**IN THE SUPREME COURT OF THE UNITED KINGDOM**
**ON APPEAL FROM THE COURT OF APPEAL (CIVIL DIVISION)**

**B E T W E E N:**

**THE MIDDLE ENGLAND UNIVERSITY HOSPITAL NHS TRUST**

**Appellant**

**v**

**ANTON BANKS**

**Respondent**

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# SKELETON ARGUMENT ON BEHALF OF THE APPELLANT

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## Introduction

1. This appeal arises out of a Court of Appeal decision to overturn a first instance judgment of Holding J which had dismissed Anton Banks' (**"Mr Banks"**) claim in negligence against the Middle England University Hospital NHS Trust (**"the Trust"**).

2. Mr Banks was engaged to be married, with a wedding date set for the Summer of 2018. He had a long standing concern about the appearance of his nose. He was self-conscious about it appearing misaligned, and in recent years his breathing quality (and consequently, his quality of sleep) has been drastically affected. He was also concerned that his fiancé was affected by his breathing difficulties at night, and this was putting a strain on his relationship which was causing him to feel very low and affecting his ability to concentrate at work.

3. Mr Bank's GP, Dr Larry Grayson, had informed him that he had developed severe Obstructive Sleep Apnoea, and had indicated that this problem would worsen without surgical intervention.

4. After a referral from his GP, Mr Banks saw Dr Paula Carlos (**"Dr Carlos"**), a Consultant Plastic Surgeon at the Trust's hospital, for a ten minute consultation. During the consultation, Anton informed Dr Carlos of his desire to improve his appearance, his breathing quality, and his sleep, and explained that the pressure of his impending wedding and his worsening symptoms had prompted him to consider surgery. Dr Carlos proposed a combination of rhinoplasty and septoplasty. She also advised Anton that there were risks involved with the procedure, including risks of bleeding, scarring, pain and discomfort following surgery, possible dissatisfaction with the appearance of the nose, infection, and poor wound healing. At the end of the consultation, Dr Carlos asked Anton if he had any further questions; however, being mindful of the time, Anton said that he was happy to go ahead. Dr Carlos asked Anton to sign a pre-prepared form listing these standard risks of surgery, which he did, and she also gave him a leaflet to take home, telling him that this contained some further information. Anton glanced at the leaflet, but had been largely reassured by the consultation with Dr Carlos. The leaflet contained a more detailed list of risks than Dr Carlos mentioned in the consultation, including a very small, (in the region of 1-2%, even where surgery is not performed negligently) risk of septal perforation, which can affect the aesthetic appearance of the nose, and which may require further surgery or may sometimes be impossible to repair.

5. On 10th September 2017, Mr Banks underwent surgery carried out by Dr Carlos. Mr Banks was not happy with the appearance of his nose, which was not as straight as he had hoped. On examination, Dr Carlos informed him that there was a small perforation to the septum. She explained that it was possible that the hole would grow with time, requiring further surgery, and that the appearance of his nose might always be affected if revision surgery was unsuccessful. Dr Carlos advised Anton that it would be best to wait 3-6 months before deciding whether this was necessary.

6. In light of the potential need for further surgery, Mr Banks postponed his wedding. He is still with his fiancé, but their future together is uncertain.

7. Mr Banks brought a claim in negligence against the Trust, claiming damages in respect of the need for an additional procedure, pain and suffering, the financial losses

from having to postpone his wedding, and the emotional distress that the negligent procedure has caused.

8. At first instance, Mr Banks alleged that:

    a. His perforated septum was caused by a failure to carry out the surgical procedure with the necessary care and skill;

    b. He was not advised of the material risk of sustaining a perforated septum, the potential risks of future surgery, and psychological distress that this would cause prior to agreeing to undergo the procedure; and

    c. If he had known of those risks he never would have undergone the surgery when he did and he would have avoided the injury.

9. On behalf of the Trust, it was contended that:

    a. The risk of septal perforation is an unfortunate but unavoidable consequence of surgery, and not a consequence of any negligence;

    b. Mr Banks was made aware of the relevant risks by Dr Carlos, in line with the principles in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] AC 1430, and of the associated risks of dissatisfaction with the outcome, before agreeing to undergo surgery; and

    c. Even if he had not been aware of the risk, which was not admitted, Anton would still have undergone surgery when he did given the clinical need for surgical intervention at the time. On that basis, factual causation could not be established.

