Neutral Citation Number: [2015] EWHC 1058 (QB)

Case No: HQ13X00338

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 21 April 2015

Before :

HIS HONOUR JUDGE COLLENDER QC
(SITTING AS A JUDGE OF THE HIGH COURT)

- -

Between :

DAVID SPENCER	**Claimant**
- and -	
HILLINGDON HOSPITAL NHS TRUST	**Defendant**

- -
- -

Mr Peter Skelton (instructed by **Messrs Leigh Day & Co**) for the **Claimant**
Mr Roger Harris (instructed by **Messrs Clyde & Co LLP**) for the **Defendant**

Hearing dates: 23-25 March 2015

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

.....

HHJ Collender QC :

INTRODUCTION

1. The Claimant, Mr Spencer claims damages for personal injuries and consequential loss arising from the alleged negligence of the staff of the Hillingdon Hospital following a surgical operation performed upon him at the hospital on 1 February 2010.

2. The Defendant is the National Health Service Trust responsible for the medical and surgical services at the hospital. It is agreed that the Defendant is vicariously liable for any negligent care given to Mr Spencer at the hospital.

3. Breach of duty and causation are disputed. Quantum of damages, subject to liability, is agreed at the sum of £17,500 subject to the court's determination of the issue of contributory negligence raised by the Defendant against Mr Spencer.

THE FACTS

4. I will set out the facts that are not, or on the evidence before me cannot sensibly be disputed.

5. Mr Spencer was born on 27 November 1960, so was aged 49 at the time of the operation and is now aged 54. He works as a property services manager.

6. In late 2009, Mr Spencer began to suffer symptoms of pain in his right groin. His GP suspected a right inguinal hernia and Mr Spencer was referred to the hospital where, on 19 January 2010 he was seen for a pre-operative assessment in the surgical outpatients department by Mr S Chaudhry, a locum General surgeon. Mr Chaudhry diagnosed that as well as suffering from a hernia on the right side, Mr Spencer was also suffering from a hernia on the left side. It was proposed that bilateral extraperitoneal repairs be performed upon both hernias by the use of a laparoscope so as to avoid an open wound operation. Mr Spencer was told at the hospital that in its course, the operation might have to be converted from a laparoscopic to an open procedure. Before he signed a consent form in respect of the operation, Mr Spencer sought reassurance from Mr Chaudhry that in the case of such a conversion to an open procedure, priority would be given to repairing the hernia on the right side. Following these discussions, Mr Spencer signed a form of consent for the operation which warned him of the risks of:

> *'Bleeding, infection, scar, recurrence of problem, conversion to open procedure, injury to bowel'.*

7. No mention was made in the course of Mr Spencer's discussions with any staff at the hospital on 19 January 2010 that he might suffer a deep vein thrombosis or pulmonary embolism as a consequence of the proposed surgery and the immobility that it would cause. He was not given any information as to the likely signs and symptoms that he might suffer in the event of the development of such conditions.

8. Before the operation was performed on 1 February 2010, Mr Spencer had pneumatic boots placed on his legs. These are a device that is intended to improve a patient's

blood circulation so as to reduce the risk of a patient suffering from deep vein thrombosis.

9. The operation was begun laparoscopically but, in its course, the procedure was converted to an open procedure because the balloon procedure carried out extra-peritoneally caused some bleeding that obscured the surgeon's view. A right inguinal repair was performed but no repair was attempted on the left side. The operation took some 53 minutes.

10. Mr Spencer's immediate post operation recovery took the expected course so that he was discharged from the hospital on the day of the operation. Mr Spencer was provided in the course of his treatment at the hospital with a pamphlet entitled:

> *'Hernia Repair – Information for Patients' which stated:*
>
> *"If you have any problems following your discharge then please telephone the Hillingdon Hospital switchboard … and ask to speak to the Senior House Officer".*

11. What Mr Spencer was not told was that he might suffer a deep vein thrombosis or pulmonary embolism as a consequence of the surgery. He was not given any information as to the likely signs and symptoms that he might suffer in the event of the development of such conditions.

