

Neutral Citation No: [2002] EWCA Civ 724
Case No: B3/01/0068/QBENF

IN THE SUPREME COURT OF JUDICATURE
COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT OF JUSTICE
(His Honour Judge Robert Walker)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 27th May 2002

Before :

LADY JUSTICE HALE
SIR CHRISTOPHER SLADE
and
SIR DENIS HENRY

Between :

CAROLE GAY OGILVY CHESTER

Respondent

- and -

FARI AFSHAR

Appellant

Mr M Spencer (instructed by Hempsons) for the Appellant

Miss J Perry (instructed by Eversheds, Manchester) for the Respondent

Hearing dates : 4 and 5 December 2001

**JUDGMENT : APPROVED BY THE COURT FOR HANDING DOWN (SUBJECT
TO EDITORIAL CORRECTIONS)**

Sir Denis Henry:

This is the judgment of the court to which all its members have contributed.

1. The defendant appeals against the order made by His Honour Judge Robert Taylor, sitting as a Judge of the High Court in the Queen's Bench Division, on 21 December 2000 in a medical negligence action. The judge found that the defendant had not been negligent in his conduct of the operation but had been negligent in failing to warn the claimant of the risk of paralysis which in fact ensued. He held the defendant liable for the injuries sustained in the operation and gave judgment for the claimant for damages to be assessed.

2. The appeal raises the important and difficult question, not so far considered at appellate level in this country, of when a doctor should be held to have caused the injury, the risk of which he failed to give proper warning to his patient. The judge gave permission to appeal on that issue. The defendant also wishes to challenge the judge's finding of fact that a proper warning had not been given and to argue that the allegation should not have been pursued because it was not properly pleaded. The claimant wishes to challenge the judge's finding of fact that the operation had not been negligently performed, but only should she lose the appeal on the main issue. She also has permission to appeal against the costs order made by the judge, but that has not been argued pending the determination of the current appeal.

The facts

3. The claimant in this action, Miss Chester, was a working journalist born in 1943, who had had various episodes of back pain from April 1988. For these she was conservatively treated by Dr Wright, a consultant rheumatologist. In September of 1994 she had a fifth episode of back trouble, very shortly before she was to undertake a professional engagement in France. The episode was so severe that walking was painful. She consulted Dr Wright, who gave her an epidural injection to tide her over the trip, and on her return arranged for her to have a MRI scan.
4. On 13 October 1994, Dr Wright saw Miss Chester again, having seen the results of the scan which showed "A very substantial centro-lateral variation at L2/3, central canal stenosis at L3 and L4/5". He advised the claimant to consider surgery to her back. She made it clear that she wished to avoid surgery if at all possible, expressing a general aversion to it. Accordingly, he gave a sinu-vertebral block injection at L2 level and a large volume epidural injection. As this brought about no clear improvement, Dr Wright repeated his advice as to surgery, this time recommending two practitioners, one of whom was the defendant, Mr Afshar, an eminent neurosurgeon.
5. Miss Chester was not impressed by this choice. She wanted a consultant (a word she understood as "advisor") to advise her on alternatives to surgery, while Dr Wright was advising surgery and sending her to a surgeon. In his letter of referral to Mr Afshar, Dr Wright wrote that she was "... anxious to avoid surgery if at all possible ... I feel sure she will take a long time to recover without your assistance." As the last sentence implied, surgery then was elective rather than necessary. She did not need emergency surgery.
6. Miss Chester had her consultation with Mr Afshar as his last appointment on 18 November 1994, a Friday. He examined her for 15 minutes and some 30 minutes was spent in discussion. It is common ground that Mr Afshar advised Miss Chester that the three intra-vertebral discs in question should be removed. But there was a sharp conflict of evidence as to the detail of the conversation. Mr Afshar gave an account in which he dealt with the risk of cauda equina nerve root disturbance, while according to

Miss Chester there was no such explanation. Miss Chester's account was summarised thus by the judge (we have corrected clerical errors in his verbatim quotations from the witness statements but adopted his summaries of the oral evidence, taken from his notes):

"23. According to the Claimant, she was never adequately warned of the possible risks involved in such an operation. Her account of what she was told by the Defendant on 18 November 1994 is set out in the following terms in paragraph 5 of her first witness statement, which is dated 22 September 1999 [TB Volume 1, pages 64-65]:

'I first met the Defendant, Mr Afshar, on 18 November 1994 when I attended his Harley Street surgery for examination. On that occasion, I was accompanied by my husband and, after studying the MRI scan which was taken on 6 October 1994, Mr Afshar quite matter of factly said I needed surgery to remove three discs, which were the cause of my problem. As I was very concerned about having to undergo surgery for my problem, I asked what the success rate of such an operation was, but did not receive a clear answer from Mr Afshar, although he did tell me that he performed about 300 operations such as this per year. As I was concerned, I told him of the many horror stories I had heard about back operations and he laughed, stating that he had never crippled anybody yet. Indeed, so confident was he that I distinctly remember that, almost as an aside, he stated: "Of course, you could be my first". Certainly it occurred to me that removal of three discs was rather a lot, and when I put this to Mr Afshar, he almost dismissively agreed. Further, when he told me the time at which he was to perform the surgery, I did suggest that it was rather late in the evening, but Mr Afshar responded that he would not be tired and was capable of working through the night when necessary. As a result of Mr Afshar's confidence in performing the surgery, and because he was recommended by Dr Wright, I agreed to undergo the operation. However, at no time was it suggested to me that there could be serious complications which could lead to any form of paralysis or leave me in a wheelchair. Indeed, if I had been aware of the major complications associated with this surgery then, due to my fear of surgery, I would have obtained at least a second, if not a third, opinion. Unfortunately, Mr Afshar never provided me with information on the seriousness of possible complications and as a result I lost the opportunity to seek an alternative opinion.'