10. At first instance, Holding J dismissed the claim. She found that:

    a. Both parties' surgical experts agreed – and it was accepted by the Court – that the risk of a perforated septum was unavoidable and not necessarily caused as

a result of substandard performance of a surgical procedure. In this case, Dr Carlos had carried out the procedure with the skill and care expected of a reasonably competent Consultant Plastic Surgeon.

b. Applying *Montgomery*, Mr Banks had properly given informed consent to the procedure. Dr Carson had discussed the risks of surgery in a face to face consultation, including the risk of him being unsatisfied with his appearance. The very small risk of septal perforation had been brought to Mr Bank's attention, though indirectly in the form of a leaflet. This was in line with the advice which one could expect from a medical professional operating under time constraints, and would be supported by a responsible body of surgeons under the *Bolam* standard.

c. Mr Banks would have undergone the surgery when he did in any event. It was clear that medically his difficulty breathing was worsening and needed timely resolution, and the evidence suggested that Mr Bank's insecurities about his appearance would have led him to undergo surgery promptly in any event. Her Ladyship found that it was not necessary for her to consider *Chester v Afshar* [2004] UKHL 41; [2005] 1 AC 134 as a result.

11. Mr Banks appealed to the Court of Appeal on the basis that: (i) Holding J had misapplied the test for informed consent as stated in *Montgomery*; and (ii) Holding J erred in failing to apply the test in *Chester*, which did not require Mr Banks to establish that he would not have undergone the surgery when he did.

12. The Court of Appeal, in a unanimous decision, agreed with Mr Banks and allowed the appeal. The President of the Queen's Bench Division, Sir Malcolm Marshall, with whom Ambrose and Walsh LJJ agreed, held that:

a. Holding had erred in her statement of the test in *Montgomery*. Doctors were now under a duty to take reasonable care to ensure that the patient was aware of any material risks involved in any recommended treatment. The test of materiality was whether, in the circumstances, a reasonable person in the patient's position would be likely to attach significance to the risk, or the

doctor was or should reasonably have been aware that the particular patient would be likely to attach significance to it, and the application of the *Bolam* standard of assessment by Holding J was erroneous. The risk of septal perforation and the risk of further surgery was one of which any reasonable person in the patient's position would want to be aware – and merely giving a leaflet containing this information was insufficient. Additionally, Holding J had effectively found that Mr Banks was in a precarious emotional state, which was communicated to Dr Carlos, and so a reasonable patient in his particular position would want to know of the risks of future surgery and associated emotional distress. This case differed from the situation in *Duce v Worcestershire Acute Hospitals NHS Trust* [2018] EWCA Civ 1307, where it was common ground that the risk of developing chronic pain was not common knowledge at the time.

b. Applying the "exceptional" principle of causation in *Chester*, though the risks which eventuated in this case were found to be inevitable, rather than as a result of negligence, Mr Bank's right to make an informed choice had been violated irrespective of whether he would have deferred the surgery or not, and so his injury should be regarded as having been caused by the failure to warn of the material risks of undergoing surgery. *Duce* not followed.

13. The instant appeal is brought by the Trust on the basis that the Court of Appeal erred in both respects.

14. Submissions regarding each of the grounds are made in paragraphs 15 – 49 and 50 – 74 respectively.

**The First Issue – Informed Consent**

***The Test***

15. It is accepted that Holding J erred in her statement of the test at first instance. Following *Montgomery*, *Bolam* does not apply to a doctor's failure to advise her patients of the risks of a particular treatment.

16. It is also accepted that the Court of Appeal was correct when they laid out the test in the following terms:

> "Doctors were now under a duty to take reasonable care to ensure that the patient was aware of any material risks involved in any recommended treatment. The test of materiality was whether, in the circumstances, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor was or should reasonably be aware that the particular patient would be likely to attach significance to it"

17. In the above passage, the Court of Appeal was echoing the test set out at [87] of *Montgomery*. That test is put in context at paragraphs 18 – 25 below in order that it can be applied to the facts of the instant case with the broader principles of *Montgomery* in mind at paragraphs 26 – 49 below.

***The Montgomery Judgment***

*Case law before Montgomery*

18. Lord Kerr and Lord Reed began their judgment in *Montgomery* by analysing *Sidaway v. Board of Governors of the Bethlem Royal Hospital* [1985] AC 871. They held that *Sidaway* was not an unqualified endorsement of the application of the *Bolam* test to the giving of advice about treatment. Only Lord Diplock's judgment supported such a view [57]. Their Lordships found that the correct approach was substantially that adopted by Lord Scarman [87].