12. On 2 February 2010, Mrs Spencer rang the hospital to report that the Claimant was *'feeling unwell'*. She was told to ring the Claimant's GP or the hospital Accident and Emergency Department *'for any further problems'*. There is no record that Mr Spencer complained of problems with his calves at that time and entries in Mr Spencer's GP records for 2 February and 8 February 2010 of telephone calls from Mr Spencer or his wife do not mention any problems involving Mr Spencer's calves.

13. On 8 and 16 February 2010, Mr Spencer saw the practice nurse at his GP's surgery for his dressings to be changed. He was seen again at the hospital on 25 March 2010 by Mr Chaudhry's surgical Senior House Officer and on 19 April 2010 by Mr Ariyarathenam, a surgeon, for further assessments in respect of his left inguinal hernia. As a result of these visits it was decided that he need not have a further repair operation performed.

14. There is a GP record of a telephone call made on 23 April 2010 from or on Mr Spencer's behalf that records:

> *"Had hernia op feb 1st – feels heart beat and sob had calf pain 2 weeks ago"*

15. Later that day Mr Spencer was admitted to the hospital via the Accident and Emergency department suffering from severe shortness of breath. It was discovered that he was suffering from bilateral pulmonary emboli originating from the main right and left pulmonary arteries. He was treated appropriately with blood thinning medication and his condition improved so that he was able to be discharged home with medication on 27 April 2010.

16. I need not further describe the history in respect of the treatment of Mr Spencer as the potential damages in this case have been agreed.

THE RESPECTIVE CASES OF THE PARTIES

17. There are some minor evidential issues. There is some uncertainty, if not dispute as to the advice given to Mr Spencer by the nursing staff on discharge and in particular by the nurse who discharged him, Nurse Woods. He accepts that he was given advice from nursing staff in respect of pain relief, and for the use of laxatives to avoid straining. He does not recall that he was advised by Nurse Woods, as is asserted by the Defendant in the Defence, that he should see his GP or go back to the hospital Accident and Emergency Department if he had any problems post operatively. In any event, as already noted, he did receive such advice by means of the pamphlet to which reference has already been made.

18. It was not accepted by the Defendant in the course of the trial that Mr Spencer suffered the symptoms he described in his legs shortly after his discharge home.

19. There is no evidential issue but that Mr Spencer was not advised by staff of the hospital at any time before his discharge as to any risk that he ran of developing deep vein thrombosis or pulmonary embolism after the operation and as to the signs and symptoms that may attend the development of that condition.

20. The principal issue I have to determine in this case is as to Mr Spencer's pleaded case that before his discharge he should have been provided with verbal and written information as to:

> (a) The signs and symptoms of deep vein thrombosis and pulmonary embolism including:
>
> (i) Pain and swelling in his leg;
>
> (ii) Hotness or discolouration of the skin on his leg, other than bruising around the operation site;
>
> (iii) Numb or tingling feet;
>
> (iv) The appearance of larger than normal or more noticeable veins near the surface of his legs;
>
> (v) Shortness of breath;
>
> (vi) Pain in his chest, back or ribs which gets worse when breathing in deeply; and/or
>
> (vii) Coughing up blood; and
>
> (b) The importance of seeking medical help and who to contact if deep vein thrombosis, pulmonary embolism or another adverse event was suspected.

21. Causation has been substantially agreed. The Defendant accepts that if Mr Spencer had gone to see his GP in February 2010, he would have been referred to hospital and

received treatment that would have prevented the two acute episodes of pulmonary embolism that he suffered. Mr Spencer has been put to proof as to the nature of his post-operative symptoms and whether he would earlier have sought medical advice, if he had been advised as he asserts he should have been.

22. Finally, as already noted, the Defendant seeks to reduce any award of damages the court might make by reason of what they allege to have been contributory negligence on his part.

