesthetic failure referred to by Gummow J or lightning striking the operating theatre'.

We can perhaps gain an insight as to how the court might approach this issue from the wrongful birth case *Khan* v *Meadows.*[126] The claimant had consulted her GP as she was concerned that she may be a carrier of haemophilia. Blood tests were performed; however, those tests could only detect whether the claimant herself had haemophilia, not whether she was a carrier. Falsely reassured that the results of the tests were normal and that any child she conceived would be free from haemophilia, the claimant became pregnant and gave birth to a son, Adejuwon, who was diagnosed as having haemophilia. If the claimant had known that she was a carrier of haemophilia before she became pregnant, she would have undergone foetal testing, which would have revealed that her foetus was affected, and she would have terminated her pregnancy. Therefore, but for the negligence, Adejuwon would never have been born. Adejuwon had also developed autism which was unrelated to his haemophilia. The claimant sought damages in relation to his haemophilia and autism. The defendant admitted negligence in failing to warn the claimant of the risk of haemophilia, but denied liability for the costs associated with Adejuwon's autism. It was clear that but for the defendant's negligence, Adejuwon would not have been born. Factual causation was therefore established. However, the defendant's duty was to provide information in relation to the risks of haemophilia *only*, not the risk of autism. Additionally, the defendant's breach of duty had not increased the risk of autism, this risk was inherent. The Court of Appeal held that a mother who consults a doctor in order to avoid the birth of a child with one disability could not recover damages for the costs associated with a different disability. Distinguishing the claimant's action from *Chester* Lady Justice Davies observed:

> 'Central to the reasoning in *Chester v Afshar* was the fact that the misfortune which befell the claimant was the very misfortune that the defendant had a duty to warn against. A fundamental distinction with the facts of this case … In the context of this case, the development of autism was a coincidental injury and not one within the scope of the appellant's duty'.[127]

The Appeal Court emphasised that in *Chester*, policy was invoked because the risk which materialised was within the scope of the duty to warn, the risk was caused by the breach of that duty and therefore on policy grounds the legal causation test was met. In *Meadows*, the defendant's duty was to give advice relating to the haemophilia, not to give advice generally about the risks of pregnancy or more specifically autism. In *Chester* the injury suffered was the very injury about which the surgeon owed a duty to warn. In *Meadows* there was no duty to warn of the risk of autism, therefore there was no causal link between the duty and the loss.

Meadows demonstrates that if the courts should invoke policy at the legal causation stage, then the claimant's injury must be intimately connected to the breach – that is, the injury must be a consequence of a risk that the claimant would not have accepted had she been made aware. This approach is consistent with that taken by the Australian High Court

126 [2019] EWCA Civ 152.
127 *Ibid* at [30].

decision in *Wallace v Kam*.[128] In *Meadows* the general risks associated with pregnancy and more specifically autism were wholly distinct from the risk of haemophilia. In *Wallace* the risk of nerve damage to the thigh caused by the patient needing to lie stationary for a protracted period of time was wholly unrelated to the more serious one-in-twenty risk of paralysis. *Khan* and *Wallace* perhaps can be distinguished on the basis that in *Khan* the defendant was not under a duty to disclose the risk (autism) that materialised; in *Wallace* the defendant was in breach for failing to disclose the lesser risk that materialised and the more serious risk that did not occur.[129] However, in both cases the two risks were separate and distinct and the claimant would have had a different response to each risk had he/she been aware of that risk.[130] More significantly, it is evident that there can be no compensation for the materialisation of a risk that in all likelihood the claimant would have accepted.

Therefore, will the courts be inclined to apply policy in relation to an associated coincidental risk? The definition of what is a coincidental risk and how it affects the causal enquiry is problematic. As Turton notes, the notion of coincidence can be used both to deny and establish causation.[131] There is no better illustration of this than *Chester* itself. In *Chester* the minority considered that the risk remained constant whenever the operation took place and it was a mere coincidence that it materialised when it did; the majority held that the risk that materialised could not be labelled coincidental as it was the very risk of which the claimant should have been warned.[132] Clark and Nolan argue that what makes damage non-coincidental in a negligent non-disclosure claim is that the risk occurred when the 'patient was unwilling to subject herself to that risk'.[133] They contend that as Carole Chester was willing to run the risk of cauda equina syndrome (albeit on a different day), the injury which befell her was a mere coincidence and the non-disclosure could not be regarded as a cause of her injury. Although agreeing with Clark and Nolan that the damage in *Chester* was coincidental, Turton argues that the correct question is framed in probability: does the 'non-disclosure affect the degree of risk to which the patient is exposed?'[134] As Carole Chester would have exposed herself to the identical risk

128 *Supra* 65. In *Wallace v Kam* (2013) 250 CLR 73 the claimant, like Miss Chester also had a history of back pain. He agreed to undergo lumbar fusion surgery which carried with it two inherent risks. The defendant failed to inform *Wallace* of either risk and he succumbed to the lesser of the two risks. It was not claimed that the operation was performed negligently, the claimant's case was solely that the negligent failure to disclose the risks had caused him injury. Although accepting that the defendant was in breach of his duty to disclose the risk, the High Court concluded the claimant had not established causation. Had a warning of the risk which eventuated been given, the High Court considered the claimant would have proceeded with the surgery even though he would have declined the surgery if he had been made aware of the second more serious risk. The Court concluded that the *Wallace* 'should not be compensated for the materialisation of a risk he would have been prepared to accept'. See also Carver and Smith, Medical Negligence, Causation and Liability for Non-Disclosure of Risk: A Post Wallace Framework and Critique 37 UNSWLJ 972, 1019 (2014) who conclude that '*Wallace* reflects a policy choice that, in failure to warn cases, liability ought only to attach to physical injury the risk of which was unacceptable to the patient'.