In the course of her evidence, she somewhat expanded this account in response to counsel's questions. In her evidence-in-chief, the Claimant said this:

'After examination Mr Afshar showed me the scan. He pointed out three bulges and said they shouldn't be there and would all have to come out. When I was told this I felt terrible because he was, in effect, saying that I would have to have surgery. I didn't want to have surgery. I asked Mr Afshar if there was any other way to escape having surgery. He didn't give me any alternatives. He said I had three discs which would have to be removed - and that in a couple of months I would be back doing the work I had always done. He said I would be eight to ten days in hospital, after

which I would have to rest up a bit. I said I had heard a lot of horror stories about surgery and I wanted to know about the risks. The reply I got from Mr Afshar was: "Well, I have never crippled anybody yet". It was a throw-away line. He did add: "Of course, you could be my first". I didn't take this seriously, in a crippling sense. I just took it that it was a very easy operation - Zum! Zum! Zum! One of my questions to Mr Afshar in Miss Martin's office was: "Isn't three discs rather a lot?" the answer was matter-of-factly: "Yes" ... I agreed to the surgery because Mr Afshar made it sound really simple. He did not tell me about any downside or risks whatever. He made it sound easy. He said he did about 300 such operations a year, so I said: "Let's do it". If I had been provided with an alternative that didn't involve surgery, as I now know them to be, I would have taken it. If I had been told of the risks of surgery, as I now know them to be, I would not have had the operation on Monday 21 November. I would have had a very shaky weekend and called various journalist friends as to who I should go to see. I would also have contacted the BMA. I would have wanted at least two further opinions as to whether an operation was necessary in the first place. Nobody had said to me that this was a life-and-death matter and: "If you don't have this operation you will end up in a wheelchair". Dr Wright and Mr Afshar had never said this. The operation sounded so simple and routine.'

When cross-examined, she replied:

'I asked a lot of questions about the operation. Before I went to see Mr Afshar I knew surgery was a possibility. I hadn't done any research about surgery beforehand. Mr Afshar did not discuss any risks with me whatsoever. He didn't mention haemorrhage. I did not mention paralysis specifically, but I may have implied this when I spoke of horror stories. If I had learnt that, as has subsequently come out, I was a high risk patient, I would not have gone for operation on the Monday, nor would my husband have let me. Mr Afshar never mentioned the risk of paralysis. He never mentioned the risk of being crippled, except in a throw-away line at which we laughed. It was not mentioned that there was a small risk of nerve damage, infection and bleeding. I have a good memory for the conversation on that particular occasion.'

7. Mr Afshar's account was that he had warned Miss Chester of the risks, as the judge recounts:

"25. The defendant dealt with this issue in paragraphs 7 to 9 of his first witness statement, which is dated 23 September 1999 [TB Volume 1, pages 81-83]:"

'I recollect that the Claimant attended the appointment on 18.11.94 with her husband and she asked numerous questions regarding the surgery and the risks and all matters were discussed in great detail with her. I believe that she was the last patient of the day and that she was continuing to ask questions when we left my consulting room and went into my secretary's room in order to book the operation. My secretary clearly remembers the Claimant asking further questions in the secretaries' office in her presence. The Claimant could therefore be in no doubt about the procedure or the

risks associated with it. I explained to her that there was a small risk of cauda equina and nerve root disturbance. I explained that this could mean weakness and sensory disturbance leading to reduction in power in her legs and alterations to touch, temperature and position sense. I would have explained that the risks were not great and this advice would be based on my own experience of having performed many hundreds of similar operations since 1975 and I had not experienced these problems previously. I also explained that there was a small risk of haemorrhage and infection. Following similar operations, I have experienced a case of infection in about three or four cases, but I have never had a case of haemorrhage and this is very rare. I would have explained that all operations carry certain risks but that the risks of this particular operation were not great in comparison to surgical procedures that are carried out on the brain and spinal cord. The Claimant asked a number of questions in addition to what the operation involved and what the risks were. She asked what would happen if nothing was done, how long she would be in hospital, and when she would be able to go back to work. I went into the procedure very thoroughly and explained that if she did not have the operation performed then she would certainly have continual problems due to the substantial L2/L3 disc. I would not have described the operation as straightforward, although I may well have described it as routine as I perform up to three or four of these operations per week. I would not have expressly stated to the Claimant that I was entirely competent to carry out the procedure, although I accept that this would be implicit as the Claimant would not have been referred to me if I was not competent to carry out the procedure. I would not have expressly said to her that she could only experience improvement in her symptoms if she had the operation performed, and that she had nothing to lose and only to gain. However I would have told her that her pain would have the optimal chance of improvement as a result of the operation and the operation would decrease the risk of the discs causing damage in the future. I did not tell her that there should be no delay in carrying out the procedure. The Claimant asked me when she could have it done and I explained that I would check with my secretary. The Claimant was not someone who needed emergency surgery. As it was routine surgery, I explained that she would be able to have the operation performed at the next available slot. When we went to see my secretary it was apparent that there was space for her on the operating list on 21.11.94 and we booked her in for that date.'