THE LAW

23. As a preliminary and relevant to a matter in this case namely, the absence of certain potential witnesses, I would note the authority of *Wisniewski v Central Manchester Health Authority* [1998] (CA) PIQR p.324. In that case Brooke LJ reviewed the case law on the circumstances in which the court may draw adverse inferences about the non-attendance of witnesses at trial and said at p.14:

> *'From this line of authority I derive the following principles in the context of the present case:*
>
> *(1) In certain circumstances a court may be entitled to draw adverse inferences from the absence or silence of a witness who might be expected to have material evidence to give on an issue in an action.*
>
> *(2) If a court is willing to draw such inferences, they may go to strengthen the evidence adduced on that issue by the other party or to weaken the evidence, if any, adduced by the party who might reasonably have been expected to call the witness.*
>
> *(3) There must, however, have been some evidence, however weak, adduced by the former on the matter in question before the court is entitled to draw the desired inference: in other words, there must be a case to answer on that issue.*
>
> *(4) If the reason for the witness's absence or silence satisfies the court, then no such adverse inference may be drawn. If, on the other hand, there is some credible explanation given, even if it is not wholly satisfactory, the potentially detrimental effect of his/her absence or silence may be reduced or nullified.'*

24. The test to be applied in respect of breach of duty in respect of clinical negligence is well known. It was set out in a jury direction by McNair J in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 583 as follows:

> *"I myself would prefer to put it this way, that [a medical practitioner] is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a*

responsible body of medical men skilled in that particular art. ... Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view."

25. In his speech in *Bolitho v City and Hackney Health Authority* [1998] A. C. 232 Lord Browne-Wilkinson commented on the *Bolam* test as follows at 241F-242B:

> *"in my view, the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. In the Bolam case itself, McNair J. stated [1957] 1 W.L.R. 583, 587, that the defendant had to have acted in accordance with the practice accepted as proper by a "responsible body of medical men." Later, at p. 588, he referred to "a standard of practice recognised as proper by a competent reasonable body of opinion." Again, in the passage which I have cited from Maynard's case, Lord Scarman refers to a "respectable" body of professional opinion. The use of these adjectives - responsible, reasonable and respectable-all show that the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter."*

26. At page 243 A-D after reference to authorities, he said:

> *"These decisions demonstrate that in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence (I am not here considering questions of disclosure of risk). In my judgment that is because, in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied upon is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of*

> *withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.*
>
> *I emphasise that in my view it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence. As the quotation from Lord Scarman makes clear, it would be wrong to allow such assessment to deteriorate into seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported. It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the bench mark by reference to which the defendant's conduct falls to be assessed."*

27. An important recent decision upon the nature of the duty of care owed by members of the medical profession to patients in relation to advice and information given to patients before their consent is sought to the performance of an operation is the unanimous decision of the Supreme Court in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

28. The judgment of the Court was given by Lords Kerr and Reed with which the five other Justices sitting on the appeal agreed. In the judgment the decision of the Court of Appeal in *Pearce v United Bristol Healthcare NHS Trust* [1999] PIQR P53 and the dissenting opinion of Lord Scarman in *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871, were approved.

29. The Court said at para. 86:

> *'... because the extent to which a doctor may be inclined to discuss risks with a patient is not determined by medical learning or experience, the application of the Bolam test to this question is liable to result in the sanctioning of differences in practice which are attributable not to divergent schools of thought in medical science, but merely to divergent attitudes among doctors as to the degree of respect owed to their patients.'*

30. The principles to be followed in determining the duty of care to be applied in considering whether or not a medical practitioner has fulfilled their duty of care when informing a patient in respect of a medical procedure or operation to be performed on that patient so that they can decide whether or not to consent to that procedure or operation were summarised at para. 87 as follows:

> *'An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware*

> *of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.'*

31. The Court noted the need to consider the full facts and circumstances of the individual patient in each case, stating at para. 89:

