[2015] JMCA Civ 56

JAMAICA

IN THE COURT OF APPEAL

SUPREME COURT CIVIL APPEAL NO 50/2012

BEFORE: THE HON MR JUSTICE PANTON P
THE HON MISS JUSTICE PHILLIPS JA
THE HON MRS JUSTICE McDONALD-BISHOP JA (AG)

BETWEEN	**ANNISSIA MARSHALL**	**APPELLANT**
AND	**NORTH EAST REGIONAL HEALTH AUTHORITY SAINT ANN'S BAY HOSPITAL**	**1ST RESPONDENT**
AND	**THE ATTORNEY GENERAL**	**2ND RESPONDENT**

Norman Hill QC and Raymond Samuels instructed by Samuels and Samuels for the appellant

Miss Tamara Dickens instructed by the Director of State Proceedings for the respondents

16, 17 December 2014 and 6 November 2015

PANTON P

[1] I have read the judgment of my learned sister Phillips JA and agree with her reasoning and conclusion. I have nothing to add.

PHILLIPS JA

[2] This is an appeal from a judgment of Fraser J delivered orally on 7 March 2012, upholding a no case submission made by the respondents at the close of the appellant's case. The learned judge stated that the appellant had sought against the respondents by way of amended claim form damages for negligence and medical malpractice, in that, the respondents had by themselves or by their servants performed surgery on her without her consent. He found that on the totality of the evidence, the appellant had not established her case on a balance of probabilities, and accordingly, entered judgment for the respondents with costs to be agreed or taxed.

Factual background - the pleadings and witness statements

Pleadings on behalf of the appellant

[3] Mrs Marshall, who was married and a 28 year old office manager, felt abdominal pains on 26 June 2004 and consulted a private practitioner, who referred her to the Port Maria Public Hospital. On 27 June 2004, she attended the Port Maria Hospital but was not treated on that day for her condition. She returned to the said hospital the next day, 28 June 2004, as the pains persisted. On 29 June 2004 an abdominal and pelvic ultrasound was performed which revealed that the endometrium was normal, but the appellant was suffering from a hemorrhagic left ovarian cyst. Based on the result of this test the appellant was referred to the 1st respondent, the Saint Ann's Bay Hospital (the hospital) for treatment. The appellant was admitted to the hospital on 29 June 2004 and consented to an operation which was done on 1 July 2004 to remove the cyst.

[4] The appellant was re-admitted to the hospital on 5 July 2004 as she was still in pain. On 14 July 2004, an abdominal and pelvic ultra sound examination was performed on her. It revealed inter alia:-

> "(a) The Endometrial Stripe is within normal limits
>
> (b) Fluid filled dilated lops of bowel with free fluid within the abdomen. No evidence of an interloop collection"

[5] On 15 July 2004, a second operation was performed on her. During surgery a colostomy bag was attached to the left side of her lower abdomen. Having recovered from the anesthetic administered to her during surgery, the appellant claimed that she was informed by a doctor on duty that she had undergone surgery for abdominal obstruction and that the colostomy bag was necessary. He assured her that it would be removed shortly.

[6] The appellant attended the hospital in October 2004 to remove the colostomy bag. However, she was told that the operating theatre was unavailable, as it was under construction. The appellant made several requests of the hospital to have the bag removed and finally returned to the said hospital on 29 December 2004 at which time due to the appellant's illness, the colostomy bag could not be removed.

[7] The appellant filed the claim form and particulars of claim on 27 March 2006 and contended that the operation performed on 15 July 2004 was inconsistent with the ultra sound reports of 29 June 2004 and 14 July 2004 respectively, was arbitrary and done

without her consent. She claimed that the hospital was negligent, and in the particulars of claim, the particulars of negligence were set out, namely, that:

> (i) the operation of 15 July 2004 had been performed when the ultra sound examination had not indicated that it was necessary;
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> (ii) the operation was performed without her consent; the operation carried a risk of a complication of the colon and she had not been advised of the risk;
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> (iii) the operation carried the risk of wearing a colostomy bag and she had not been advised of that risk or the likely period for which that condition would last.

[8] The appellant also pleaded and relied on the doctrine of *res ipsa loquitur*.

[9] The appellant pleaded further that being 28 years of age and married she would not have consented to an operation which carried the risk of wearing a colostomy bag, and that the hospital was therefore negligent in denying her the right to choose whether to undergo such an operation. She also claimed that she had suffered a surgical opening in her lower left abdomen with the attachment of a colostomy bag which had resulted in her being traumatized by the constant feeling of unwellness, and the knowledge of not enjoying proper social hygiene, and that this was known to those with whom she had to maintain social intercourse from time to time. Additionally, she had observed that her husband had shown a lack of sexual appetite for her and she had also experienced a loss of libido herself.

[10] She pleaded the particulars of injuries suffered namely:- the laparatomy without her consent; damage to the colon and the attachment of the colostomy bag without

her consent. She claimed that she had suffered psychological trauma by being clinically depressed, preoccupied with the conditions brought about by wearing the colostomy bag, adjustment disorder with depressed mood and a psychological impairment of 30%. She also claimed special damages including past medical expenses, future costs to remove the colostomy bag and for loss of earnings.

[11] The appellant claimed that she had not returned to the hospital subsequent to her last visit in December 2004 in respect of any treatment in relation to the removal of the colostomy bag, as she felt that she had been given the "run around" with regard to its removal. She later had the bag removed by way of an operation done overseas. Subsequent to that, as indicated aforesaid, on 27 March 2006, she had filed the claim against the respondents for negligence setting out the allegations mentioned above.

Pleadings on behalf of the respondents

[12] The defence filed on behalf of the respondents on 19 July 2006, accepted certain facts alleged by the appellant, such as the treatment administered to her up to and including the operation to which she consented on 29 June 2004 for the removal of the ovarian cyst. The respondents disputed the appellant's claim however, on certain bases. It was their contention that when the appellant had been re-admitted to the hospital she had been complaining of abdominal distension, pain and vomiting. Further, that the x-rays performed on her showed a picture in keeping with intestinal obstruction of the large bowel type.

[13] The respondents therefore maintained that following the results of the x-rays, the need for further surgery and the possibility of the colostomy bag were explained to the appellant and she consented to the further surgical procedure which was performed on 15 July 2004. It was specifically denied in the defence, that the explanation for the surgery and the necessity for the bag had not been given to the appellant until after the procedure was performed. Indeed, the respondents asserted that the appellant had been informed that the bag was to have been removed within three months after the operation, but unfortunately that time frame had not been met. This the respondents said was due to the fact that on one occasion the appellant had developed acute abdominal pains and had to be referred to the gynaecological department, so surgery could not be performed, and secondly, the operating theatres at the hospital had to be closed for refurbishing. The respondents averred that the appellant failed thereafter to attend at the hospital to have the surgery performed on her.

[14] In their defence the respondents denied any negligence on their part, stated that the doctrine of *res ipsa loquitur* did not apply, denied preventing the appellant the right to choose whether to have the operation, and failing to remove the colostomy bag. Finally, the respondents particularly denied causing any injuries to the appellant or being liable for the damages claimed.

[15] Bearing in mind that the respondents succeeded on its submission that there was no case to answer, it is important, in my view, to have in mind what was understood by the parties as the issues between them before trial, on the pleadings, and also, with regard to what had been alleged in the witness statements. On the

request of the appellant for information, the respondents complied, by providing the following answers:

> "(a) The [respondents] are unsure whether the x-rays performed on the Claimant were reduced in writing. If they were reduced in writing, a radiology report reflecting same would have been generated. A search was carried out at the Saint Ann's Bay Hospital and a radiology report was not found. However Dr. Titus had been the surgeon on call, he had interpreted the x-rays and proceeded with the [appellant's] care. His findings were recorded in the [appellant's] medical docket.
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> (b) It is customary for patients to sign a consent form. But the respondents could not locate the consent form signed by the appellant. The respondents averred that the appellant had given her consent orally or impliedly for the surgical procedure, "the sigmoid collectomy" and that the possibility of a colostomy was explained to the appellant by medical personnel at the 1st respondent.
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> (c) The x-rays and or the written consent could not be located; they would have been contained in the medical docket and that also could not be located."

[16] The appellant relied on her own witness statement and certain documents to prove her case. The respondents filed the witness statements of Dr Ian Titus and Dr Patricia Sinclair, which represented the evidence they proposed to call at the trial. There were also two affidavits filed in respect of the issue of the consent form, one by Miss Sharon O'Connor-Wray and the other by the appellant herself. There was also the expert report of Deputy Superintendent of Police (DSP) William Smiley.

The appellant's witness statement

[17] In summary the appellant's witness statement covered the following material particulars: Essentially, she restated the facts pleaded in the amended particulars of claim and importantly confirmed that she had not given her consent to the second operation on 15 July 2004, and that it was only when she "woke up from the anesthesia" that she found the colostomy bag on her left side and she was told that she had undergone an operation for abdominal obstruction and that the bag would be removed shortly. She stated that she had made several efforts to have the bag removed without success.

[18] She set out as pleaded in the particulars of claim her distress and trauma with wearing the colostomy bag. She said that she had been married for eight years and had no children and was worried because of her loss of sexual appetite as well as her husband's due to the bag, that she would not have any children. She also stated that what she wanted was to have a normal family life.

[19] She maintained that the surgery was arbitrary, as the ultra sound report did not indicate any condition referable to the need for surgical intervention. She complained bitterly that the hospital had performed surgery on her which carried a serious risk and she had not been informed of that risk. She deposed that the hospital ought to have known that the operation carried a risk of wearing the colostomy bag and yet they had not advised her of the same, or the length of time that the condition would last. She

therefore stated that the hospital's conduct had been wrongful and resulted justifiably in the claim being made by her.