In the course of his evidence he said this in chief:

'With all patients who undergo neuro-surgery, whatever the procedure is, it is important to tell them of the risks. This was indelibly imprinted on me from my one-and-a-half years' residence in the United States. I was doing the majority of the surgery there and having to get consents. Informed consent was then as big an issue in the United States as it has become here. It is always my practice to explain the risks to the patient. She was an articulate, highly intelligent lady. She was nervous and anxious. She asked many questions. I explained to her about nerve damage. In particular she asked about paralysis and leg weakness. I can't remember the exact words but she expressed herself in terms such as "crippling". I

tried to reassure her. I told her that I had never caused any damage to the cauda equina or nerve roots in many hundreds of operations I had carried out in 20 to 25 years of spinal surgery. I can't remember verbatim what I told her but, if she had asked what the risk was, I would have told her that the risk was less than one in 100. I would have gone on to speak of my own experiences, which is really what she was interested in, in the terms she has said in her witness statement. I do not feel that I misled her about the risks. I do not think that I would now alter what I said to her.'

In cross-examination, the Defendant replied:

'I can't remember verbatim what I said about the risks to Miss Chester. I said in general terms that the risks of nerve damage in someone who was neurologically intact were not great. I didn't think that operating as I did would cause a high risk, or indeed any significant risk, of cauda equina syndrome. Otherwise I would have told Miss Chester of this. Pre-operatively I had not come across a case where disc surgery had caused cauda equina syndrome. Before the surgery I would have said that the risks of cauda equina syndrome were small. It was a possible risk. Every operation has possibilities. I discussed with Miss Chester the outcomes of having surgery or not having surgery. In order to remove any disc by any route you have to manipulate the nerve root and dural sac. There is a small risk of nerve damage in any routine micro-discectomy. The more compression and the greater the prolapse, the greater the risk. The higher the disc, the bigger the risk. I showed Miss Chester where the disc was, what it was doing to the nerve roots and why I recommended surgery. I can't remember the percentage terms I told her for that particular disc. Cauda equina syndrome can lead, at one end of the spectrum, to minor disturbance of nerve roots. At the other end there is paralysis. I thought I had spent a great deal of time spelling out the risks. Miss Chester asked me a lot of questions about nerve damage and I told her. I told Miss Chester that she would have continuing problems without surgery: I meant the problems she had experienced before. I would not have agreed before the event that she was at risk of paralysis without surgery. There was a risk of paralysis but I did not think it sufficient to mention it to an already nervous patient. She had a potential risk of paralysis without surgery, but if you ask me what the degree of risk was or when it could occur, I cannot say.'

He also accepted that he had not made a note about his discussion about risks with the Claimant, adding: 'Certainly since the mid-nineties we have been making notes of our discussions but I have no note of this discussion.' Finally, in re-examination, he said:

'Pre-operatively this was not an exceptional case. It was a large prolapsed disc. It was at an unusual site. Most prolapsed discs are lower down but prolapses at this site are not uncommon.'"

8. The operation took place when scheduled on Monday 21 November 1994, three days after the consultation. The consent form, signed without further explanation on the afternoon of the operation, was for an L2/3, L3/4 and L4/5 micro-discectomy. It took some two hours. At first Mr Afshar thought

the operation had been successful. His operation note reflects this. His evidence was

"There was no complication during the operation. When I said in note 'Roots and cauda equina fully decompressed', that is what I could actually see using the microscope. The goals of my original operation were fully met."

But when Miss Chester recovered consciousness, it was clear that all was not well. There was both motor and sensory impairment. Mr Afshar mobilised a full radiological team, and a scan showed that full decompression had not been achieved in the first operation. So Mr Afshar conducted a second operation. The site was re-explored immediately. But still Mr Afshar could not, during his second operation, find any explanation for Miss Chester's condition which satisfied him. Accordingly, a second post-operative scan was performed the following day; this revealed only a small fragment of material which Mr Afshar did not think would have contributed to "the profound change which had occurred". In his contemporaneous note he recorded:

"My only explanation for the current situation is one of cauda equina contusion that may have occurred on the routine medial retraction of L3 root and cauda equinal dura during the L2/L3 disc removal at the first procedure."

He said in evidence "Because a nerve had been damaged, I assumed that I had caused the damage by manipulation. That is only an assumption. There could be other factors, such as interruption of vascular supply."

9. Post-operatively, Miss Chester made progress in certain respects. Within two or three weeks her right leg function returned virtually to normal, but on her left side progress was much slower, and at trial, six years later, she still suffered substantial disability in a number of areas. Paragraph 8 of her Statement of Claim reads:

"Following the said surgical procedures set forth in Paragraph 7 hereinbefore, the Plaintiff's condition was worse than it had been pre-operatively. She has, since that date been suffering extensive neurological deficit which has resulted in gross functional deficit, continuing pain, unemployability and every aspect of her life has been diminished if not ruined."

10. Miss Chester's claim was put in two ways. First, it was said that in breach of contractual duty and negligently, Mr Afshar failed to advise, explain or otherwise counsel her as to the real risks attached to the surgical procedure, thereby depriving her of an opportunity to reflect, consider and/or seek alternative medical or other opinion as to the options which might be open to her; second, that the first surgical procedure was negligently carried out by Mr Afshar, that he used the wrong technique, and that he caused bruising (and so neural damage) to the cauda equina and/or nerve roots (no criticism is now made of the second or remedial operation). It follows that if Miss Chester succeeded in proving negligence

in the first operation, she would not have to prove the issue as to warning of risks inherent in that operation.

The judge's findings: the operation

11. The judge found that Miss Chester had

"52. ... suffered a cauda equina syndrome as a result of contusion or damage to her already compressed cauda equina occurring while the defendant was retracting or at least manipulating the relevant nerve root and theca during the L2/L3 disc removal".

That was a known risk of the surgery advised and performed by Mr Afshar, put by him at about 0.9% (para 53). Mr Firth (the claimant's expert) described the risk as "the terror of neurosurgery" (para 54). Mr Findlay (the defendant's expert) reported that "Nerve root injury or injury to the cauda equina is a recognised risk in lumbar surgery, and said:

"54. ... Most of us would put a figure of one to two percent on the risk of nerve damage (including both single and multiple nerves) and other serious risks."