> *'... the assessment of whether a risk is material cannot be reduced to percentages. The significance of a given risk is likely to reflect a variety of factors besides its magnitude: for example, the nature of the risk, the effect which its occurrence would have upon the life of the patient, the importance to the patient of the benefits sought to be achieved by the treatment, the alternatives available, and the risks involved in those alternatives. The assessment is therefore fact-sensitive, and sensitive also to the characteristics of the patient.'*

32. *Montgomery* is clearly a decision which demonstrates a new development in the law as it relates to the law on informed consent and strictly the *ratio decidendi* of the decision is confined to cases involving the adequacy or otherwise of information given to a patient upon which they are to decide whether or not to undergo a particular type of treatment. It is not of central importance to a consideration of the facts of this case. However, there is force in the contention advanced by Mr Skelton that the basic principles – and the resulting duty of care – defined in *Montgomery* are likely to be applied to all aspects of the provision of advice given to patients by medical and nursing staff. Insofar as the judgment in *Montgomery* emphasises the need for a court to take into account a patient's as well as their doctor's point of view as to the significance of information for a patient I consider it relevant to a consideration of the facts of this case.

THE EVIDENCE

33. I turn now to the evidence. I heard from Mr Spencer. In his written evidence he concluded that the nurse who discharged him did not tell him that he should see his GP or go back to the hospital Accident and Emergency Department if he had any problem post operatively. In his oral evidence he was rather more accepting that he may have been told that; in any event that advice was given by the leaflet that he was provided with on discharge.

34. His evidence was that he began to suffer aching calf muscles from the morning of 4 February 2010. He put that down to his lack of activity over the preceding days. He said that it did not cross his mind that these symptoms were to do with his recent surgery. On his return to work on 15 February 2010, he recalled that his calves were still aching and that he became short of breath on climbing stairs. Again, he put this down to loss of fitness. He did not mention these symptoms to his GP during his wound check on 16 February 2010, or when he saw Mr Chaudhry on 25 March 2010.

35. Mrs Spencer, whose evidence was not challenged, confirmed that her husband complained of pain in both calf muscles in the days after the operation and that his calf muscles were both rock hard. Her recollection was that he thought that the problem was his calves because he had not been able to take exercise.

36. Expert evidence was lead on Mr Spencer's behalf from Professor Poston who gave evidence by way of a written report dated 7 June 2014, a supplementary letter dated 20 January 2015, the joint statement of the expert witnesses, and by way of his oral evidence before me.

37. Professor Poston was critical in his evidence of the failure of the staff of the hospital to undertake a formal assessment of the Claimant's risk of deep vein thrombosis. However, he accepted that Mr Spencer did not fall into the category of those patients who should be prescribed blood thinning medication as prophylaxis by reason of their particular risk of developing the condition.

38. In his written report he noted his opinion as follows:

> *'... all patients undergoing surgery are at some risk and that risk must be addressed by the provision of appropriate advice.'*
>
> *'Therefore, there was a basic duty of care to advise Mr Spencer of the symptoms of DVT should it arise in the postoperative period.'*
>
> *'As such, the failure by the hospital to advise Mr Spencer of the signs and symptoms of deep vein thrombosis would not be supported by a responsible body of surgical opinion.'*

39. In his letter of 20 January 2015, Professor Poston referred to a 2005 report of the House of Commons Health Committee on *'The prevention of venous thromboembolism in hospitalised patients'* that noted that deep vein thrombosis in hospitalised patients causes between 25,000 and 32,000 deaths a year. That report recommended that Guidelines already produced by the National Institute for Health and Clinical Excellence (NICE) in respect of Venous Thromboembolism be extended in their scope to cover the majority of hospital patients.