Witness statements of the respondents

[20] A witness statement was filed on behalf of the respondents in respect of Dr Ian Titus. He was an eminently qualified surgeon and was head of the department of surgery at the hospital at the material time, and in 2009 when giving the witness statement. He had practiced at the hospital since 1997. He confirmed the surgery for the removal of the ovarian cyst. He said that on admission to the hospital, the appellant had signed a consent form authorizing all treatment and surgery. He stated that all went well with that surgery but the appellant was re-admitted to the hospital complaining of severe abdominal and back pains, abdominal distension and vomiting. She had been, he said, referred to the hospital by a private practitioner who had diagnosed her as having peritonitis. She was treated at the hospital. Based on her clinical examination and x-ray, she had been assessed as having intestinal obstruction. He stated that a nasogastric tube had been inserted to drain the fluid and air which had accumulated due to the obstruction. She was further treated, and as she did not improve she was taken back into surgery on 15 July 2004.

[21] In surgery, he said that it was noticed that her "sigmoid colon (lower large bowel) was completely obstructed with a constricting mass with dilation of the bowel before the mass". The segment of the large bowel that contained the mass was removed. He explained the surgery and the bringing of a large part of the intestine

through the abdominal wall to the outside as a colostomy, through which faeces could pass to a bag, outside of the abdomen. He stated that the steps to be taken to manage and cope with the colostomy were explained to the appellant by various medical and nursing staff after she had had the colostomy. He stated that on her second admission to the hospital on 5 July 2004, the appellant had signed a further consent form giving general authorization for treatment and surgery. He stated further at paragraphs 11 and 12:

> "11 … In so doing, she consented to this second surgery. The nature of the 2nd surgery would have been explained to Ms Marshall by a member of the general surgical team. The surgical exploration was necessary because a part of her intestines was obstructed and she was not improving with the use of the nasogastric tube. The normal procedure is that a doctor would explain to the patient the reason that the surgery is required and nature of the surgery. No patient is ever taken to theater for surgery to be operated without an explanation as to the reason for the surgery, unless it is a case of emergency and the person is unconscious.
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> 12 The wearing of the colostomy bag would not have been explained to Ms. Marshall prior to the second surgery as it was not known prior to surgery that she would have needed it. It is only on seeing her internal condition in surgery that a decision was made to perform the Hartman's procedure which necessitated the use of the colostomy bag. After the surgery, Ms. Marshall was advised that the wearing of the colostomy bag would be temporary."

[22] Dr Titus stated that the mass had been tested and analysed and found not to be malignant, but the subsequent histological analysis of the removed segment of the large bowel showed "endometriosis", a condition which he stated would not have

improved without the surgery, and the appellant would have progressively deteriorated and eventually died. He thereafter explained the treatment for the closure of the colostomy and the respondents' stance on the failure of the appellant to undergo the further surgery required.

[23] Dr Patricia Sinclair, a qualified consultant pathologist, gave a witness statement on behalf of the respondents, and confirmed that examination of the colonic mass showed grossly prominent endometriosis and scarring which was responsible for the clinical stricture. She also indicated that although the process was not malignant it could be severely debilitating, and was a condition which could be difficult to diagnose on clinical grounds alone, due to the different ways that it may present itself and depending on the organ affected. Neither Dr Titus nor Dr Sinclair was called to give oral evidence at trial, so their witness statements could not stand as evidence-in-chief or otherwise.

[24] The following affidavits were included in the record filed in the Court of Appeal. There was no specific indication in the record as to how they were utilized in the court below. I will nonetheless set them out for what they are worth. They both focused on the issue of the consent form.

[25] Miss Sharon O'Connor-Wray, a registered nurse, swore to an affidavit on 12 August 2012 on behalf of the respondents wherein she confirmed, inter alia, that she had been on duty in the female surgical ward on 5 July 2004 and was the nurse who admitted the appellant to the hospital. She stated that the appellant had signed the

consent form and she had witnessed it. She referred to entries made by her in the "nurses notes" and affixed a copy of the consent form and the copies of the relevant entries in the nurses notes to the affidavit. Although the form in the record was a completely blank form save as to the signature of the appellant, the form was said to be in the same terms as that signed by the appellant on 29 June 2004.

[26] The appellant deposed to her affidavit on 28 July 2009. In that affidavit, she stated that, on 29 June 2006, she had, on admission to the hospital, signed a consent form giving the hospital general authorization for her treatment there. She stated though that on her second visit to the hospital on 5 July 2004, she was very ill, had been whisked into the hospital in a wheel chair and neither her husband who had accompanied her, nor herself, had signed a consent form on that occasion. She deposed that she had seen three consents in her medical records at the hospital; namely, documents dated 29 June, 5 July and 29 December 2004. She challenged stridently that the signature on the consent document of 5 July 2004 was not hers. She attached all three consent forms to her affidavit and documents which she confirmed were duly signed by her, namely the relevant page of her passport, her drivers' licence, a copy of the relevant page of her employment card, all in an effort to confirm that the consent document of 5 July was not signed by her.

[27] The appellant submitted the above documents to DSP William Smiley, document examiner in charge of the questioned document section, technical services division of the Jamaica Constabulary Force, along with a specimen signature of her own and then

attended on his offices and gave another specimen signature of hers to a member of his staff. He examined the same and gave his report dated 6 February 2012. The appellant filed an application, which was to be heard at the trial, for the report of DSP Smiley to be admitted into evidence. The respondents filed a notice of intention to rely on the said expert report at trial, pursuant to the orders of Sinclair Haynes J and Campbell J. The report was actually tendered into evidence at the trial by consent of the parties as exhibit 2.

The expert report

[28] DSP Smiley indicated in his report, having examined all the documents submitted to him, that in his opinion, the specimen signature given to him in his office, and the specimen signature submitted to him by the appellant and the questioned consent form "were written by one and the same". The signature of the questioned consent form also appeared to be the same signature as that on the other consent forms as well as the relevant page of the passport. He was unable to confirm whether the impugned signature on the consent form dated 5 July 2004 and the signatures on the other documents were similar, as the signatures on those documents were barely legible so "fine details" could not be analysed.

[29] At the close of the pleadings, and also subsequent to the filing of the witness statements as detailed above, the appellant outlined the facts in dispute, and legal issues in the following way:

Facts in dispute

1) When the appellant was re-admitted to the hospital, did she consent to an operation being performed on her and one that could leave her initially with a colostomy bag?

2) Did the x-ray indicate that surgical intervention was warranted? Was the surgical intervention appropriate? Was the operation done with the requisite care? Was the surgical intervention sufficiently explained to the appellant or at all, particularly that a colostomy bag would be necessitated?

3) Was she given the right to choose whether the hospital should proceed with the operation? Did she suffer psychologically as a result? Did the wearing of the bag affect her socially, reduce her self esteem, affect her marriage, libido, ability to have a normal life especially since the bag gave offensive odours?

4) Did the hospital refuse or neglect to remove the colostomy bag?

Legal issues

1) Was the hospital negligent in deciding to perform the operation when the ultra sound did not indicate any condition requiring the operation?
2) Was the hospital negligent in not first obtaining the consent of the appellant in respect of the operation to be performed?
3) Was the operation necessary even if the appellant's consent had been obtained?
4) Whether the hospital failed to mitigate the damages by delaying the removal of the colostomy bag?
5) Whether the hospital failed in the exercise of its duty of care owed to the appellant, it's patient?

The following were the respondents' facts in dispute and legal issues:

Facts in dispute

1) The appellant having had pain in the abdomen for four days, was admitted to the hospital, and signed a consent authorizing all treatment and surgery.
2) When re-admitted to the hospital the appellant was diagnosed as having intestinal obstruction. The mass was removed in the surgery and the colostomy bag placed on the

appellant. Prior to the second surgery the need for the same was explained to her.

3) On the second admission to the hospital, the appellant signed a further consent authorizing all treatment and surgery.

4) Necessity for the colostomy bag was only discovered during surgery. After surgery the management and coping mechanisms were explained to the appellant.

5) The bag should have been removed within three to six months; this was dependant on the appellant and was only therefore a temporary measure.

6) The mass having been sent to the laboratory proved to be endometriosis.

7) The appellant was unable to have the colostomy bag removed as firstly she attended on the hospital with abdominal pain, and nausea and had to be treated for the same, and then subsequently the hospital was closed for two months due to refurbishing.

8) The appellant defaulted on her treatment to remove the colostomy bag.

Legal issues

1) Whether the appellant consented to the second surgery to remove the constricted mass in her intestines?
2) Was the second surgery necessary based on the clinical findings of the hospital?
3) What would have been the likely prognosis had the surgery not been performed?
4) Were the hospital's medical team negligent in the performance of their duties?
5) Was the surgery necessary?
6) Was the appellant advised of the likely length of time for the wearing of the colostomy bag?
7) Did the appellant take all necessary steps to remove the bag?
8) Did the appellant mitigate her losses?
9) Was the appellant's psychological injury caused by the hospital's negligence?
10) Did the appellant really suffer any of the injuries claimed in the amended particulars of claim?

The trial

[30] The appellant first made an application for an amendment to include the cause of action of assault in the particulars of claim, as an alternative, in that the hospital's servants and or agents had committed an assault on the body of the appellant. The

word "assault" was also to be added after the word "negligence" in the heading of the particulars. The issue in the application on behalf of the appellant, was that the consent form was not legible; the consent in any event must be real, in that, the appellant ought to have been told what she was signing for; no explanation having been given in relation to the surgery would have vitiated consent; the consent would not have been valid, and the operation would therefore have been an assault on her. The respondents maintained that the consent form had been duly signed and was valid; it was a general authorisation for treatment; the terms would have permitted the surgery that was done; the surgeon could only disclose what was known; the need for the surgery was explained; the need to wear the colostomy bag however, was not; the constriction required the surgery and had it not been done the respondents would have been negligent; the diagnosis was endometriosis, which required surgery; the real issue was whether the consent form on 5 July 2004 had been signed and that issue had been settled in the expert report. The application, it was contended, had been made late in the day, after three previous adjournments of the trial date and, in any event, the appellant could not achieve the high standard of proof required of her.