12. It was common ground that the risk of cauda equina damage from microdiscectomy was no less and no greater than from other forms of lumbar surgery, such as laminectomy, and that cauda equina damage can occur during lumbar surgery without any negligence on the part of the surgeon (paras 55 and 56). Mr Firth spoke of the

"irreducible minimum of risk inherent in all lumbar surgery - that one can lose movement of the legs, bowels and bladder in what can be quite a 'simple' operation."

Mr Findlay confirmed that damage to the cauda equina "... does not in itself indicate a sub-standard performance of the surgery".

13. The judge concluded that the defendant had not been negligent in the first operation:

"76. I am not satisfied that any of Mr Firth's criticisms of the way in which the Defendant performed the first operation have been made out. I accept that Mr Firth is very eminent in the field of neurosurgery, and that his research interests include microsurgery. But he was in the difficult position of trying to criticise the conduct of a delicate operation at which he had not been present. The Defendant, who had sole conduct of the operation throughout, gave a very clear account of what he had done, supported by a detailed contemporaneous note. I find it improbable that a man of his undoubted skill and experience, performing an operation he had done many times before, would not have removed as much bone as he needed to give himself the access that he required. I also find it improbable that he would have concluded the first operation without achieving full decompression, when this had been his objective. I also accept that he confirmed this when he carried out the second operation. I do not think that the post-operative scans are a reliable guide to whether or not

decompression had been achieved, for the reasons given by Mr Findlay (which I accept).

77. As I have already said, it is common ground that, in an operation of this kind, nerve damage can occur without any negligence on the part of the operating surgeon. I think that this was the position in the present case. In my judgment, the Claimant has failed to establish that the Defendant was in any [way] negligent in his conduct of her surgery."

We have not been asked to consider and rule on that conclusion in the single issue of causation that we have to consider. Miss Perry, for the claimant, has indicated that she wishes this issue to be kept open in the event that she fails on the causation issue.

The judge's findings: the warning

14. The relevant law on the duty to warn is not controversial. The judge summarised it in this way:

"44. ... Effectively this claim has been pursued on the basis that the appropriate test to apply to the Defendant's conduct was the well-known test enunciated by McNair J in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 and approved by the House of Lords in *Sidaway v Governors of Bethlem Hospital* [1985] 1 AC 871.

45. In *Sidaway* Lord Bridge of Harwich said (at p 898B-C) that, when questioned by a patient of apparently sound mind about risks involved in a particular treatment proposed, the doctor's duty must be to answer both as truthfully and as fully as the questioner requires. That case concerned a laminectomy operation, and Lord Templeman said that, if the plaintiff concerned had asked questions about this operation, "she could and should have been informed that there was an aggregate risk of between one per cent. and two per cent. risk of some damage either to the spinal cord or to a nerve root resulting in some injury which might vary from irritation to paralysis."

15. It was common ground at the trial (para 57) that the defendant in accordance with good medical practice should have warned the claimant of the risk of damage involved in the surgery and its possible consequences, such as paralysis. In the light of the questions she asked, and the observations of Lord Bridge and Lord Templeman in *Sidaway*, she should have been fully told what the risk was. The only issue was whether she was told.
16. That brings us back to the details of the initial discussion which took place between Miss Chester and Mr Afshar on 18 November 1994 resulting in the "routine" operation being performed on the 21 November, the Monday after that Friday. The varying accounts given by parties are set out at paragraphs 6 and 7 above. The judge accepted Miss Chester's account and gave his reasons for this:

"64. Despite all these difficulties, I am satisfied that the Claimant's account of the discussions is the more accurate of the two. This is because I find it the more plausible and probable, for the following reasons:

(1) She is an intelligent and articulate woman, whose work is likely to have developed her abilities to absorb and retain information;

(2) To her this was a unique and extremely important event, whereas for the Defendant it was one of many;

(3) Her description of the Defendant's response to the possibility of her being crippled seems to me to have the ring of truth and most unlikely to be the result of either invention or reconstruction;

(4) At a very early stage, albeit after the outcome of the surgery was known to her, she was telling Mr Polkey that she had not been advised about the risk of being crippled;

(5) There can be no doubt that prior to the consultation, the Claimant was very averse to the idea of any surgery, and was anxious to avoid it if at all possible: this is confirmed by Dr Wright's letter of referral to the Defendant;

(6) It is not in dispute that neither the Defendant nor the Claimant regarded the operation as a matter of urgency, and that it was fixed for the following Monday as a matter of convenience;

(7) In all these circumstances I find it extremely improbable that, if the Claimant had been adequately informed that the proposed surgery carried a recognised, albeit small, risk of nerve damage possibly resulting in paralysis, she would have agreed without demur to the operation going ahead in three day's time (with a weekend intervening). It seems to me that, given her pre-existing aversion to surgery and her expressed concern about being crippled, the very least that she would have done would have been (as she says) to seek a second, or even third, opinion - which would inevitably have meant that the proposed operation would not have gone ahead on 21 November 1994;

(8) In reaching these conclusions, I am alert to the dangers identified by Hutchison J (as he then was) in *Smith v Barking Health Authority* [1994] 5 Med LR 285, at p 289, of giving weight to assertions by a plaintiff, after the adverse outcome of an operation is known, as to what she would have decided before the operation had she been given proper advice as to the risks inherent in it. However, if I apply the suggested test of what a reasonable claimant in Miss Chester's position would have done - assuming, as I think I should, a reasonable person with Miss Chester's documented aversion to surgery - my conclusion is still the same."