40. Of importance to the issues in this case are the Guidelines produced in response to that recommendation that were published very shortly before Mr Spencer's operation by NICE as Clinical Guideline 92: *"Venous thromboembolism: reducing the risk"* subtitled "*Reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted to hospital."*(NICE 92)

41. These Guidelines and previous NICE Guidelines on the same subject, principally that published in 2007 as Clinical Guideline 46 (NICE 46) were considered in some detail by Professor Poston in his report and in his oral evidence to the court. His contention before me was that by reason of the contents of both NICE 46 and NICE 92 the Defendant was under a mandatory obligation to inform Mr Spencer of the signs and symptoms of deep vein thrombosis so that he could recognise the same. In the joint statement Professor Poston stated:

> *"The Guidance is intended to encompass those patients on the cusp of the very specific risk factors for increased risk of DVT stated in both guidelines, which in the Claimant's case was at attempted laparoscopic procedure, an anaesthetic time of just under 1 hour in a patient whose BMI was just less than 30."*

42. I will deal with some of the detail of NICE 46 and NICE 92 at this point in my judgment.

43. Under NICE 46 only adults undergoing inpatient surgical procedures that carried *'a high risk of VTE'* were covered by the Guidelines. *'High Risk'* is a concept limited to those Guidelines. It is common ground that Mr Spencer did not fall into that classification at the time of his operation.

44. Under NICE 92, a wide range of patients are classified as requiring to be risk assessed for their likelihood of developing deep vein thrombosis. Under the heading, *"Groups that will be covered"* the Guidelines state:

> *a) Adults (18 years and older) admitted to hospital as inpatients or formally admitted to a hospital bed for day case procedures, including …"*

45. There follows a list that includes:

> *"patients admitted to a hospital bed for day-case medical or surgical procedures."*

Clearly, Mr Spencer fell within this classification at the time of his operation.

46. Under the heading, "Assessing the risks of VTE and bleeding" the Guidelines state:

> *'all patients' should be assessed on admission to hospital to ascertain whether they are at increased risk of VTE."*

47. Under the heading *"Planning for discharge"* the Guidelines state:

> *"As part of the discharge plan, offer patients and/or their families or carers verbal and written information on:*
>
> *the signs and symptoms of deep vein thrombosis and pulmonary embolism…"*

48. It was accepted by Professor Poston that not all patients apparently within the classification of groups that will be covered under the Guidelines have to be provided with information about signs and symptoms of deep vein thrombosis and pulmonary embolism. For example, it would not be appropriate to provide such information to those undergoing colonoscopy; sigmoidoscopy and other procedures that did not involve the administration of a general anaesthetic to the patient. His view was that it was implicit in the Guideline '*Planning for discharge'* that the words '*have undergone general anaesthetic'* should be included after the after the word *'patient'* although he accepted that there was nothing in that Guideline which stated expressly that it did apply to those who had undergone general anaesthetic.

49. Potential witnesses for the Defendant included Mr Chaudhry, Nurse Woods, and Senior Sister Gibson, in respect of whose evidence a witness statement was served in these proceedings and who was in charge of the day surgery unit at the time of Mr Spencer's admission. Mr Prabhudesai, Mr Chaudhry's successor, who provided a substantive response to a letter of complaint from Mr Spencer and who sought in that letter to explain the hospital's practice in day case surgery cases was another potential witness.

50. In the event none of these potential witnesses gave evidence before me but a letter was placed before me from the Defendant's solicitors that sought, somewhat ineffectively to demonstrate why, Mr Choudhry and Nurse Woods were not available at the time of the trial.

51. The evidence I heard in support of the Defendant's case was that given by an expert surgeon, Mr Thomas. He gave evidence by way of a written report dated 28 May 2014 and the joint statement of the experts.