[31] Fraser J refused the application on the basis that the new claim was against the weight of the evidence, particularly, in the light of the report of the expert DSP William Smiley with regard to the appellant having signed the consent form. The issue as to whether the hospital having not provided the appropriate information to the appellant, its patient, in respect of the surgery, could vitiate the consent, remained moot. However, the learned judge stated that as the respondents had come to trial to meet

a case in negligence and not one of assault, the amendment would be prejudicial to the respondents. The learned judge therefore ruled that it was not in the interests of justice to allow the amendment sought.

[32] The respondents then made an application to strike out the claim pursuant to rule 26.3(b) and especially 26.3(c) of the Civil Procedure Rules (CPR). Counsel submitted that the court in keeping with the overriding objective ought not to allow a matter to proceed which disclosed no real prospect of success. He also relied on rule 26.1 of the CPR. It was clear, counsel argued, that there was no duty of care on a doctor to disclose a risk which was unknown to him. Further, failure to disclose any possible risk would not vitiate consent. There was no duty of care in the conduct of the treatment administered to the appellant before, during or after the surgery, and in any event that had not been pleaded by the appellant. Additionally, the appellant's pleading did not, he submitted, satisfy the **Bolam** test (**Bolam v Friern Hospital Management Committee** [1957] 1 All ER 118). There was no medical evidence, he argued, to refute the respondents' case that the appellant's condition required the surgery and the subsequent wearing of the colostomy bag or that the hospital ought to have known of the risk of the appellant having to wear the colostomy bag after the surgery. If there is no duty of care, he reasoned, then there could be no breach of the same resulting in consequential loss. The appellant's case had depended, he said, on the "alleged non consent", which the report of DSP Smiley had rendered hopeless.

[33] Counsel for the appellant responded, submitting that the **Bolam** test was inapplicable as the skill of the doctors was not being challenged, but the right to object to what was done to the appellant's body was the issue. The question was, was there a genuine consent to the surgery from which the damage arose. The radiological report did not indicate the need for the surgery. The hospital/surgeons ought not to have operated on the appellant without her consent. The consent form signed for the first surgery could not operate as consent for the second surgery. Whether the surgery was helpful was not relevant to the right to know what surgery was to be performed and the failure to give such an explanation was negligent.

[34] The learned judge ruled that the jurisdiction of striking out a claim ought to be used sparingly as it deprives a party of their right to trial. The respondents would therefore have had to show that on the statement of case, no basis had been disclosed to bring the claim as a matter of law. The test to be applied was whether the claim was bound to fail, as opposed to being merely "fraught with difficulty" which was insufficient. The issue was whether there was a failure to give proper advice, from which damages could flow, but, that, the learned judge opined, may have been difficult for the appellant to prove in the absence of medical opinion; and further, any contrary medical opinion to the respondents' evidence that the procedure likely saved her life, and that left untreated, the appellant would have died from endometriosis.

[35] The learned judge referred to the appellant's contention that she had lost the opportunity of obtaining a second opinion, and that even if the consent form had been

signed, it was not related to the surgery performed. The appellant also contended that there was a breach of duty by the medical team not to have known that there was a possible intestinal obstruction, which would have required the Hartman procedure, and which could have resulted in the need to wear a colostomy bag. The learned judge remained concerned however that there was no medical evidence put forward by the appellant. He referred to the plea of *res ipsa loquitur*, and wondered whether the doctrine would have any applicability to the instant case. He ultimately concluded that whilst the appellant's case may be "fraught with difficulty", it could not be said that if the facts alleged by the appellant were true, the claim was bound to fail as a matter of law, and accordingly, he refused the application to strike out the claim.

The viva voce evidence of the appellant

[36] The witness statement of the appellant was received as her evidence-in-chief, and the following was the only viva voce evidence adduced at the trial.

She stated that she had stipulated that in respect of the operation which took place on 15 July 2004, and the one contemplated on 29 December 2004, there should be "no blood transfusion". Those words were actually endorsed on the consent forms dated 29 June and 29 December 2004, respectively.

[37] During cross-examination of the appellant the impugned consent form dated 5 July 2004, and the expert reports of DSP Smiley, Dr Jeanette Yee and Dr Ann M Fenna were adduced into evidence as exhibits 1, 2, 3, and 4 respectively by consent. I will deal with the latter two reports in detail later.

[38] Under cross-examination, the appellant admitted to being in terrible pain and conscious before the surgery, although unaware that she was to undergo surgery. She said that nurses had told her that they were getting her ready for theatre, but no doctor had come to say anything to her. She insisted that she had not been told that she had been diagnosed with an abdominal infection. She thought that she was being treated for peritonitis. She said that she had not been informed by any member of the surgical team that the second surgery was to remove an abdominal obstruction. She testified that while in the hospital from 5 July 2004, she had done tests but she was not aware of the results of those tests before the second operation on 15 July 2004. She had asked about the results of the tests, but she had not been told what they were. She had been treated by the public doctor but had not been given any diagnosis.

[39] She insisted that it was after the surgery that she was been told that she had bowel obstruction and that a Hartman procedure had been performed, and further that the colostomy bag was a necessary result of the Hartman procedure which would be worn for three to six months. She said that she could not say whether the Hartman procedure was necessary as she had not been given a chance to get a second opinion. She admitted that she had no medical evidence to support any of her allegations.

[40] She accepted that she had submitted a document with her signature to DSP Smiley, but maintained that she had not signed the consent form of 5 July 2004, but had signed the consent form of 29 June 2004 which related to the surgery to remove the ovarian cyst, which surgery had been explained to her. She said that if the court

found that she had signed the consent form on 5 July 2004, it would not mean that she had consented to the surgery. She also later said that it would mean that she had consented. She told the court that the reason for giving the instructions that there should be no blood transfusion was due to religious beliefs, as her grandparents were Jehovah's witnesses, and that despite the finding of DSP Smiley, she had not signed the consent form as she was in severe pain when she was brought to the hospital and, it was her recollection that her husband had to register her in the Accident and Emergency department.

The notes of evidence concluded with this notation: "Subject to question of damages if it arises, case for the claimant".

No case submission

[41] Mr Nigel Gayle, counsel for the respondents in the court below, having indicated his intention to make a submission of no case to answer, was put to his election by the learned judge, called no evidence and made his submission. He relied on the submissions made in support of the application to strike out the claim. He argued repeatedly that there was no evidence to satisfy the high standard of proof required when a claim of negligence was made against medial surgeons as was done in the instant case, and centred his submissions on that basis. He canvassed the evidence to show that the issue of consent should really address the cause of action of assault, which was not before the court, although counsel conceded that if there was no consent, that could ground a cause of negligence, but submitted that in the instant case

there was express or implied consent, so no breach of the duty of care had been proved.

[42] Counsel for the appellant responded by submitting that the issue in the case was one of consent. That the patient must give consent to the exact operation that she was being called to submit herself to. She had been deprived of the right to know, she had not signed the consent form, or alternatively, the signature on the form in the circumstances was not "real". Counsel for the respondents in reply insisted that it was incumbent on the appellant to say that had the surgery been explained to her, she would not have undergone the same which had not been done in this case.

The ruling of Fraser J on no case submission

[43] The learned judge identified the main issue in the case as being whether the appellant had consented to the surgery performed on her on 15 July 2004. He said that issue raised two matters for consideration namely (i) did she sign the consent form on 5 July 2004? and (ii) even if she did sign the consent form, did she consent to the specific surgery performed on her?

[44] He referred to the appellant's particulars of claim in negligence against the respondents and indicated that for the appellant to succeed, a duty of care must first be established, then a breach of that duty and damages which have resulted from that breach. He accepted that the hospital owed the appellant a duty of care to give proper advice and not to proceed to operate on her without her consent. He posited a concern about the damages recoverable in the instant claim in circumstances where there did

not appear to be any issue taken with either the surgical procedure or the post-operative care. He commented that if the court were to find that the appellant had signed the consent form, then to succeed in negligence the appellant would have to prove that there was a duty of care established to warn the appellant of a known risk, or that the risk ought to have been known and that there was a breach of that duty, and as a result she had suffered damages. Additionally, she should demonstrate that had she been warned of the risk, she would not have undergone the surgery.

[45] He accepted that as the respondents had been put to their election, and had decided to make their no case submission, if the submission failed they were not entitled to call any evidence and he recognized and acknowledged that the appellant had to prove her case on a balance of probabilities.

[46] The learned judge canvassed the evidence given by the appellant already referred to herein including adverting to the fact that the appellant had been in the hospital from 5 to 15 July on the second occasion and when she was taken to the operating theatre and was being prepared for surgery, she had not objected to the same nor had she indicated that she wanted to leave the hospital. He made the following conclusion at paragraph [13] of the judgment:

> "On the totality of the evidence adduced on the claimant's case the court finds and accepts that the claimant signed the form dated 05.07.04. The court accepts the finding of the expert that the claimant signed the form. The court also finds that the experts' conclusion is consistent with the evidence of the claimant's non-objection to the surgery at the time she was being prepared for this surgery. This is significant; especially as the evidence is that the claimant had undergone surgery at the

> same hospital a mere 14 days before when she had an oophorectomy to remove a haemorrhagic ovarian cyst. She would therefore have been all too familiar with the procedures leading up to surgery and would have been expected, as any reasonable person would be expected to, to object or at least query what was happening, had she not consented to the surgery."

[47] The learned judge then addressed the issue as to whether the appellant's position that she had not consented to the specific surgery had any merit. He referred to the consent form and noted that there were three parts to it; firstly, the general authorization which he had found had been signed by the appellant; and the other two sections, (i) in respect of the release from responsibility for the discharge or refusal of treatment, and (ii) which deals with permission to leave the hospital, neither of which had been completed or signed by the appellant. This, he said, showed that the appellant could have indicated whether she wished to leave the hospital or not be treated and she had not done so.

[48] The learned judge then dealt with the appellant's claim that she ought to have been informed of the possibility of a removal of part of her colon which would have necessitated the carrying out of the Hartman procedure with the result that she had to use a colostomy bag temporarily after the surgery. The learned judge dealt with that concern, as he put it, by "the assessment of medical negligence". He referred to **Whitehouse v Jordan** [1980] 1 All ER 650, with particular attention to the fact that the more serious the allegation the higher the degree of probability that is required. He

also referred to what he said had become the gold standard of the test of negligence in respect of medical matters, namely **Bolam** at page 121, which stated the test as being:

> "… the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art…"

The learned judge made it clear that he accepted the standards and principles set out in those two cases as being applicable in the judgment of medical negligence cases.