19. Lord Scarman in *Sidaway* took, as his starting point, "the patient's right to make his own decision" [43]. He found that the decision to consent does not depend solely on

medical considerations but depends on the circumstances, objectives and values of the individual patient [45]. Lord Kerr and Lord Reed agreed with this at [46], and at later at [73] they reiterate the sentiment, stating that:

> "the doctor's duty of care takes its precise content from the neds, concerns and circumstances of the individual patient, to the extent that they are or ought to be known to the doctor"

20. Lord Scarman delineated the duty to disclose risks as follows:

> "[t]he critical limitation is that the duty is confined to material risk. The test of materiality is whether in the circumstances of the particular case the court is satisfied that a reasonable person in the patient's position would be likely to attach significance to the risk" [49]

21. In addition to their endorsement of Lord Scarman's dicta as above, Lord Kerr and Lord Reed also, at [64], endorsed the approach of Lord Woolf MR who, in the case of *Pearce v United Bristol Healthcare NHS Trust* [1999] PIQR P 53, said:

> "if there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or she adopt."

*The emerging landscape of patient autonomy*

22. After considering the relevant case law, Lord Kerr and Lord Reed next paid heed to the evolution of the medico-social landscape. At [75], they say: "patients are now widely regarded as persons holding rights, rather than as the passive recipients of the

care of the medical profession." At [76], they remark that "it has become far easier, and far more common, for members of the public to obtain information" about treatment, through media such as the internet, and that it would "be a mistake to view patients as uninformed, incapable of understanding medical matters, or wholly dependent on a flow of information from doctors."

23. Their Lordships also looked to the development of Human Rights and fundamental values such as self-determination and respect for private life at [80]. They conclude as follows at [81]:

> "The social and legal developments which we have mentioned point away from a model of the relationship between the doctor and the patient based on medical paternalism. They also point away from a model based upon a view of the doctor as being entirely dependent on information provided by the doctor. What they point towards is an approach to the law which, instead of treating patients as placing themselves in the hands of their doctors (and then being prone to sue their doctors in the event of a disappointing outcome), treats them so far as possible as adults who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives and living with the consequences of their choices."

*The structure of the test*

24. As the Court of Appeal in this case correctly identified, Lord Kerr and Lord Reed come to setting out the test for informed consent at [87] (above). The question of materiality as addressed therein can be divided into two limbs.

    a. First, the reasonable person limb (Limb 1) : "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". This limb reflects the approaches of Lord Scarman in *Sidaway* and Lord Woolf MR in *Pearce.*

b. Second, the particular patient limb (Limb 2) : the doctor should warn of a risk if she "is or should reasonably be aware that the particular patient would be likely to attach significance to it".

25. One can see these two distinct aspects of the test operating on the facts of *Montgomery* at [94]; first Dr McLellan "was aware that the risk of shoulder dystocia was likely to affect the decision of a patient in Mrs Montgomery's position" (Limb 1), and second "Mrs Montgomery herself was anxious about her ability to deliver the baby vaginally" (Limb 2).

***Application of the Test to the Facts***

26. The Court of Appeal should have found that, had Holding J applied the correct test, she would have arrived at the same conclusion.

***The Reasonable Patient (Limb 1)***

27. The Court of Appeal found that:

> "The risk of septal perforation and the risk of further surgery was one which any **reasonable person in the patient's position** would want to be made aware and merely giving a leaflet containing this information was insufficient." (my emphasis)

28. In response to this finding, the Trust makes the following two submissions in the alternative.

***(i) There was no duty to disclose the risk of septal perforation and the risk of further surgery***

29. Dr Carlos, in accordance with her duty, disclosed all of the risks that were material to the reasonable person in the patient's position, which she correctly judged to not include the risk of septal perforation and the consequent risk of further surgery.

30. For a reasonable person in the patient's position, that is, someone who has worsening symptoms and considerable dissatisfaction with their appearance and no alternative but surgery to remedy those issues, the more minor risks of that surgery are far less significant than to someone choosing between options carrying varying degrees or kinds of risk – such as a patient choosing between natural birth or caesarean section. See Montgomery at [89].

31. Dr Carlos disclosed all of the risks detailed on the standard form, which evidences that they are the objectively material risks of this surgery, and that it was reasonable for her to think so.

*Septal Perforation*

32. This risk is not material to patients. What *is* material is the fact that septal perforation might result in dissatisfaction with the appearance of the nose and accordingly Dr Carlos disclosed that risk.