52. Mr Thomas was clear that Mr Spencer was not at high risk of developing deep vein thrombosis and a pulmonary embolism and, considering the surgery performed, his underlying risk of such complications was very small. His evidence about the provision of advice about signs or symptoms of these conditions to Mr Spencer after his surgery was as follows:

> *"In my opinion the best advice is to say that if the patient does have any further or future problems, that they should contact the GP or A+E department. It is impossible to either ask or give advice as to every possible complication that can occur after hernia operation or anaesthetic. The list would be huge – furthermore the patient would not be able to take such a list in. Therefore patients are only warned or questioned over common complications after such surgery."*

53. Mr Thomas suggested that if there were a requirement to provide information about non-material risks then the process of providing information pre-discharge would be transformed. He estimated that it would take 30 minutes to provide a person in the position of Mr Spencer with information as to all the problems he might develop after surgery of the kind undergone by Mr Spencer. However, he accepted that such complications, e.g. wound infection, were not analogous to deep vein thrombosis which puts patients' lives at serious risk and constitutes a medical emergency, but could be countered by a patient seeking urgent medical attention, and would be something that many patients would be unaware of unless they had been told about it.

54. In line with that opinion he considered that the advice given to Mr Spencer on discharge was appropriate. His contention was that a responsible body of surgeons would not have provided the Claimant with such information and that the provision of such information was not mandatory under either NICE 46 or NICE 92.

55. In the joint statement Mr Thomas stated:

> *"The Guidance is aimed at patients within the 'risk' category – and according to the guidelines, the patient did not fulfil these criteria"*

56. Mr Thomas argued that the requirement under Guideline 92 was to assess all patients within the scope of the guidance as required. His interpretation of the Guidelines was that the NICE Guidance on information for discharge was only directed at those patients who fell into the *"Increased Risk"* category because it would be illogical to require information about deep vein thrombosis to be provided to those who were not at risk of developing the condition.

57. It is pertinent to note that the experts concluded their joint statement by stating that:

> *"For future clarity, it would be wise to seek guidance directly from NICE as to its intention with regard to the use of their Guidance in patients such as the Claimant undergoing the procedure which the Claimant underwent, in the particular circumstances of the Claimant's operation."*

58. The Defendant argued that the risk of Mr Spencer developing deep vein thrombosis was in the region of 1 in 50,000 based on a research paper (Zurawska et al 2007) that suggested that the risk of developing deep vein thrombosis as a result of day surgery was in the region of 0.04%. A further research paper before the court (Anwar and Scott 2003) referred to a further paper (Dudda et al 1990 - not before the court). From those rather convoluted references Professor Poston extracted the statistics that the incidence of pulmonary embolism after inguinal hernia repair was 0.9% for pulmonary embolism and 0.7% for deep vein thrombosis. However, it appears that the two research papers were not *in pari materia*, the Dudda paper including surgery other than day case procedures.

59. In answer to a question posed at the joint meeting – namely '*Was Mr Spencer at risk from suffering from a deep vein thrombosis or a pulmonary embolism as a result of his surgery on 1st February 2010* the experts stated:

> *"The experts are agreed 'no' for a straightforward inguinal hernia repair."*

60. It was, or became clear in the course of the trial, that both experts qualified that answer by the insertion of the word *"material"* before the word *"risk"* when answering that question. Professor Poston accepted that he understood a *'material risk'* to mean a risk that *'a reasonable person in the Claimant's position would be likely to attach significance to'*.

CONCLUSIONS

61. I turn to my conclusions.

62. I will deal firstly with the few evidential issues for determination that are separate from the expert evidence.

63. What if anything was Mr Spencer told by Nurse Woods on his discharge? In his exchanged written statement Mr Spencer said that he was not told to report any problems; in cross examination, he accepted that he was told to report any problems albeit he gave this oral evidence with some reluctance or uncertainty. I heard no evidence from Nurse Woods about this but Mr Spencer accepts that he was given the leaflet that is in evidence that says, essentially, what it is alleged Nurse Woods would have said to Mr Spencer.

64. Secondly, what, if any post-operative signs and symptoms did Mr Spencer suffer in his calves in the days following his discharge? Again, I accept Mr Spencer's account, supported as it is by the unchallenged evidence of his wife.