[49] The learned judge noted that it was not an issue in the instant case whether the operation had been performed negligently. Thus, he stated, the case referred to by counsel for the appellant, **Cassidy v Ministry of Health** [1951] 1 All ER 574, was not applicable to the instant case, as in that case there was a challenge to the prima facie case of negligence on the part of the person in whose care the plaintiff had been. There was no such challenge on behalf of the appellant in respect of the quality of care-surgical and post operative in the instant case.

[50] The learned judge then referred to the question of the duty to inform the appellant of the risk attendant with the surgery. He made reference to several cases which had been submitted to him, namely **Sidaway v Board of Governors of the Bethlem Royal Hospital and Others** [1985] 1 AC 871; **Pearce and another v United Bristol Healthcare NHS Trust** 48 BMLR 118; **Chatterton v Gerson and Another** [1981] QB 432; and **Chester v Afshar** [2005] 1 AC 134. He made the point that in each of these cases cited by counsel for the appellant, the risk of damage

suffered and complained of had been known. The issue was therefore whether the doctor had disclosed the risk to the claimant in the particular case, to allow the claimant to make a decision based on the adequate facts.

[51] The learned judge then made the following statements in paragraphs [26], [27] and [28] of his judgment, which have been the subject of serious scrutiny and complaint. I have set them out in their entirety.

> "[26] In the case at bar however, that was not the factual situation. On the evidence before the court the contention of the defence is that the risk of the wearing of the colostomy bag was not known prior to the surgery as it was only on the surgeon's seeing the internal condition during surgery that the decision was made to perform a Hartman's procedure which necessitated the use of the colostomy bag.
>
> [27] The surgical exploration had become necessary because of the obstruction to her intestines and the lack of improvement by the other methods of treatment. The claimant has produced no medical evidence that would be able to establish, suggest or substantiate the position that the doctors knew or ought to have known about the possibility, whether slight or significant, of the need for a Hartman procedure with the resultant need for colostomy bag, prior to the surgery being conducted.
>
> [28] On that basis alone the claimant has failed to establish a prima facie case of negligence on the basis of a failure to inform in light of the ***Bolam*** standard. Based on that standard, the claimant could only succeed if it was shown that in accepted medical practice it would have been expected that the doctors who performed surgery on Miss Marshall at least ought to have known of the risk and hence should have specifically disclosed that risk to her."

He referred to **Chatterton v Gerson** to conclude that it was necessary for the appellant to show that, even if she had been informed of the surgery and the risk attendant thereto, she would not have had the surgery. Indeed, the learned judge put it this way at paragraph [30] of the judgment:

> "In the claimant's evidence she has maintained that she would have desired the opportunity to seek another opinion. However in the absence of any evidence as to what the likely second opinion would have been, there is no evidence before the court to establish the view that she would not have chosen to have the operation. Even if I am wrong on that point, the primary point is that there is no medical evidence challenging the defence position that the doctors did not know prior to the surgery that a Hartman procedure with resultant need for a colostomy bag was likely and neither is there medical evidence to suggest that the doctors ought to have known of that possibility or likelihood."

[52] The learned judge dealt with the post operative care with regard to the removal of the colostomy bag and found that the appellant had not made out a claim in negligence, when, on her own evidence, the recovery period was three to six months, and as she had initially attended the hospital to do the surgery in October 2004, and the theatre was unavailable due to it being refurbished, and then in December when she attended again, surgery could not have been performed on her because she was ill. The time promised by the hospital for the removal of the bag was just at an end, so her claim of having been given the "run around' was not, he found, sustainable.

[53] The learned judge concluded that although the appellant had not challenged the conduct of the surgery she had challenged the basis for it, but he was not prepared to accept the interpretation of a lay person in respect of the radiology report without any

supporting medical evidence, particularly since the surgical procedure itself had not been challenged. He referred to the fact that a mass had been removed from the appellant's colon which when tested had proven to be endometriosis, which if not treated would have resulted in death.

[54] On that basis, the learned judge concluded that the appellant had not established her claim on a balance of probabilities and so the no case submission succeeded. He then entered judgment for the respondents.

The appeal

[55] At the hearing of the appeal counsel for the appellant referred to the application filed on 2 December 2004 to amend the notice and grounds of appeal to add grounds p, q and r, which in essence stated that the learned judge had erred in deciding that the appellant had not made out a prima facie case by looking at the totality of the evidence which included the unsworn testimony of the respondents' witnesses. It was stated in proposed ground of appeal "r" that the evidential burden had shifted to the respondents once the appellant had been admitted as a patient, and therefore the burden was on the respondents to rebut and discharge the duty of care in relation to diagnosis treatment and advice. We heard arguments on the application and refused it due to the fact that, in the court's view, it was being made very late in the day and, in any event, we were of the opinion that the matters being addressed fell within the purview of other grounds of appeal already stated.

[56] Counsel for the appellant filed copious grounds of appeal lettered 'a' to 'o'. His complaint was that the no-case submission had been upheld in error by the learned judge on several bases. In grounds a, c, d, i, m, and o (which for the purposes of analysis are labeled grounds i-vi), he contended that the learned judge had arrived at unreasonable conclusions and had utilized the wrong standard of proof. These grounds are considered below under the general heading "unreasonable conclusions/ standard of proof". In grounds of appeal b, e, f, g, h, j, k, l, and n (labeled herein as grounds vii-xiv), he contended that the learned trial judge erred in finding that the appellant consented to the surgery conducted on 15 July 2004 having also erroneously found that she had signed the consent form dated 5 July 2004. These grounds will be examined under the heading "whether the appellant gave informed consent to the surgery on 15 July 2004". Finally, in ground "k" (labeled herein as ground xv) the appellant challenged the refusal of the learned judge to permit the application for an amendment at the commencement of the trial to add a claim for assault. This will be examined under its own heading "refusal of the application to amend the particulars of claim".

Grounds i to vi - Unreasonable conclusions/standard of proof

> i "The Learned Trial Judge; generally failed to evaluate or to properly evaluate the evidence given by the witness-in-chief and elicited in cross-examination and in his recital thereof avers to conflicting and unreasonable conclusions." (ground a)
>
> ii "The Learned Trial Judge erred when he relied on the Standard of Proof as posited in **Whitehouse v Jordan** (supra). The civil standard however is not broken down into sub-categories and he placed too high a regard and much weight on **Whitehouse v Jordan** (supra) and fell into error." (ground c)

iii "The Standard of Proof apparently exercised by the Learned Trial Judge is inconsistent with that required in a civil case." (ground d)

iv "The Learned Trial Judge's decision was against the weight of the evidence as to whether any information was provided to the Appellant as the Witness statement of Dr. Ian Titus provided no evidence that the Appellant was spoken to or given any information as to the nature and basis of the surgery so that the Appellant could weigh such information and exercise such options which could have presented itself." (ground i)

v "The findings of the Learned Trial Judge were not in accordance with the evidence given and Pleadings in the case." (ground m)

vi "The Learned Trial Judge erred in finding on a balance of probabilities that the Appellant had failed to prove her claim at the close of the Appellant's evidence and not at the close of the Claimant's case." (ground o)

The appellant's submissions (grounds i to vi)

[57] Learned Queen's Counsel submitted with regard to ground of appeal (i) that the learned judge erred in that he ought not to have taken the consent form of 5 July 2004, even if signed by the appellant, to have meant that it authorized the surgery performed on 15 July 2004, as the form was not specific and could have referred to any operation done on the appellant, in which case the consent would not have been informed, as is required.

[58] In respect of grounds (ii) and (iii) counsel claimed that the learned judge had erred in law when he accepted the respondents' submission that an elevated level of the standard of proof was necessary, relying as he did on the dicta in **Whitehouse v**

Jordan, that in civil cases, where the allegations are serious, such as allegations in negligence against medical practitioners, a higher degree of probability was required. Counsel referred to the dicta in **Regina (N) v Mental Health Review Tribunal (Northern Region) and others** [2005] EWCA Civ 1605, **Re CD** [2008] UKHL 33, [2008] 1 WLR 1499 and **Re B (Children) (Care Proceedings: Standard of Proof)** [2008] UKHL 35, [2009] 1 AC 11, to confirm that there is no upward adjustment of the standard of proof in civil cases and that the position as stated in **Hornal v Neuberger Products Ltd**, [1956] 3 All ER 970 and approved in **Whitehouse v Jordan** had been repudiated.

[59] Counsel contended with respect to ground (iv) that there had been no disclosure of information to the appellant by the doctors who had a duty to do so. The appellant should have been informed of the purpose of the surgery and what was involved in performing it. In support of those submissions learned Queen's Counsel relied on the case **Williamson v East London and City HA Orette Anthony and others** 41 BMLR 85 where the 2nd defendants were found negligent having not conveyed their intentions as to the full nature and extent of the surgery with sufficient clarity to the plaintiff. Lack of information would, he submitted, deprive a patient of the ability to make a free and informed choice necessary to protect the patient's dignity and autonomy. Counsel said that it was important also for the patient to be informed of the risk of the surgery and it was the duty of the doctor to ensure that the patient understood that risk. Counsel submitted that the invasive procedure highlighted in Dr Titus' witness statement was

not even known to him prior to the surgery and so the appellant could not have been informed. She also did not know the results of tests done on her.

[60] Counsel submitted further in relation to grounds (v) and (vi) that the learned judge erred in so far as he concluded that there was implied consent, as that was not possible without any information having been given to the appellant in respect of her treatment, advice and diagnosis. Additionally, the learned judge erred in upholding the no case submission at the close of the appellant's evidence but not her case, as her evidence was incomplete due to the fact that there remained outstanding the evidence in respect of her special damages. The learned judge therefore included in his survey of the material in the matter, unsworn evidence not properly before him and adjudicated and decided that the appellant had not proved her case on a balance of probabilities without hearing all the appellant's evidence.