17. We find those reasons compelling. Points (1) and (2) show that Miss Chester was potentially a good and reliable witness. The judge was entitled to find that points (3) to (5) had the ring of truth and that her questions as to "horror stories" were laughed off, and not confronted. Point (6) emphasises that there was no hurry for this elective operation,

and that the claimant was unlikely to agree to a timetable which for practical purposes would have excluded the opportunity to take a second or third opinion - further supporting the downplaying of the risk (see point (7)). Lastly (point (8)), whether one takes a subjective or objective view of her aversion to surgery, the judge was fully entitled to find that her account rang true, and was consistent with reconciling Miss Chester's change from aversion to acquiescence in 72 hours. He concluded:

"66. Having accepted the Claimant's account of what was said at the consultation, I am satisfied that she was never given adequate or proper advice by the Defendant as to the risks involved in the proposed surgery, in particular as to the risk of nerve damage possibly resulting in paralysis. Despite her requests for information about such risk, she was given to understand in effect that there were none. Accordingly I find that in this respect the Defendant's failure to advise the Claimant adequately was negligent under the principle in *Bolam*."

18. Mr Spencer has asked for permission to appeal against the judge's factual findings on this issue but we do not think it appropriate to give permission. The judge saw and heard the witnesses. There is no reason to think that he did not make the most of that opportunity. He gave detailed and compelling reasons for preferring the claimant's account of the conversation. There are no grounds which would justify our interfering with his findings of fact. He also gave an explanation of why the defendant did not warn. He concluded that Mr Afshar would

"65. ... naturally be anxious to avoid alarming or confusing the patient unnecessarily. In the present case, as the defendant indicated during his evidence, he clearly thought that the risk of damage to the claimant was extremely small. Furthermore he knew that he personally had never caused any nerve damage in the many hundreds of operations he had carried out over 20 to 25 years. It may be that he considered the claimant over-anxious or over-preoccupied with 'horror stories' and the possibility of being crippled. I do not find it improbable that, in an attempt to reassure, he deflected her inquiries by answering them in the light-hearted terms she has described - and which he accepts he may have used at some stage. However understandable such a response may have been in psychological terms, it was not an adequate response in legal terms, as Lord Templeman indicated in *Sidaway*."

The judge's findings: causation

19. The next step was for the judge to consider what would have happened if Miss Chester had been adequately warned as to the risk. The judge accepted (para 67) Miss Chester's evidence that if she had known the actual risks of the proposed surgery, she would not have consented to the operation taking place on 21 November, and that before deciding what to do, she would have sought a second or possibly even a third opinion. In all the circumstances, that finding brings with it the conclusion that, on the balance of probabilities, she would not have been operated on on the 21st had she been properly advised of the risks of the operation. There was no urgency about the operation, and the 21st would not have allowed time to

satisfy Miss Chester's reasonable requirements of taking a second and perhaps a third opinion before making up her mind. The judge found that a reasonable person with her aversion to surgery would have done something. He took it as an indicator of her truthfulness that she never went further to claim that she would never at any time or under any circumstances have consented to surgery.

20. Mr Spencer for the defendant urged the judge to find that had she sought a second opinion it would probably have been from Professor Crockard, who would have advised her that she was at lesser risk of paralysis with surgery than without, and that the probable outcome would have been that Miss Chester would in due course have consented to the same surgery. However, the judge declined to make these findings. While he accepted both as possibilities, he rejected them as probabilities because had Professor Crockard given such advice as a second opinion, Miss Chester, having made her own enquiries of journalist colleagues, would have sought a third opinion.

21. The judge concluded that it would be impossible to determine whom she would have seen, what she would have been advised, and how she would have acted in response to that advice. The judge had heard a considerable amount of evidence on this topic, which revealed a considerable divergence of views as to whether the claimant was in November 1994 at serious risk of paralysis without surgery (summarised in para 69 (1) and (3)). He found (para 69 (4) and (5)) that, if the claimant had gone to another consultant, it was more probable than not that the consultant would have tried to meet her concerns by suggesting some alternative course presenting her with a number of different options both surgical and conservative. He concluded (para 70):

"Accordingly - while it is impossible to say what the probable outcome would have been if the claimant had sought a further opinion or opinions - I think it improbable that any surgery she might eventually undergo would have been identical in circumstances (including the nature of the surgery, procedure and surgeon) to the operation she actually underwent on November 21, 1994."

The judge was entitled to his view that it was impossible for him to draw an inference as to the probable outcome if Miss Chester had sought a further opinion or opinions. If, however, this court disagreed with that view, and if the material were there, this court could draw its own inference.

22. The judge went on to conclude that this was sufficient to prove a causal link between the failure to warn and the damage suffered:

"81. ... On the findings that I have made, the risk that materialised during the operation on 21 November 1994 was the risk about which she should have been, but was not, adequately warned. Had she been adequately warned, the operation in question would not have taken place and she would not have suffered damage. In these circumstances, and without more, it seems to me that the necessary causal link is sufficiently

established. I do not see how the fact that the claimant cannot prove that at no future time would she have undergone such an operation can break the causal link thus established. This is especially so when, as I have found, it is improbable that the circumstances of any future surgery would have been identical to those in which the risk, on any view a small one, actually materialised."

What might happen in future was relevant to quantum:

"82. Of course, the possibility that the Claimant might in future undergo such an operation, or even another type of lumbar operation carrying a similar risk, may well be relevant. But it seems to me that such a possibility would be relevant to the issue of damages rather than liability (as was the view of Gaudron and Gummow JJ in *Chappel v Hart*) [see para 30 et seq later] . . . Let me suppose a case similar in type to – but more extreme than – the present one in which the court found on the facts that, had the claimant been adequately advised, the operation in question would have been postponed for six months, at the end of which period she would have undergone surgery and probably suffered the same damage. . . . In such a case the claimant's damages would presumably be limited to six months pain, suffering and consequential loss, but it seems to me that there would be a causal link between the failure to advise and such damages."