65. Finally, has Mr Spencer established that he would have sought medical advice if he had been warned of the signs and symptoms that were indicative of the development of deep vein thrombosis and pulmonary embolism? Mr Spencer came over to me as a sensible and prudent man. It is notable that he was anxious not to give his consent to the hernia operation until he had been re-assured that if the laparoscopic procedure had to be changed to an open procedure the right hernia would be repaired in preference to the left. It seemed a little strange that Mr Spencer did not associate the calf symptoms with the operation. That comment is perhaps easily made with hindsight. Mr Spencer gave a reasonable explanation as to why he did not make the association; he attributed the calf symptoms simply to being laid up as a result of the operation and not taking exercise. The fact that the symptoms were remote from the operation site is of significance.

66. I discount the possibility that if Mr Spencer had been expressly told something to the effect that signs and symptoms in the calves would be indicative of a rare but highly dangerous condition that could be treated effectively if caught early, he would not have responded by seeking medical advice so soon as that condition developed.

67. I turn to the issue to which the expert evidence was directed, namely the duty of care to be fulfilled by the hospital staff towards Mr Spencer in the circumstances of this case and whether or not that was fulfilled.

68. In the light of the *Montgomery* decision already discussed above, I would express the test that I should apply to be the *Bolam* test with the added gloss that I should pay regard to what the ordinary sensible patient would expect to have been told. Put in the form of a question, the test I consider to be, would the ordinary sensible patient be justifiably aggrieved not to have been given the information at the heart of this case when fully appraised of the significance of it?

69. I say at once that I was generally impressed by both the surgeons who gave evidence before me. They were both properly, but vigorously, cross - examined. They held to their opinions which were clearly genuinely held by both and in support of which both argued well and with considerable supporting material on both sides. They did not make my decision in this case easy; likewise, their understandable concern as to the correct interpretation of the NICE Guidelines and the need for them to be clarified.

70. The background to the present Guidelines is the problem of unnecessary deaths from venous thromboembolism identified by the House of Commons Health Committee. The general thrust of the Guidelines is clearly intended to raise awareness of the

conditions dealt with by the Guidelines both amongst health care professionals and their patients and to improve communications between both groups so that unnecessary deaths can be avoided.

71. I note that the information that it is contended should have been given would have been easy and practical to give either verbally or within a discharge leaflet. It cannot sensibly be doubted that the giving of that information to patients who in fact develop signs and symptoms of deep vein thrombosis and pulmonary embolism would be very likely to improve the prospects of early and therefore more favourable treatment for those patients.

72. Whilst, as already noted, I accept that the NICE Guidelines are not wholly clear in identifying the group of patients to which the specific guidance noted in the Guidelines should be given on discharge, on balance, I consider that the better view is that of Professor Poston, namely, that it is intended to be directed at all patients who fall within the groups expressly covered by the Guidelines save those where no risk could possibly arise – e.g. the patient formally admitted as a day care patient for a procedure that carried no risk, however remote, of deep vein thrombosis or pulmonary embolism. I reach this conclusion based on the substantial change from Guideline 46 to Guideline 92 which demonstrates that the committee preparing the Guidelines were anxious to make changes that would produce a real reduction in the numbers of those suffering from deep vein thrombosis and pulmonary embolism following surgical procedures.

73. I accept that the determination as to whether a given practice is in accordance with the NICE guidelines is not by itself determinative of negligence, but it is highly relevant.

74. It is clear to me from the papers referred to by the expert surgeons that outside the identified risk group of patients the development of deep vein thrombosis and pulmonary embolism is properly characterised as rare. How rare has been the subject matter of lively debate between the experts on those papers. I will not attempt to rule definitively on that debate by proposing a statistic purportedly extracted from the material placed before me. What is clear to me on the evidence is that it is known to, and accepted by, the medical profession that there is a cadre of patients who, following a surgical procedure under general anaesthetic develop deep vein thrombosis/pulmonary embolism and who may be saved from suffering or death if the early well known markers of those conditions are picked up.