The respondent's submissions (grounds i to vi)

[61] Counsel relied on the principles expressed in the Blackstone's Civil Procedure (2009) 5th edition pages 743 – 744 to submit that the learned judge was correct in upholding the respondents' submission of no case to answer. Counsel argued that the appellant had failed to establish on the evidence on a balance of probabilities any negligence on the part of the respondents. There was no medical evidence or expert opinion to substantiate any of the allegations raised by the appellant. The appellant had failed to comply with the principles as set out in **Bolam** in order to establish her case.

The appellant she said had failed to discharge both the legal and the evidential burden.

She maintained that the appellant has "no real prospect of success".

Grounds vii to xiv- Whether the appellant gave consent to the surgery on 15 July 2004

vii. "The Learned Trial Judge failed to evaluate or to properly evaluate the evidence given by the Appellant which demonstrates that the Appellant was in the care of the Respondent and they operated on her without first seeking her consent." (ground b)

viii. "The Learned Trial Judge failed to consider or appreciate that the Consent Form allegedly signed by the Appellant on the 5th day of July 2004 could not be consent to surgery as at the material time no surgery was being contemplated for the Appellant." (ground e)

ix. "The Learned Trial Judge failed to consider the Appellant's evidence as it related to consent and thereby fell into error as for consent to be valid it must be real and in the circumstances the Appellant was not told about the surgery or the basis for the said surgery and in so doing the consent relied on was not real." (ground f)

x. "The Learned Trial Judge erred in placing reliance on the Bolam Principle - **Bolam v Friern Barnett Hospital Management Board [1957] 1 WLR [sic] 582** when the Appellant's claim was based on a failure to inform of the surgery and not the performance of the said surgery and as such the Bolam Principle would not apply and should not have been relied on any or at all." (ground g)

xi. "The Learned Trial Judge's judgment was against the weight of the evidence as the Respondent provided two diametrically opposed responses to whether the Appellant was informed of said surgery see Defence paragraph 5 and the Witness Statement of Dr. Ian Titus paragraph 11-12." (ground h)

xii. "The Learned Trial Judge erred in taking into account irrelevant consideration in that the surgery saved her

life and failed to take into account that she should have been provided with the necessary information so as to give her consent or otherwise to the surgery." (ground j)

xiii. "The Learned Trial Judge erred in accepting that the Appellant had consented to surgery on July 5th 2004 the date of admission to the Hospital when there was no evidence to suggest that on the 5th July 2004 surgery of any sort was being contemplated." (ground l)

xiv. "The Learned Trial Judge erred in failing to take into consideration the Doctor's duty to provide the patient with the information as to the basis for surgery and why it had to be carried out. In so doing inflating and placing reliance on a duty of the Appellant/patient to ask questions. The duty of the Respondent its servants and/or agents was demonstrated in the Statement of Dr. Titus dated 15th day of May 2009 which highlighted such a duty owed to patients at paragraph 11 "…The normal procedure is that a doctor would explain to the patient the reason for the surgery." The Appellant was not however allowed this courtesy and/or duty of being informed." (ground n)

The appellant's submissions (grounds vii to xiv)

[62] Counsel also relied, in respect of these grounds, on the failure of the hospital to inform the appellant of the surgery which was, as already indicated, a breach of the duty of care owed to the appellant. This, he contended, resulted in there being no real consent to the surgery, in spite of the fact that the learned judge had found that the consent form had been signed by her. He maintained that the **Bolam** principle was not applicable. Additionally, he argued that there had been differing responses given to the appellant by the hospital, that irrelevant factors had been considered by the learned

judge, as indicated previously, and that the learned judge had failed to consider the doctor's duty to his patient.

[63] With regard to grounds (vii), (viii) and (ix) the complaint continued to be whether there was any consent to the specific surgery and that the learned judge's finding that the appellant consented either impliedly or expressly to the surgery was erroneous and against the weight of the evidence. He relied on Justice Cardoza's statement in **Schloendorff v Society of New York Hospital** 211 NY 125 (1914) that every person has the right to decide what should be done to their body, which is the reason why the consent to surgery can only be real if the patient has been informed in broad terms of the procedure which is intended (see **Chatterton v Gerson**). Counsel argued further that the consent allegedly signed in the instant case could only have been for a clinical diagnosis to have been carried out and not for surgery which took place 10 days later. In that situation, there is no certainty that the appellant was competent to make decisions of her own free will and understood the import of what was to be done to her.

[64] Counsel submitted that in respect of grounds (x) and (xi), whereas the **Bolam** principle is applicable when one is relying on a body of medical opinion to say whether certain treatment, advice or diagnosis was correct, it is not so in the circumstances which obtained in the instant case. The **Bolam** principles could only apply, he contended, with regard to the extent of the information that should be supplied, but not whether information should be provided at all, as that was an accepted duty owed by the hospital to the appellant. Further, in the instant case, the responses from the

respondents were diametrically opposite. On the one hand, they averred that the appellant had been informed of the surgery and had consented to it, and on the other hand, that she had not been informed of the risk of the surgery and had not known before the surgery had been undertaken, that surgery was to be done on her. In these circumstances, the judgment, counsel submitted, was against the weight of the evidence.

[65] Grounds (xii) and (xiii) have been subsumed by arguments already proffered but in respect of ground of appeal (xiv), counsel for the appellant contended that the learned judge placed too much weight on the role of the appellant whereas the main duty and role that ought to have been considered was that of the doctor and his duty to the patient. It was not a matter of whether the appellant had not objected or made a query in respect of the treatment to be administered, or the surgery to be undertaken, as the case may be, which counsel observed the learned judge had noted, whilst referring to the appellant's familiarity with the surgical process, and assuming her implied consent thereto, as she had not questioned the process or asked to leave the hospital. Counsel argued, that that was not sufficient to amount to consent. Additionally, counsel stated that the learned judge erred, when he appeared to accept that since the surgery had not harmed the appellant, but to the contrary, had assisted in her health, that the failure to inform her of the surgery and its attendant risks, so that she could have obtained a second opinion, was unimportant, particularly if there was no information as to what that second opinion would have been and the effect it would have had on her decision to have surgery. Counsel referred to and relied on **St**

George's Healthcare NHS Trust v S; **R V Collins and others**, **exparte S** [1998] 3 All ER 673, **Chester v Afshar**, and **Sidaway v Board of Governors of the Bethlem Royal Hospital and Others** for these submissions.

The respondents' submissions (grounds vii to xiv)

[66] Counsel submitted that on the basis of the evidence of DSP Smiley and the cross-examination of the appellant, it was clear, and the learned judge had no other course but to find, that the appellant had consented to the surgery.

[67] With regard to the appellant's complaint that the hospital breached their duty to warn of the risk of surgery which vitiated any consent to the surgery of 15 July 2004, counsel referred to paragraph [28] of the learned judge's judgment (referred to in paragraph [49] herein), wherein the learned judge commented that the appellant had not produced any evidence to confirm that the hospital knew about the possibility for the need of the Hartman procedure, which could have resulted in the need for the use of a colostomy bag. Counsel further submitted that the appellant's witness statement disclosed no negligence on the part of the respondents and in particular, as there was no medical evidence to substantiate the allegations raised by the appellant, the judge's findings were unassailable.

[68] Counsel posited that the appellate court should not disturb findings of fact by a trial judge unless they were plainly wrong and relied on the dictum of Brooks JA in **Codner v Codner** [2013] JMCA Civ 13.

Ground of appeal xv - refusal of the application to amend the particulars of claim

[69] Counsel claimed that the learned judge had erred in refusing to grant the amendment to the particulars of claim, which formed ground of appeal (k), and is numbered xv, below.

Refusal of the application to amend the particulars of claim

> xv. "The Learned Trial Judge erred in disallowing the Appellant's Application to amend her Particulars of Claim on the basis that it was against the weight of the evidence and that the Respondent [sic] was not prepared to meet a claim for assault when based on the pleadings before the court the Appellant provided notice of such a claim and the Respondent met such notice in their Defence". (ground k)

The appellant's submissions

[70] Counsel for the appellant argued that the application to amend the particulars of claim to include the cause of assault should not have been refused, as the respondents would have suffered no prejudice, as the added claim was similar to the claim as currently constituted they being claims that the respondents were already prepared to meet and so, they could not have been taken by surprise. Counsel relied on **Gloria Moo Young and Erle Moo Young v Geoffrey Chong, Dorothy Chong and Family Foods Limited (in Liquidation)** SCCA No 117/1999, judgment delivered 23 March 2000 which states that an amendment may be permissible however late if: it is necessary to decide the real issue in controversy; no prejudice will be created; it is fair in all the circumstances; and it is a proper exercise of the judge's discretion.

The respondents' submissions

[71] Counsel submitted that the amendment to include assault could not have been allowed, as the surgery was done on 15 July 2004, so any amendment to the claim to include a new cause of action would have had to have been made before July 2010. The application was being made more than eight years after the event, and so had no merit. It was caught by the Limitation of Actions Act, and pursuant to rule 20.6 of the CPR, could only have been permitted if the amendment was to correct a mistake as to the name of the parties, which mistake was genuine and not one to cause reasonable doubt as to the identity of the person, which was not the situation which obtained in the instant case.

Analysis

[72] I will not attempt to address each and every ground of appeal, but I will deal with the grounds under the broad headings in law that I have already identified and apply the principles discernable to the case at bar. I hope that this approach will do no injustice to the copious grounds filed and the respective detailed arguments presented.