The issue in this appeal

23. The issue on causation is easy to state. Miss Perry for the claimant submits that, to establish a causal link between the defendant's failure to advise and warn the claimant of the risk and the damage (and its consequences) which she sustained, it is sufficient for the claimant to prove that, had she been properly advised, she would not have consented to undergo that operation on that day. Miss Perry relies on the majority decision of the High Court of Australia, *Chappel v Hart* [1998] 72 Australian Law Journal Reports 1344; [1999] Lloyd's Law Reports (Medical) 223.
24. Mr Spencer, for the defendant, submits that to establish the causal link, the claimant must go further than that. She must prove that, had she been properly advised, she would never have undergone the surgery in question, either on 21st November or on any subsequent date. Effectively she must show that, had the operation been postponed and had she taken a second opinion, she would then have refused to have surgery of the type proposed at any stage. Mr Spencer submitted that the minority view in *Chappel v Hart* was to be preferred. He drew attention to a line of first instance decisions in this country pre-dating *Chappel v Hart*, which are consistent with the approach for which he contends.
25. First in time was *Smith v Barking, Havering and Brentwood Health Authority* [1994] 5 Med LR 285, a decision of Hutchison J in 1988. The claimant was not properly warned of the risk of tetraplegia resulting from the difficult operation recommended by her surgeon; but without it she would have become tetraplegic within about nine months in any event. He

accepted that the question of what the claimant would have done had she been properly warned was to be approached subjectively rather than objectively – ie what would this particular claimant have done rather than what would a reasonable claimant have done. He rejected a submission that the onus was on the defendant to prove that the claimant would not have refused the operation if properly advised. In reliance on the House of Lords' decisions in *Hotson v East Berkshire Health Authority* [1987] AC 750 and *Wilsher v Essex Area Health Authority* [1988] AC 1074 he held that the burden of proving causation lay with the claimant. He accepted the submission that 'the plaintiff could only succeed if she established on the balance of probabilities that, had she received proper warning and advice, she would have elected against the operation.' But he found on the balance of probabilities that she would have consented to it, even if properly advised. This case is obviously correct as to where the burden of proof lies. It is also correct as to the legal consequence of the factual finding reached: if a claimant would have had the operation even if properly advised, then the lack of a warning cannot have caused the injury. The judge did not have to address the more subtle question at issue here.

26. Next in time was *McAllister v Lewisham and North Southwark Health Authority* [1994] 5 Med LR 343, a decision of Rougier J in December 1993. The claimant underwent lengthy brain surgery to correct a neurological deficit in her left leg. She was warned of the risk that it would make her leg worse rather than better but not of the general risks affecting brain surgery or of the risk of hemiplegia which in fact occurred. The judge held that this was negligent. The claimant herself was reluctant to say what she would have done had she been properly warned. The judge was confident that she would not have had the operation when she did and would have seized the opportunity of postponing it at least until after she was secure in her job and could take the risk of a long period of time off. He went on to conclude that on the balance of probabilities she would have continued to decline the operation. Hence she had succeeded in proving the necessary causal connection. Thus Rougier J adopted the same approach as that signalled by Hutchison J in *Smith v Barking, Havering and Brentwood* but reached the opposite conclusion on the facts. His Honour Judge Taylor commented in this case:

"I acknowledge that Rougier J in *McAllister* decided liability on the basis that it was necessary for the plaintiff to establish that she would have continued to decline the operation in question; but it does not appear that he was ever invited to adopt any different approach to the question of causation, or that the interesting point which I have to decide was ever canvassed before him. Furthermore the decision in *Chappel v Hart* was several years later than *McAllister*."

27. The same comment could be made of *Smith v Tunbridge Wells Health Authority* [1994] 5 Med LR 334, in which Morland J reached a similar result. He found that the claimant had not been properly warned of the risk of impotence and bladder malfunction from rectal surgery. The major part of his judgment is devoted to whether a warning should have been given and if so whether it was done sufficiently clearly. He was entirely

satisfied that if a proper warning had been given, the claimant would have refused the operation.

28. Last in the line was *Smith v Salford Health Authority* [1994] 5 Med LR 321. Potter J found that the defendant was at fault in his pre-operative investigations and assessment of the situation, in failing to give proper advice, and in his conduct of the operation. He found the defendant liable on the basis of the use of an inappropriate instrument. He would not have found the defendant liable on the basis of the failure to warn, because he was not satisfied that the claimant would have declined the operation if he had been properly advised.
29. We thus have two cases finding against the claimant on the basis that he or she would have had the operation in any event and two cases finding for the claimant on the basis that he or she would have refused the operation. Not surprisingly, both parties to the present case draw some support from these decisions. Mr Spencer relies upon the way in which Hutchison J, Rougier J and Potter J asked themselves the question: had the claimant satisfied them that he or she would have refused the operation? Miss Perry points out that there is no case denying liability on the basis of the factual findings in this case: ie that she would have refused this particular operation but it was impossible to predict whether she would have consented to some form of surgery in the future.
30. We come, therefore, to the majority decision of the High Court of Australia in *Chappel v Hart*, which the judge found 'extremely persuasive'. The facts were, in his careful words, 'reasonably similar' to this case. The claimant, a school teacher, had a strong clear voice, which was important to her, both professionally and generally. She had a 'relentlessly progressive' throat condition which would require surgery at some time, sooner or later. That surgery carried with it a very slight risk of injury which would leave her with a weak voice. Whether the operation was done well or badly, it would carry with it an inherent risk of perforation of the oesophagus, which could lead to infection and damage to her voice. She brought her anxieties as to her voice to Dr Chappel's attention, but he did not warn her of the risk inherent in the operation. In the event, he operated on the claimant with due skill and care, but perforation occurred notwithstanding, infection set in, and her voice was permanently damaged. She sued Dr Chappel both in contract and in tort for his failure to warn her. The Supreme Court of New South Wales awarded her damages. The trial judge found that had Mrs Hart received an appropriate warning, she would not have had surgery when she did, but would have had it done later by 'the most experienced surgeon with a record and a reputation in the field'. The Court of Appeal of New South Wales dismissed the doctor's appeal. He then appealed to the High Court of Australia. The appellant contended that there was no causal connection between the failure to warn and her injury, because surgery was inevitable and carried the risk which eventuated, she had not lost any real or valuable chance of the risk being diminished or avoided, and the injury resulted from a random risk that she was willing to accept. Hence she was entitled to only nominal damages. The doctor's appeal was dismissed.