33. It is accepted that the risk of septal perforation is a risk of a magnitude that has been found, in other cases, to be material and as such it is accepted that a 1-2% risk has the *potential* to constitute a serious risk. However, it is submitted in this case that in light of the features of the patient's position elucidated at paragraph 30 above, and in particular in light of the nature of the risk, it was not material.

*Further Surgery*

34. It is incorrect to describe further surgery to correct appearance as a risk. It is an option that a patient may pursue as *a result of* the risk of 'dissatisfaction with appearance'

manifesting. Further or alternatively, the 'risk' of further surgery to correct appearance was *implicit* in the risk of dissatisfaction with appearance.

35. The risk of further surgery *necessary* to correct septal perforation was so small as to be immaterial, such that the Respondent has not put a figure on it. It was a risk of <u>less</u> than 1-2%: there is a 1-2% risk of septal perforation which *can* affect the aesthetic of the nose and which *may* require further surgery.

***(ii) The risk of septal perforation and the risk of further surgery were disclosed to the patient***

<u>The Consultation</u>

*Septal Perforation*

36. As above, during the consultation, Dr Carlos said there was a risk of 'possible dissatisfaction with the appearance' of the nose, which was the aspect of septal perforation that was material to the patient. Using the technical term would add little or nothing to a patient's comprehension. See Montgomery at [90].

*Further Surgery*

37. As above, the 'risk' of further surgery to correct appearance was implicit in the risk of dissatisfaction with appearance. Though surgery to repair a septal perforation unrelated to appearance is not logically implied, the risk is so similar in kind as to mean that Mr Banks was sufficiently aware of it.

<u>The Leaflet</u>

38. The leaflet was an adequate means of communicating the risks of septal perforation and further surgery and Mr Banks was given it almost three weeks before his surgery. This is a more than reasonable amount of time in which to read it.

39. Reliance on a leaflet detailing minor risks allows clinicians to speak more broadly with their patients and to focus on material risks during consultation. It strikes the balance that *Montgomery* delineates.

40. Lord Kerr and Lord Reed, in the passages below, implicitly endorse the notion that leaflets can inform patients of risks in the following passages from *Montgomery*:

> "[a] person can of course decide that she does not wish to be informed of risks of injury (**just as** a person may choose to ignore the information leaflet enclosed with her medicine)." [85] (my emphasis)

> "it has become far easier, and far more common, for members of the public to obtain information about symptoms, investigations, treatment options, risks and side-effects via such media as the internet (where, although the information available is of variable quality, reliable sources of information can readily be found), patient support groups, and **leaflets** issued by healthcare institutions ... **It would therefore be a mistake to view patients as uninformed**, incapable of understanding medical matters, or wholly dependent upon a flow of information from doctors." [76] (my emphasis)

41. Use of leaflets is accepted practice within the NHS. *Montgomery* was seen as aligning the law with current consent practice and thereby endorsing it, see [77].

42. Finally, that Mr Banks only "glanced at the leaflet" is not evidence of its insufficiency. It was reasonable for the doctor to assume that a reasonable patient would read the leaflet, or that if he didn't it was because he preferred not to know the risks, as was his right.

43. Taking the consultation and the provision of the leaflet together, the risk of septal perforation and the risk of further surgery were disclosed to the patient.

***The Reasonable Patient (Limb 2)***

44. The Court of Appeal also found that:

> "Holding J had effectively found that Mr Banks was in a precarious emotional state, which was communicated to Dr Carlos, and so **a reasonable patient in his particular position** would want to know of the risks of future surgery and associated emotional distress." (my emphasis)

45. It is not clear which limb of the test the Court of Appeal was applying since the wording blurs elements of both. The phrase "precarious emotional state" is also unclear and was not used at first instance. Presumably the phrase relates to the emotional condition of Mr Banks and how that may have affected materiality. This suggests that the Court of Appeal was applying Limb 2 and the following submissions proceed on that assumption, in the alternative it is submitted that this elucidation of Limb 2 of the test is an error of law.

46. It is agreed that Mr Banks "explained that the pressure of his impending wedding and his worsening symptoms had prompted him to consider surgery". It is submitted that this did not affect the scope of Dr Carlos's duty as other information about the patient might have. Getting married and having worsening symptoms are not facts that distinguish the particular patient from the reasonable man. As such, the reasoning under Limb 1 applies in relation to the risk further surgery (above at paras 29 - 43) under Limb 2. As to 'emotional distress', *Montgomery* does not create a duty to warn patients of risks that are either so obvious and/or fall short of physiological or psychiatric symptoms or side-effects.