No case submission

[73] No case submissions in civil cases are rare. This is perhaps because it has quite clearly been laid down that the court will generally refuse to rule on such a submission unless the defendant indicates that he is not going to call any evidence. He will therefore, except in extraordinary cases, be put to his election. In the instant case the respondents were put to their election and they called no evidence. This is important

for several reasons. In the case **Trevor Boyce v Wyatt Engineering et al** [2001] EWCA Civ 692, Lord Mance in explaining the reason for this approach by the courts made the point at paragraph 4 that:

> "… where a defendant is put to his election, that is the end of the matter as regards evidence. The judge will not hear any further evidence which might give cause to reconsider findings made on the basis of the claimant's case alone. The case either fails or succeeds, even on appeal…"

In commenting on the process Lord Mance went on to say at paragraph 5 that:

> "**...** it is not right that the judge of fact should be asked to express any opinion upon the evidence until the evidence is completed. There may be some cases, probably rare, in which nothing in the defendant's evidence could affect the view taken about the claimant's evidence or case,…"

He indicated that the circumstances in the **Boyce** case were not one of them, but that care would be required to identify such cases.

[74] In **Michael John Miller (t/a Waterloo Plant) v Margaret Cawley** [2002] EWCA Civ 1100, Lord Mance indicated at paragraph 18 that:

> "…The issue after an election is, in other words, *not* whether there was any real or reasonable prospect that the claimant's case might be made out or any case fit to go before a jury or judge of fact. It is the straightforward issue, arising in any trial after all the evidence has been called, whether or not the claimant has established his or her case by the evidence called on the balance of probabilities."

[75] In my view, what can be gleaned from the above authorities is that the learned trial judge having put the respondents to their election, he ought to have dealt with the matter solely on the appellant's evidence and decided whether she had established her case on a balance of probabilities.

[76] In the instant case, on a review of the pleadings the real issue in the case was whether the respondents had performed the surgery on the appellant on 15 July 2004 without her consent. Additionally, whether she was told that the surgery carried a risk, that is the possibility of wearing a colostomy bag. She pleaded *res ipsa loquitur* and claimed that the hospital was negligent in denying her the right to choose whether to undergo the operation. The respondents in their defence claimed that she had been told of the surgery and the risks attendant therewith before the operation and she had consented thereto. In the answers to request for information, which is also a statement of case, pursuant to rule 2.4 of the CPR, the respondents maintained that not being able to locate the consent form allegedly signed by the appellant, then in the alternative, the appellant had given her consent either orally and or impliedly when the surgical procedure had been explained to her by medical personnel at the respondent. Those, therefore, were the competing contentions on the pleadings before the learned judge, and which would have been his focus when assessing the evidence adduced only by the appellant to determine whether there was a case to answer.

[77] The facts and issues later identified by the respondents, as set out in paragraph [28] herein, only arose subsequent to the filing of the witness statements of Dr Titus and Dr Sinclair particularly, with regard to the allegation that the discovery of the

necessity for the use of the colostomy bag became apparent during surgery and that the mass which was removed from the intestines proved to be the serious condition of endometriosis. Thus, those statements ought therefore not to have been a part of the learned judge's deliberations.

[78] The witness statements of Dr Titus and Dr Sinclair without more did not constitute evidence. If the respondents, having served the same, wished to rely on the evidence of the witnesses who made the statements they must call the witnesses to give evidence, unless the court orders otherwise (rule 29.8(1)(b) of the CPR). The respondents decided however, not to call any evidence and were correctly put to their election, so it was unfortunate that the learned judge when ruling on the submission of the respondents that there was no case to answer, referred to material in the respondents' witness statements as this was not acceptable. Furthermore, there was an evidential departure of the witness statements from the pleadings. This inconsistency in the case advanced by the respondents needed to have been reconciled.

[79] The learned judge's reference to the material filed by the respondents evidently affected, or influenced his findings which were adverse to the appellant (see paragraph [49] herein, referring to paragraphs [26], [27], [28] and [30] of his judgment). At the end of the appellant's case there was evidence by her that she had not been informed of the surgery or the risks attendant to the surgery and that any alleged consent would have been vitiated. She testified that she had wanted an opportunity to obtain a second opinion and that she had been deprived of the opportunity of being able to do so. That, would, in my view, have called for an explanation from the respondents. As there

was no indication that she lacked credibility, that evidence, without more, ought to have satisfied the burden and standard of proof relating to the cause of action of negligence, in respect of the lack of informed consent to the surgery and the risks associated therewith. The appellant would therefore, in my view, have been entitled to judgment, the respondents having elected not to call any evidence.

[80] There were four exhibits tendered in evidence by consent at the trial which therefore formed a part of the material which was properly before the learned judge for consideration on the no case submission at the close of the appellant's case. Exhibit 1 was the consent form dated 5 July 2001; exhibit 2 - the expert report of DSP William Smiley, dated 6 February 2012; exhibit 3 - the expert report of Jeanette Yee, dated 14 July 2004; and exhibit 4 - the expert report of Dr Ann M Fenna dated 29 June 2004. I have already referred in some detail to exhibits 1 and 2. Exhibits 3 and 4 were radiology reports done by consultant radiologists.

[81] Exhibit 4 showed findings of an abdominal and pelvic ultra sound examination done on the appellant on 29 June 2004, addressing lower abdominal pain. The findings were as follows:

> "The liver is normal in size and echogenicity. It is unremarkable for focal lesions or dilated intrahepatic duct. The gallbladder is normal. No calculus, polyps or stigmata of inflammation is evident. The CBD spleen, pancreas and abdominal aorta are normal.
>
> Both kidneys are normal in size and echogenicity. No mass, calculus or hydronephrosis is seen. Neither kidney is obstructed.

> The anteverted, non-gravid uterus is normal in size and echogenicity. The endometrium is normal. The left ovary is enlarged by a 5.3 cm hemorrhagic cyst. The right ovary is normal in apppearnace. There is no free pelvic fluid.
>
> CONCLUSION: Hemorrhagic left ovarian cyst"

[82] Exhibit 3 also showed findings of an abdominal and pelvic ulta sound (Transabdominal & Endovaginal) done on 14 July 2004 addressing abdominal pain, back pain with abdominal distention, decreased bowel motion and a provisional diagnosis of intestinal obstruction. The findings were as follows:

> "The liver, intra-and extrahepatic ducts, gallbladder, pancreas, spleen and both kidneys are unremarkable in appearance. Neither kidney demonstrates any evidence of a mass or calculus. Free fluid is noted in the abdomen particularly peri-hepatically. No evidence of an inter-loop collection seen. Dilated loops of bowel are noted. They are fluid filled.
>
> The uterus is normal in size and echogenicity. The endometrial stripe is within normal limits. Neither ovary is identified. Free pelvic fluid is noted.
>
> CONCLUSION: Fluid filled dilated loops of bowel with free fluid within the abdomen. No evidence of an interloop collection."

[83] Whereas the report of Dr Fenna, which informed the surgery done two days later on 1 July 2004, declared a conclusion of a "hemorrhagic left ovarian cyst", which was later removed in surgery, the report of Dr Yee two weeks later and a day before the surgery on 15 July 2004 concluded "fluid filled dilated loops of bowel with free fluid within the abdomen. No evidence of an interloop collection". There was on the face of this report, no indication of any mass in the colon or that any emergency surgery was

recommended or required. It would have been the respondents' servants and or agents who would have interpreted this report and seen it necessary to remove a part of the appellant's colon. Therefore, any explanation for the surgery ought to have come from them. The assertions of the appellant and the reports tendered did warrant some explanation from the respondents. So, although the learned trial judge stated in his reasons that he was not prepared to take the layman's interpretation of the radiology report, without any other evidence, the question must arise as to whether in respect of exhibit 3, on a balance of probabilities, there was any information given to the appellant relating to the particular impending surgery with attendant risks.

Consent to the surgery

[84] It is trite law and is not in dispute in this case that the appellant having been admitted into the hospital, she was owed a duty of care by the hospital and all medical staff into whose charge she was placed (**Cassidy v Ministry of Health**). In this case, the appellant was not claiming that what happened to her arose as a consequence of negligence in respect of the operation on her abdomen, but she was positing the question - ought a competent surgeon who was about to operate on her intestines not be aware of the nature and complexity of the surgery that he was about to undertake and also of the risk attendant thereto? Further, would that happen in the absence of ordinary care? The facts of this case are not similar to the leading case on the principle of *res ipsa loquitur*, where six bags of sugar fell from a crane and injured a customs officer walking underneath from one warehouse doorway to another.

However, the principle is still applicable to the instant case for as Earle CJ stated in **Scott v London Dock Co**, 3 H & C, 601:

> " … where the thing is shown to be under the management of the defendant or his servants, and the accident is such as in the ordinary course of things does not happen if those who have the management use proper care, it affords reasonable evidence, in the absence of explanation by the defendants, that the accident arose from want of care.."

The further question therefore would be, that since the doctor ought to be aware of the surgery to be undertaken by him, and any risks attendant thereto, ought he not also to inform the patient, and if not would that not occur from a want of care? I would think so. In this case the appellant pleaded and relied on the doctrine of *res ipsa loquitur* but the learned trial judge, although he made mention of the doctrine when ruling in favour of the appellant on the respondent's application to strike out the claim, made no mention of the same when he ruled that the defendant had no case to answer. In my view he erred in that regard.

[85] That brings me to a review of five of the authorities referred to by counsel in order to assess the extent of the duty of the doctor to inform the patient. This review is considered necessary in order for one to ultimately determine whether all these issues were properly assessed by the learned trial judge when deciding whether the appellant had proved her case in negligence against the respondents on a balance of probabilities, or whether his summary disposal of the matter was in error.

[86] In **Sidaway v Board of Governors of the Bethlem Hospital and Others**, the court held that the question whether an omission to warn a patient of inherent risks of proposed treatment constituted a breach of a doctor's care towards his patient was to be determined by an application of the **Bolam** test. The court also held that the degree of disclosure required for a particular patient was also to be judged primarily on the basis of medical evidence. In that case, Lord Diplock described the "merit of the **Bolam** test" as being "that the criterion of the duty of care owed by a doctor to his patient is whether he has acted in accordance with a practice accepted as proper by a body of responsible and skilled medical opinion". Having reviewed several authorities, Lord Diplock concluded that although the degree of disclosure may be based on clinical medical judgment, he did not see the necessity "to hand over to the medical profession the entire question of the scope of the duty of disclosure, including the question whether there has been a breach of that duty". Indeed, he finally decided:

> "... I am of opinion that the judge might in certain circumstances come to the conclusion that disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it." [page 900]

It is true that Lord Diplock stated that the situation that he had in mind was an operation involving substantial risk of grave consequences such as a 10% risk of a stroke, but I do not think that subsequent authorities are that limited in scope of application. And in any event, it was clear that it was the judge who should make the determination on the evidence given by the patient.