31. The majority (Gaudron J, Gummow J and Kirby J) rejected the appellant's arguments and held that his negligence had caused the injury. All three of them declined to treat the case as one involving the loss of a chance. Her loss was the physical injury suffered. Gaudron J said this (we quote from the report at [1998] 72 Australian Law Journal Reports 1344 because the paragraphs are numbered):

"9. Where there is a duty to inform it is, of course, necessary for a plaintiff to give evidence as to what would or would not have happened if the information in question had been provided. If that evidence is to the effect that the injured person would have acted to avoid or minimise the risk of injury, it is to apply sophistry rather than common sense to say that, although the risk of physical injury which came about called the duty of care into existence, breach of that duty did not cause or contribute to that injury, but simply resulted in the loss of an opportunity to pursue a different course of action."

Further,

"12. . . . The argument proceeds on the erroneous footing that the damage sustained by Mrs Hart was simply exposure to risk, not the harm which eventuated. And to say that Mrs Hart would inevitably have been exposed to risk of the harm which she suffered is not to say that she would inevitably have suffered that harm."

As Gaudron J also pointed out (para 17), the risk may have been the same, but the likelihood of that risk eventuating in future was not the same. There was evidence that the risk diminished with the skill and experience of the surgeon concerned. It was in any event extremely rare (para 20).

32. Gummow J referred to previous High Court authority in *March v Stramare (E & MH) Pty Ltd* (1991) 171 CLR 506, per Mason CJ at 514, that

"62. . . . generally speaking, a sufficient causal connection is established if it appears that the plaintiff would not have sustained the injuries complained of had the defendant not been negligent. However, the 'but for' test is not a comprehensive and exclusive criterion, and the results which are yielded by its application properly may be tempered by the making of value judgments and the infusion of policy considerations. . . .

66. In the present appeal, not only was the damage which Mrs Hart suffered reasonably foreseeable, but the fact that the relevant conjunction of circumstances could occur should have been the subject of any adequate warning and the reason for giving it. It is true that in some cases of a failure to warn by a medical practitioner an application of the 'but for' test without qualification could lead to absurd or unjust results. Such would have been the situation if, for example, instead of suffering damage to her laryngeal nerve, Mrs Hart had been injured through misapplication of anaesthetic. Whilst it would still be open to conclude that, but for Dr Chappel's failure to warn her of the possibility of damage to her voice, she would not have opted for the operation at that time and would not have

been injured by the anaesthetic, the law would not conclude that the failure to warn of the risk of injury to the laryngeal nerve caused the injury resulting from the anaesthetic.

67. The present appeal is significantly different from the situation described. In Mrs Hart's case, the very risk of which she should have been warned materialised. In his written submissions filed by leave after the hearing of the appeal, Dr Chappel conceded that, if the surgery had been performed at a different time, then '[i]n all likelihood' Mrs Hart 'would not have suffered the random chance of injury'. In addition, the particular risk involved had been the subject of specific inquiry by Mrs Hart of the medical practitioner who was then engaged by her to perform the surgery. She was a person for whom the potential consequences of damage to her voice were more significant than the 'statistical' risk. Those additional factors, combined with the satisfaction of the 'but for' test were sufficient to establish causation in this case."

33. Kirby J described his thought process thus:

"94. . . . The strongest arguments for Dr Chappel, as it seems to me, are those which lay emphasis upon a logical examination of the consequences which would have flowed had he not breached his duty to warn his patient. Dissecting the facts in that way affords a powerful argument which would banish from consideration the events which in fact occurred in the operation which he carried out. All that would have happened, had he given the requisite warning, would have been a change in the timing of the operation and of the identity of the surgeon. For Dr Chappel, these were irrelevant changes as the evidence showed that, whenever the operation was performed and whoever did it, the tripartite chances which had to combine to produce the misfortune which Mrs Hart suffered were extremely rare. There was thus an equivalence of unlikelihood. They were risks inherent in the procedure, not wholly avoidable even by the most skilful and experienced of surgeons. In the view which Dr Chappel urged of the case, Mrs Hart was left with nothing more than the time sequence. To burden a surgeon, in whose actual performance no fault would be found, with civil liability for randomised chance events that followed the surgery would not be reasonable. It would penalise him for chance alone. It would do nothing to establish a superior standard in the performance of the work of surgeons generally.