129 However, in both cases it is evident that there can be no compensation for the materialisation of a risk that in all likelihood the claimant would have accepted.

130 *Khan* and *Wallace* can be distinguished from *Moyes v Lothian Health Board* [1990] 1 Med LR 463 where the claimant was allowed to recover for harm caused due to the materialisation of risks peculiar to the particular patient which were not disclosed. In this instance, the risks were cumulative and the claimant would have declined treatment had they been aware of the total risk.

131 *Supra* n 26.

132 *Supra* n 1 at [9] and [94].

133 *Supra* n 25.

134 *Supra* n 26 at [126].

on a different day, the materialisation of the risk on any particular day was coincidental as it was unaffected by the non-disclosure.[135] How the courts approach coincidental risk will wholly depend on whether the courts depart from the general principles of the scope of liability, which is, as Turton observes, 'not simply concerned with the vindication of rights'.[136] Like Turton, we would endorse a more mathematical approach to coincidental risk: was the risk that materialised a consequence of the non-disclosure or was it a discrete risk, an occurrence that may be more properly labelled independent or unaltered by the failure to warn? The role of causation is about the attribution of responsibility, nothing more. However, deference to patient autonomy resulted in the rejection of the *Bolam* test in *Montgomery*. Autonomy is now centre stage. There is perhaps a dawning realisation that the courts' new commitment to supporting autonomy may lead to unexpected or even undesirable outcomes in a departure from traditional causation rules and that perhaps in the right circumstances, an exception will be made. What those circumstances are remains to be clearly and coherently mapped by the courts.

Conclusion

Given the increased focus on patient autonomy and the more patient-friendly inquiry at the breach of duty stage post-*Montgomery*, it is likely that the courts will face more causation conundrums. In relation to factual causation, it appears that the furore in the aftermath of *Chester* has abated. The claimant in *Chester* was able to satisfy the but for test, thus the decision of the House of Lords in that case does not provide authority to dispense with this test where a claimant struggles with factual causation, as confirmed by subsequent case law.

The only outstanding issue appears to be how a claimant's evidence should be assessed when determining factual causation. On this point, it is the case of *Montgomery* rather than *Chester* which will be significant. Although the but for test itself is addressed subjectively, a claimant's witness evidence is first subjected to an objective assessment and compared to what a reasonable patient would have decided had he/she known about the relevant risk. It is only when it is established that the reasonable patient would have agreed to the procedure that the court will then consider extraneous factors. Post *Montgomery*, this initial objective assessment to assess the claimant's witness evidence should no longer be the inevitable starting point. Where, for instance, the need for disclosure arises due to the characteristics of the 'particular patient', then such a case would demand an exclusively subjective approach and the claimant's evidence should be tested without reference to the objective standard.

With regard to legal causation we have identified two ends of the spectrum of liability. *Chester* presented a relatively easy legal causation challenge. The very risk that materialised was the risk in respect of which the defendant was in breach of duty for non-disclosure. In contrast, in *Meadows* the risk that occurred was not within the scope of the defendant's duty to warn. The risk of autism was an entirely discrete risk, unconnected to the risk of haemophilia and an injury that the courts were not prepared to compensate. In the future, we envisage that the courts may be required to wrestle with cases that are not as straightforward, facts that fall somewhere between these two end points.

135 *Ibid*.
136 *Ibid* at [133].

Potentially, the English courts may adopt a more stringent approach to legal causation now that the breach of duty inquiry is more patient-friendly. Much will depend however on how the courts view the role of legal causation and what they ultimately determine should be the function of legal causation. Should legal causation simply be a necessary step for the claimant to establish in proving the avoidance of physical harm (the preferred option in for example *Wallace*), or, with the focus on patients' rights post-*Montgomery*, does legal causation have a new role to safeguard such rights, with the protection of autonomy the ultimate trump card? In *Chester* Lord Hope said:

> 'The function of the law is to enable rights to be vindicated and to provide remedies when duties have been breached.'[137]

With respect, we would suggest that is the overall aim of the law, but not the function of legal causation. Legal causation has always been about attributing responsibility for harm, connecting the breach to the physical injury and determining the scope of liability. Autonomy is a right which requires protection, but that is not the purpose of legal causation. There is a real danger in a rights-based approach to legal causation which could potentially open Pandora's box. What other rights could be judged deserving of a remedy in the absence of foreseeability of harm? Would we simply be replacing disputes about the scope of liability with disagreements over a hierarchy of rights? The new era of patient autonomy is welcome and long overdue but we must not forget that only those who are responsible for harm should be targeted.

137 *Supra* n 1 at [87].