[87] Indeed in that case Lord Templeman put it a different way with a greater focus on the right of the patient, the duty of the doctor and the responsibility of the court. This is what he said in part at pages 903-905

> "… It is for the court to decide, after hearing the doctor's explanation, whether the doctor has in fact been guilty of a breach of duty with regard to information
>
> A doctor offers a patient diagnosis, advice and treatment… Where there are dangers that treatment may produce results, direct or indirect, which are harmful to the patient, those dangers must be weighed by the doctor before he recommends the treatment. The patient is entitled to consider and reject the recommended treatment and for that purpose to understand the doctor's advice and the possibility of harm resulting from the treatment
>
> ... the doctor is not entitled to make the final decision with regard to treatment which may have disadvantages or dangers. Where the patient's health and future are at stake, the patient must make the final decision. The patient is free to decide whether or not to submit to treatment recommended by the doctor and therefore the doctor impliedly contracts to provide information which is adequate to enable the patient to reach a balanced judgment, subject always to the doctor's own obligation to say and do nothing which the doctor is satisfied will be harmful to the patient... The court will award damages against the doctor if the court is satisfied that the doctor blundered and that the patient was deprived of information which was necessary for the purposes… outlined.."

[88] The question in the case at bar therefore must be, was any information or adequate information provided by the doctors who did the surgery so as to allow the appellant to form a balanced judgment or make an informed consent in respect of the specific treatment administered which was the surgery? The answer must be, based on the appellant's evidence which is all that was before the court, in the negative. If that is

the case, some explanation would have had to come from the doctor for the departure from well established practice and requirement of the law that the patient was to have been advised as to the diagnosis and treatment.

[89] In **Pearce and another v United Bristol Healthcare NHS Trust**, Lord Woolf MR stated:

> "In a case where it is being alleged that a plaintiff has been deprived of the opportunity to make a proper decision as to what course he or she should take in relation to treatment, it seems to me to be the law, as indicated in the cases to which I have just referred, that 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 should adopt."

In **Pearce**, the claimant did not succeed as the court found that the risk was so small as to be insignificant and that the claimant would, in any event, have followed the advice of the doctor. In the instant case, the claimant wished to obtain a second opinion in order to ascertain what course of action she should take. It cannot be said, on the evidence, that the risk to the appellant was insignificant or that she would have followed the advice if she had knew that she would have had to wear a colostomy bag.

[90] In **Chatterton v Gerson and Another**, the court dealt with the effect of the failure to inform the patient of the issue of consent. So, where a doctor failed to explain in broad terms the nature of the operation, the court held that the patient would not have consented to it and any consent given in those circumstances, would be unreal

and an action would lie in trespass. The action would lie in negligence, if the patient could prove that the doctor had failed to comply with his duty to explain to the patient what he intended to do and the implications of the same in such a careful way, so that the patient understood and that had he done so, the patient would not have consented to the operation. As Bristow J said in **Chatterton**, what the court has to do in each case is to look at all the circumstances and say - was there a real consent? Were there circumstances which could vitiate the consent? In my view, this would be a question of fact for the trial judge. In the instant case, on the pleadings and the appellant's evidence, she said that there was no explanation of the nature of the surgery or the risk and she wanted an opportunity to obtain a second opinion. The question would therefore have arisen, could that evidence have met the required standard of proof even though, she did not say that had she obtained the detailed advice, she would not have had the operation.

[91] In **Williamson v East London and City Health Authority and others**, the court addressed the fact that although the claimant had given previous consent she had not been told of the much more radical surgery that was eventually performed on her. The court held that although the extensive surgery was necessary, the plaintiff had not consented to such extensive surgery and that she was therefore entitled to damages for the resultant pain and suffering, unnecessary scarring and loss of amenity. So, in the instant case, an issue would have arisen as to whether the consent form allegedly signed on 5 July 2004, could have been effective as a consent for the extensive surgery which took place, which resulted in her wearing the colostomy bag, in

respect of which the appellant was unaware. These were questions which the learned trial judge failed to answer in treating with the appellant's case and thereby fell into error.

[92] In **Chester v Afshar**, a surgeon advised a claimant to undergo an operation on her spine which carried a small risk of paralysis, even if the surgery was conducted without negligence. The patient consented to the operation but subsequently after the same became paralyzed. The trial judge found that the doctor had negligently failed to warn the claimant of the small risk of paralysis and in that respect he found the doctor negligent under the principles laid down in **Bolam**. This decision was upheld by the Court of Appeal. On appeal to the House of Lords, the issue considered was one of causation, as it was agreed that the doctor had failed to warn the claimant of the risk inherent in the operation.

[93] The House of Lords held that it was sufficient for a patient who was not properly informed about the risk of a proposed surgery to prove that if properly warned, he would not have consented to the surgery at the time it was performed. He had a right to know the risk and to decide when and at whose hands he would undertake the surgery. He was not required to prove that he would never have had that operation. As a consequence, a patient who persuades the court that he would have postponed his decision - to reconsider, take alternative advice, or to consider alternate options, will succeed in the applicable causation test.

[94] Mrs Chester had argued that had she been aware of the risk of spinal cord ischemia and paralysis that accompanied the surgery she underwent, she would not have consented to it. That she would, in all likelihood still have undergone that procedure at some later date, was considered irrelevant, as she could have sought the opinion of a surgeon more skilled in that procedure to lessen the risk. Lord Steyn observed that:

> "In modern law medical paternalism no longer rules and a patient has the right to be informed by a surgeon of a small, but well established, risk of serious injury as a result of surgery."

Lord Steyn opined that there was sufficient causal link between the defendant's failure to warn and the damage sustained by the claimant. He also held that a surgeon had a legal duty to warn a patient in general terms of any possible serious risks involved in the procedure to be adopted for treatment, except in exceptional circumstances, where, in the best interest of the patient, the surgeon may be excused from giving a warning. Lord Steyn declared that surgery without the informed consent of the patient was unlawful and the court was to be the final arbiter of what constituted informed consent. The defendant's appeal was dismissed. The right to be informed was equated with the right to choose.

[95] The House of Lords held in **Chester v Afshar** that the court had a duty to vindicate the claimant's right by imposing damages against the defendant where there

was a failure to inform of a serious risk and that risk eventuated. The court also held that in that case a departure from traditional causation principles was justified.

[96] An examination of the English cases from **Bolam** to **Chester v Afshar** clearly indicates that a doctor is required to provide the patient with sufficient information for the patient to decide whether to proceed with the treatment or not. In keeping with those principles it was therefore incumbent on the respondents to inform the appellant of the diagnosis and impending treatment. The issue would then have arisen pursuant to the principles emanated from **Bolam** as to the extent of the information required to be disclosed to her. The learned judge unfortunately using the witness statements which were not properly before him made a finding that there was no medical evidence challenging the position of the defence that the doctors did not know prior to the surgery and therefore presumably could not have informed the appellant of the nature of the surgery and or the resultant need for a colostomy bag. He also said that there was no medical evidence to suggest that the doctors should have known before then. The learned judge was therefore addressing the extent of the information required if any, particularly since he found that the appellant had not given evidence as to what the second opinion was and whether she would not have chosen to have the operation.

[97] The only evidence before the learned judge however, which was from the appellant, was that she had not been spoken to about the surgery prior to the surgery being performed on her. The fact in issue at the close of her case, was whether she had given informed consent. There was no plea from the respondents that any exceptional circumstances existed to excuse them from their obligation to give the

requisite warning to the appellant. Even if there been such a plea the respondents would have been required to give evidence of the same. Based on the authorities examined above and the circumstances of the case at bar, I would conclude that there was no real consent given by the appellant.

Standard of proof

[98] The learned judge had indicated that he had relied on the principle and standard enunciated in **Whitehouse v Jordan** and had quoted in his reasons for judgment the passage from the judgment of Lawton LJ relied on by counsel for the respondent which reads as follows:

> "The standard of proof which the law imposed on the infant plaintiff was that required in civil cases, namely proof on the balance of probabilities, but as Denning LJ said in *Hornal v Neuberger Products Ltd*: The more serious the allegation the higher the degree of probability that is required. In my opinion allegations of negligence against medical practitioners should be considered as serious. First, the defendant's professional reputation is under attack. A finding of negligence against him may jeopardise his career and cause him substantial financial loss over many years. Secondly, the public interest is put at risk. As Denning LJ pointed out in *Roe v Ministry of Health*. If courts make findings of negligence on flimsy evidence or regard failure to produce an expected result as strong evidence of negligence, doctors are likely to protect themselves by what has become known as defensive medicine, that is to say, adopting procedures which are not for the benefit of the patient but safeguards against the possibility of the patient making a claim for negligence. Medical practice these days consists of the harmonious union of science with skill. Medicine has not yet got to the stage, and maybe it never will, when the adoption of a particular procedure will produce a certain result…"

[99] I accept the submissions of counsel for the appellant that the position taken in **Hornal v Neuberger** that a higher degree of probability, or that higher or heightened standards of civil proof were required in certain instances, was not accepted by later English Court of Appeal decisions, namely, **Regina (N) v Mental Health Review Tribunal (Northern Region) and others** where the dictum of Richards LJ, set out below, when he clarified the position, was specifically approved by the House of Lords in **Re CD** at paragraph 27. He stated:

> "Although there is a single civil *standard* of proof on the balance of probabilities, it is flexible in its *application.* In particular, the more serious the allegation or the more serious the consequences if the allegation is proved, the stronger must be the evidence before a court will find the allegation proved on the balance of probabilities. Thus the flexibility of the standard lies not in any adjustment to the degree of probability required for an allegation to be proved (such that a more serious allegation has to be proved to a higher degree of probability), but in the strength or quality of the evidence that will in practice be required for an allegation to be proved on the balance of probabilities."