47. Further, or in the alternative, those risks could not reasonably be seen to be material to the particular patient in light of his conduct during the consultation and the facts about

himself he communicated to Dr Carlos. The consultation lasted approximately ten minutes, in accordance with NHS Guidelines. During that time, Mr Banks did not express concerns or ask questions. When asked directly if he had any questions, the patient said that he did not. For these reasons, even if those risks in question were in fact material to Mr Banks, Dr Carlos could not reasonably have known it.

48. At [73] of *Montgomery*, Lord Kerr and Lord Reed state: "expressions of concern by the patient, as well as specific questions, are plainly relevant" they must also be relevant by their absence. This point is taken to its logical conclusion at [85], which shows that the exercise of patient autonomy as it was characterised in *Montgomery* (discussed at paras 22 – 24) includes deference to experts and disregard to risks.

49. For the above reasons, it is submitted that the first ground of appeal should succeed.

## The Second Issue – Causation

50. The second ground of appeal is that the Court of Appeal erred in applying the 'exceptional' principle of causation in *Chester*. It is submitted that, properly understood, *Chester* is distinguishable from the instant case, in light of Holding J's findings of fact. Alternatively, or in any event, the principle outlined in *Chester* is not good law, and should be departed from.

### *Causation in negligence*

51. It is submitted that the concept of causation in negligence involves two different elements:

    a. Factual causation – showing that this particular (alleged) breach was a necessary condition of this particular injury; and

    b. Legal causation – showing that the (alleged) breach made some difference to the probability of the injury occurring.

52. The first element is commonly referred to as the requirement of showing that but for a particular breach, a particular harm would not have occurred.

53. The logic of the second element was recently explained by Leggatt LJ in *Duce* at [94]:

> "In law as in everyday life A's wrongful act is not normally regarded as having caused B's injury if the act made no difference to the probability of the injury occurring. In such a case the fact that the injury would not have occurred but for the wrongful act is merely a coincidence."

*Understanding the 'exceptional' principle of causation in Chester*

54. It is perhaps trite law that *Chester* constituted a departure from ordinary principles of causation in negligence, but it is important to establish exactly what this departure involved.

55. It is submitted that the correct understanding of *Chester* is as follows: the majority held that a breach that was merely factually causative could be *deemed*, for public policy reasons, to be also legally causative, notwithstanding that it made no difference to the probability of the injury occurring.

56. At [61], Lord Hope found that factual causation was satisfied because, had she been warned, Miss Chester would have, at the very least, deferred the operation:

> "It can be said that Miss Chester would not have suffered her injury 'but for' Mr Afshar's failure to warn her of the risks, as she would have declined to be operated on by him on 21 November 1994."

57. Yet the majority also acknowledged that legal causation could not ordinarily be made out because the probability of the eventuation of the risk of cauda equina syndrome was not affected by Mr Afshar's failure to warn Miss Chester about the risk: see [22]

per Lord Steyn, [81] per Lord Hope, and [101] per Lord Walker. In particular, at [81], Lord Hope said the following:

> "I would accept that a solution to this problem which is in Miss Chester's favour cannot be based on conventional causation principles. The 'but for' test is easily satisfied, as the trial judge held that she would not have had the operation on 21 November 1994 if the warning had been given. But the risk of which she should have been warned was not created by the failure to warn. It was already there, as an inevitable risk of the operative procedure itself however skilfully and carefully it was carried out. The risk was not increased, nor were the chances of avoiding it lessened, by what Mr Afshar failed to say about it. As Professor Honoré ... has pointed out, to expose someone to a risk to which that person is exposed anyhow is not to cause anything."

58. Indeed, his Lordship went on to state very frankly, at [84], that:

> "Did the doctor's breach of that duty [to warn] cause the patient's injury? It would appear that this question can only be answered in the negative. He did nothing which increased the risk to the patient, or even altered it. It was a risk to which she was exposed anyway. It was the same risk, irrespective of when or at whose hand she had the operation."

59. Nevertheless, the majority held that there existed sufficient policy reasons to *modify* the ordinary principles of causation in order to impose liability upon Dr Afshar.

60. As explained by Hamblen LJ in *Duce* at [66], "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".

*Distinguishing Chester from the instant case*

61. It is submitted that, with respect to the Court of Appeal who reasoned otherwise, *Chester* does not remove the requirement of proving factual causation in cases of an alleged duty to warn of a risk. Rather, it sets out a particular set of circumstances where factual causation is, without more, deemed sufficient to impose liability.