75. I cannot help but conclude that Mr Spencer fell into that category on the hospital's own tacit admission by the fact that, albeit as a blanket policy, all surgical patients appear to have been treated, when under general anaesthetic with pneumatic boots to reduce the risk of deep vein thrombosis and pulmonary embolism developing.

76. I ask myself the question, would the ordinary sensible patient expect to have been given the information contended for; put another way I ask myself, would such a patient feel justifiably aggrieved not to have been given on discharge the information contended if appraised of the significance of such information. I consider that, on the evidence before me, the answer to both questions should be in the affirmative.

77. I accept that, on the face of it, there is an apparent inconsistency in this case if there was in Mr Spencer's case no duty to warn of the risk of deep vein thrombosis or

pulmonary embolism pre-operation to obtain a properly informed consent but there was a duty to inform about symptoms and signs indicative of it. However, I consider that argument unpersuasive. Different considerations are in play. The subject matter of the first is a warning of a remote risk; the second is information as to characteristic signs and symptoms indicative of a potentially fatal condition that can be successfully treated if early diagnosed.

78. Further, even if the NICE Guidelines are not wholly clear on this issue, based on the evidence of Professor Poston, I consider that modern, safe and responsible medical practice should be to give such advice to patients undergoing general anaesthetic. Whilst in many cases such treatment will cause a small risk of deep vein thrombosis and pulmonary embolism, and one of which many patients will be unaware; to inform such patients of the very particular signs and symptoms of those conditions is a precaution that can save lives and should be given.

79. I find it telling that no evidence has been called from the hospital by the Defendant. Many relevant questions that could have been put to hospital witnesses remain unanswered such as, perhaps most importantly, was an assessment made of Mr Spencer's risk of a deep vein thrombosis? It is significant that no formal assessment of Mr Spencer's categorisation in relation to the risk of deep vein thrombosis and pulmonary embolism is documented in the hospital records. I have no evidence from the Defendant, save the note that Mr Spencer was provided with a pneumatic boots during his operation, to counter the assertion fairly made that the hospital do not appear to have had a consciousness of the need for, or to have had procedures in place, to reduce the risk of post operative deep vein thrombosis and pulmonary embolism.

80. I am persuaded that the staff of the hospital collectively failed Mr Spencer by not advising him at any time whilst he was in their care of the life threatening significance of symptoms of the kind he suffered and the consequent need for him urgently to seek medical care if he suffered such symptoms.

81. For the foregoing reasons I consider that the Defendant acted in breach of their duty of care towards Mr Spencer in the way that they treated him.

82. I consider now the allegation of contributory negligence made against Mr Spencer. The Defendant contends that there was fault on the part of Mr Spencer for failing to follow the instructions that he had received on a number of occasions to report on *'any problems'* he experienced and they contend for a reduction for contributory negligence of no less than 50%. They contend that Mr Spencer should have reported, as directed, his symptoms which were so close in time to his operation and were to a degree novel and unexplained.

83. Having found the Defendant liable to Mr Spencer on the facts of this case, I see difficulties for the Defendant in this argument. His calf pain arose several days after the operation, in an area of his body that had not been operating on, and after he had recovered from the procedure. I have accepted his evidence that he attributed the pain in his calf to his inactivity due to being generally unwell after the operation. I am satisfied that Mr Spencer did not – and could not reasonably have foreseen – that by not seeking medical attention for his calf pain he would suffer deep vein thrombosis

and a pulmonary embolism; matters that I have found should have been in the mind of the staff of the hospital and communicated to Mr Spencer.

84. For the foregoing reasons, I reject the Defendant's contention that Mr Spencer was himself negligent and therefore in part contributed to his damage.

85. It follows from the foregoing that there must be judgment for the Claimant for the total agreed sum of £17,500.