[100] In my opinion, the test for the civil standard of proof is not qualified by the seriousness of the allegations. Baroness Hale made an equally strong statement of this aspect of the law in **In Re B (children)** where she stated the following with her usual simple clarity at paragraph 70:

> "… Neither the seriousness of the allegation nor the seriousness of the consequences should make any difference to the standard of proof to be applied in determining the facts. The inherent probabilities are simply something to be taken into account, where relevant in deciding where the truth lies."

[101] It seems to me therefore that the learned judge would have erred if he had utilized a higher standard of proof than the law requires. In these circumstances, where he was deliberating on the respondent's no-case submission, his finding that the appellant, on the evidence adduced, had not established a case of negligence on a balance of probabilities, would on that basis, without more, and on the face of it, appear flawed and unsustainable.

[102] It is clear that the legal burden of proof falls on the appellant who asserted that the respondents were guilty of negligence, but the respondents had an evidential burden to rebut those allegations. In this case, the respondents had indicated that they were intending to call certain witnesses but they had not done so.

[103] On the basis of all of the above, it is clear to me that the learned judge erred in his approach to the matter. He did not apply the correct principles of the common law in relation to the duty of care owed by the respondents to the appellant, the correct standard of proof in civil cases even where the allegation is in respect of negligence against professionals in the pursuit of their discipline and the limited evidence to be addressed at the no case submission made by the defendants when they are put to their election. In all the circumstances, in my view, the learned judge failed to properly assess the evidence that was properly before him in order to conclude whether the appellant had at the close of her evidence established a prima facie case of negligence against the respondents. If the learned judge intended to put the respondents to their election, which he did, then it was necessary for him having done so to apply the correct standard of proof in a civil case, namely on a balance of

probabilities, no more no less in considering the appellant's case. He did not approach the no case submission in that way and he, therefore, fell into error. In my view, the judgment cannot stand.

[104] As stated by Lord Greene MR in **Laurie v Raglan Buildng Co Ltd** [1941] 3 All ER 332, with which I entirely agree, in respect of the facts of this case (although dissimilar to the facts of that case, which was dealing with a motor vehicle accident based on a lorry which skidded and injured the plaintiff who was on the pavement) that once the prima facie case has been established and the defence has been put to their election and has called no evidence:

> "… there can be no question of a new trial …the matter must be dealt with on the evidence as it stands. On the evidence as it stands…. in my opinion, the plaintiff has established liability. The only matter which remains is that of damages, and, with regard to that, the case did not proceed, so that we are not in a position to deal with it. The result is, therefore, that the appeal will be allowed on the question of liability and there must be a new trial on the question of damages if the parties are unable to agree them."

In my view, the appeal ought to be allowed and the question of liability having been established, the case should be remitted to the court below before a different judge for damages to be assessed, the damages having been reserved at the end of the evidence adduced by the appellant.

The refusal of the application to amend the particulars of claim

[105] The details of the submissions of both counsel in respect of the application to amend the particulars of claim to add the cause of assault, at trial, and the ruling by the learned judge refusing the application are set out in paragraphs [29] and [30] herein. At the hearing of the appeal, counsel for the appellant argued that the learned judge erred. He relied on the dictum of Ormrod LJ in **Devi v West Midlands Regional Health Authority** [1980] CLY 687, in support of that submission. In that case the plaintiff, a Shikh aged 29, whilst undergoing an abdominal operation to repair a perforation of her uterus, which had been punctured during an evacuation of retained products following the birth of her fourth child was subjected to a sterilization operation which resulted in her being unable to have any more children. She had given consent to the repair of her uterus only. It had not been discussed with her whether a sterilization should be contemplated. As Ormrod LJ put it, those circumstances could ground either an assault or failure to give proper advice, but whichever approach was taken the plaintiff had a valid cause of action and was entitled to damages as a result.

[106] In the instant case, the appellant contended that the same facts that grounded the claim for negligence through lack of informed consent grounded the claim for assault and battery. On the other hand, the respondents relied as they had done previously, on the signed consent form indicating voluntary agreement for the treatment including surgery, and on the basis that the late application to include a new cause of action had taken them by surprise, resulting in prejudice to them. They also, on appeal, submitted that the application was caught by the Limitation of Actions Act,

which provided an absolute defence to any such new cause, all properly warranting the learned judge's refusal of the application.

[107] In my view, the refusal of the application was one made within the discretion of the learned judge. It was therefore for him to assess the inconvenience and waste of judicial and other time and potential prejudice to the parties which would occur on the adjournment of the matter to facilitate the amendment to the claim to add the new cause of assault. The case was fixed for trial and there had already been previous adjournments. It was an old matter relating to incidents occurring in 2004. It was therefore crying out to be heard and the appellant really ought to have known by 2011, the causes of action on which she intended to rely at the trial.

[108] However, that notwithstanding, if as I have pointed out there was the possibility of the court concluding that there was no informed consent, which as I have indicated was the situation which obtained, then any surgery performed on the appellant without her consent could amount to a battery which would be an assault on her. It would therefore not be a claim without any merit even in the light of the alleged executed consent form, as that form, even if it was signed, would not have any relevance to the extensive surgery undertaken many days later on the appellant's intestines. That form made no reference to the specific diagnosis for which surgery was eventually done and particularly, it had no indication that the appellant was informed of that diagnosis and the treatment that would have followed.

[109] I accept the principle of law outlined by Morgan JA in **Constable Newton Bowers and The Attorney General of Jamaica v George Gordon** (1991) 28 JLR 334, accepting the words of McGregor CJ in **Charlton v Reid** (1960) 3 WIR 33, stating that:

> "There is an abundance of authority that the Court has always refused to allow a cause of action to be added where, if it were allowed, the defence of the Statute of Limitations would be defeated. The Court has never treated it as just to deprive a defendant of a legal defence."

I also accept that whilst rule 20.6 of the CPR addresses amendments to statements of case, after the end of the relevant limitation period, that provision is only in respect of allowing a change of name due to a genuine mistake. There are no provisions in the rules for substitution or addition of a new cause of action after the expiration of the limitation period.

[110] Prior to the advent of the CPR, the case **Judith Godmar v Ciboney Group Limited** SCCA No 144/2001, judgment delivered 3 July 2003, considered the issue of amending the statement of case to add a new cause of action after the limitation period had passed. Smith JA, on behalf of the court, in deciding to amend the statement of case to include an increase in the claim for special damages but not a claim for psychiatric injury, adopted the principle in **Weldon v Neal** (1887) 19 QB 394 (CA) that a plaintiff would not be allowed to amend the statement of case by setting up a fresh claim when the cause of action had become statute barred. In my view, however, that matter is distinguishable from the instant case, where no new injury is being claimed

but rather the addition of the cause of "assault" was being sought to properly characterize the nature of the claim, that is the negligent actions of the respondents which led to the assault on the appellant.

[111] K Harrison JA in **The Jamaica Railway Corporation v Mark Azan** SCCA No 115/2005, judgment delivered 16 February 2006, in respect of a procedural appeal (in chambers) endeavoured to address the gap in the current state of the law. He stated, in dealing with the application to amend after the period of limitation had expired, and I agree with him, that: "in the final analysis the decision whether or not to grant such an application, one ought to apply the overriding objective and the general principles of case management".

[112] There are several authorities which K Harrison JA referred to in the **Azan** case, which he said establish certain principles in relation to what amounts to a new cause of action, although he stated they were not exhaustive. These were:

(i) if the new plea introduces an essentially distinct allegation, it will be a new cause of action;

(ii) if the proposed amendment is only a further instance of breach, or the addition of a new remedy, there is no addition of a new cause of action (**Savings and Investment Bank Ltd v Fincken** [2001] EWCA Civ 1639, The Times, 15 November 2001) and

(iii) a new cause of action may be added or substituted if it arose out of the same set of facts or substantially the same facts, as gave rise to a cause of action already pleaded.

For example, negligent design was allowed to be added to a plea of negligent supervision previously pleaded as the former arose out of the substantially the same facts as the latter (see **Brickfield Properties Ltd v Newton** (1971) 1 WLR 862).

[113] In the instant case, it could not be said that a new cause of action had been added, as the addition of assault rested on the same facts as the cause of action for negligence. The question of whether or not the doctors did their duty in informing the appellant of the need and nature of the surgery directly impacts whether or not there was indeed consent. If they failed in their duty, there would be a lack of consent which, as previously indicated, would give rise to the claim in assault. In my view the learned judge erred in determining that allowing the application would have been prejudicial to the respondents, as the issues remained the same, and the defence thereto would not have changed. Both causes of action turn on the issue of consent. The damages claimed to have been suffered by the appellant are as a result of the failure to be informed of the surgery and the fact that the surgery was done without her consent. Assault is a tort which is actionable per se without the need to prove any damage. The appellant, however, has claimed physical and psychological damages, inconvenience and discomfort in her personal and social life, with medical expenses as

special damage, that she has alleged have flowed from the respondents' breach of duty in negligence, which also resulted in the tort of assault.

[114] I would therefore disagree with the refusal of the amendment and order that the claim proceed to assessment of damages on the basis of negligence and assault, the former being due to the lack of informed consent, which resulted in there being no consent at all, which equates to the latter cause of action of assault.

[115] In the light of all of the above, I would allow the appeal, and order that judgment be entered on liability for the appellant, with costs here and in the court below to be agreed or taxed. I would also remit the claim to the Supreme Court for a new trial for damages, to be assessed by a different judge.

McDONALD-BISHOP JA (AG)

[116] I have had the opportunity of reading in draft the reasons of my learned sister Phillips JA and I am in agreement with the reasoning and conclusion and have nothing further to add.

PANTON P

ORDER

1. The appeal is allowed.

2. The order made by Fraser J on 7 March 2012 upholding the no case submission and entering judgment for the respondents is hereby set aside.

3. Judgment is hereby entered on liability for the appellant. The matter is remitted to the Supreme Court for damages to be assessed before a different judge.

4. Costs of the appeal and in the court below to the appellant to be taxed if not agreed.