62. Accordingly, it is submitted that *Chester* is distinguishable from the instant case, where Mr Banks is unable to satisfy the requirement of proving factual causation.

63. At first instance, Holding J made two pertinent findings of fact:

    a. The risk of a perforated septum was unavoidable and not necessarily caused as a result of substandard performance of a surgical procedure [and in any event] Dr Carlos had carried out the procedure with the skill and care required of a reasonably competent Consultant Plastic Surgeon; and

    b. Mr Banks would have undergone the surgery **when he did** in any event. (my emphasis)

64. These were not disturbed by the Court of Appeal, and they should remain undisturbed.

65. Those findings place this case on all fours with *Duce*. In that case:

    a. The operation was performed non-negligently [12]; and

    b. Mrs Duce would have undergone the operation when she did in any event – the judge at first instance "concluded that it is more likely than not that [Mrs Duce] would have proceeded with the operation on that day" [28], and the Court of Appeal rejected a challenge to this finding [78].

66. Accordingly, Mrs Duce could not prove factual causation, and so could not bring herself within the exceptional principle set out in *Chester*. In dismissing the claim, the Court noted, at [92], that:

> "there is no reasonable interpretation 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"

67. It is submitted that for the very same reason – namely, that Mr Banks cannot prove factual causation as there has been a finding that he would have undergone the surgery when he did in any event – the appeal in the instant case must be allowed.

68. Simply put, as in *Duce*, Dr Castro made no difference to Mr Bank's ordinary course of events. Accordingly, Mr Banks cannot bring himself within the exceptional principle set out in *Chester*, and, with respect, the Court of Appeal erred in applying it.

69. This conclusion, it is submitted, accords with the proper conception of the tort of negligence as a cause of action rooted in notions of corrective justice. As Lord Bingham stated in *Chester* at [9]:

> "A claimant is entitled to be compensated for the damage which the negligence of another has caused to him or her. A defendant is bound to compensate the claimant for the damage which his or her negligence has caused the claimant. But the corollaries are also true: a claimant is not entitled to be compensated, and a defendant is not bound to compensate the claimant, for damage not caused by the negligence complained of."

*Why the 'exceptional' principle in Chester is not good law*

70. Alternatively, or in any event, it is submitted that the exceptional principle in *Chester* is not good law, and should no longer be followed. The decision of the majority, as

was properly recognised by Lords Bingham and Hoffman in their dissenting judgments, amounts to an unjustified departure from ordinary principles of causation in negligence.

71. The creation of exceptions, without good justification, undermines the coherence of the law. This is especially pertinent in the context of causation, which is a fundamental aspect of the law of negligence. In *Chester*, the majority's departure from ordinary principles was justified by reference to the following principal arguments:

    a. The injury that Miss Chester sustained was within the scope of Dr Afshal's duty to warn [62].

    b. There was a need to vindicate Miss Chester's autonomous right to make an informed choice [24].

72. It is submitted that these arguments do not stand up to scrutiny because, respectively:

    a. It is by no means clear that Dr Afshal owed a duty to protect Miss Chester from the risk of suffering the injury that she did *per se*; rather Dr Afshal's duty is better characterised as a duty to prevent an injury which was attributable to a risk that Miss Chester was not prepared to accept: see *Duce* at [85].

    b. "The right to make an informed choice is not a right that is traditionally protected by the tort of negligence. Rather, the purpose of the tort is to protect a person from being exposed to injury through the carelessness of another ... if exceptionally the law of negligence is to be used to protect a patient's right 'of autonomy and dignity', then it is for the invasion of that right that damages should be awarded and not for the physical injury resulting from the operation ... [but] in *Shaw v Kovac* [2017] EWCA Civ 1028; [2017] 1 WLR 4773, the Court of Appeal comprehensively rejected a claim for damages for invasion of a claimant's personal autonomy by negligently failing to warn of a material risk of an operation": see *Duce* at [88]; and/or the right of autonomy is

vindicated by the existence of the duty of care itself, not by imposing liability in circumstances where a doctor has not caused a patient any harm.

73. Accordingly, it is submitted that the departure from principle in *Chester* is not justified, and should no longer be followed.

74. As such, this second ground of appeal should succeed.

**Conclusion**

75. It is submitted that this appeal should be allowed on either or both grounds, and that, with sympathy for the position that he finds himself in, Mr Banks' claim in negligence should be dismissed.

CATHERINE HUNT
WILLIAM VAUDRY
Counsel for the Appellant

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