95. For a time I was attracted to Dr Chappel's arguments. Ultimately, I have concluded against them. The 'commonsense' which guides courts in this area of discourse supports Mrs Hart's recovery. So does the setting of standards which uphold the importance of the legal duty that was breached here. This is the duty which all health care professionals in the position of Dr Chappel must observe: the duty of informing patients about risks, answering their questions candidly and respecting their rights, including (where they so choose) to postpone medical procedures and to go elsewhere for treatment.

96. In *Environment Agency (formerly National Rivers Authority) v Empress Car Co (Abertillery) Ltd* [1998] 2 WLR 350, at pp 356-358, Lord Hoffmann

emphasised that common-sense answers to questions of causation will differ according to the purpose for which the question is asked. The answer depends upon the purpose and scope of the rule by which responsibility is being attributed. In *Rogers v Whitaker* (1992) 175 CLR 479, at p 490, this Court decided that 'a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment' and that:

'a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should be reasonably aware that the particular patient, if warned of the risk, would be likely to attach significance to it.'

These standards have fairly been described as onerous. They are. But they are the law. They are established for good reason. When not complied with (as was held to be so in this case) it should occasion no surprise that legal consequences follow. This was an unusual case where the patient was found to have made very clear her concerns. The practicalities are that, had those concerns been met as the law required, the overwhelming likelihood is that the patient would not, in fact, have been injured. So much was eventually conceded. In such circumstances, commonsense reinforces the attribution of legal liability. It is true to say that the inherent risks of injury from rare and random causes arises in every surgical procedure. A patient, duly warned about such risks, must accept them and their consequences. Mrs Hart was ready to accept any general risks of the operation about which she was warned. However, she declined to bear the risks about which she questioned the surgeon and received no adequate response. When those risks so quickly eventuated, commonsense suggests that something more than mere coincidence or irrelevant cause has intervened. This impression is reinforced once it is accepted that Mrs Hart, if warned, would not have undergone the operation when she did."

34. English law does not impose quite such a rigorous standard upon doctors as that in *Rogers v Whittaker*, but the policy point made by Kirby J would still apply.

35. The minority view can be taken from the judgment of McHugh J:

"25. The rejection [in *March v Stramare (E & MH) Pty Ltd* (1991) 171 CLR 506] of the 'but for' test as the sole determinant of causation means that the plaintiff in this case cannot succeed merely because she would not have suffered injury but for the defendant's failure to warn her of the risk of injury. However, his failure to warn her of the risk was one of the events that in combination with others led to the perforation of her oesophagus and damage to the right recurrent laryngeal nerve. Without that failure, the injury would not have occurred when it did and, statistically, the chance of it occurring during an operation on another occasion was very small. Moreover, that failure was the very breach of duty which the plaintiff alleges caused her injury. The defendant's failure to warn, therefore, must be regarded as the cause of the plaintiff's injury unless common sense or legal policy requires the conclusion that, for the

purposes of this action, the failure is not to be regarded as a cause of the plaintiff's injury."

However,

"27. Before the defendant will be held responsible for the plaintiff's injury, the plaintiff must prove that the defendant's conduct materially contributed to the plaintiff suffering that injury. In the absence of a statute or undertaking to the contrary, therefore, it would seem logical to hold a person causally liable for a wrongful act or omission only when it increases the risk of injury to another person. If a wrongful act or omission results in an increased risk of injury to the plaintiff and that risk eventuates, the defendant's conduct has materially contributed to the injury that the plaintiff suffers whether or not other factors also contributed to that injury occurring. If, however, the defendant's conduct does not increase the risk of injury to the plaintiff, the defendant cannot be said to have materially contributed to the injury suffered by the plaintiff."

The reasoning of Haynes J was to much the same effect.

36. The commentaries which we have read on *Chappel v Hart* are in general supportive of the result reached by the majority, albeit not necessarily for the reasons they gave (Whitfield [1999] Lloyd's Law Reports (Medical) 253; Cane (1999) 115 LQR 21; Stauch (2000) 63 MLR 261).

Discussion

37. The divergence of views expressed in *Chappel v Hart* shows that the issue is not an easy one and may be approached in a number of different ways. It is axiomatic that it is not enough to show that the acts or omissions of the defendant caused the damage. Obviously, in this case they did that. It is not only that Mr Afshar's actions at the operating table produced the physical effects sustained. His acts and omissions during the consultation on 18 November were clearly one cause, along with the claimant's own decision, of the claimant having the operation on 21 November. But the claimant must prove that the defendant's breach of his duty towards her caused the damage. Miss Chester must show that Mr Afshar's failure to warn her of the risk of the damage she sustained caused her to suffer that damage.
38. In accordance with logic and authority (eg *Allied Maples Group Ltd v Simmons & Simmons* [1995] 1 WLR 1602) the answer to that question must considerably depend upon the answer to the further question of what would have happened if she had been properly warned. There is a spectrum of possible answers to that second question. At each end of the spectrum the solution would be plain. If the claimant would have had the same operation at the same time in any event (as in the first and third *Smith* cases), then the defendant's failure to warn her properly would have made no difference. He would not have caused her to do anything which she would not otherwise have done. It would be as if she had chosen to have the operation knowing the risks she was running. On the other hand, if the claimant would never have had the operation had she been properly

warned (as in the *McAllister* and the second *Smith* cases), clearly the defendant's breach of duty would have caused her to have it and Mr Spencer accepts that it would also have caused her to sustain the damage. The only issue would then have become one of quantum: how does her damaged state after the operation compare with the state she would have been in without it?

39. The present case lies in between the two extremes. The claimant can show that she would not have had the operation she did, or would not have had it when she did, or would not have had it in the circumstances in which she did, but she cannot show that she would never have had some surgical procedure of this kind which would have carried the same or similar risks. Can it then be said that causing her to have the operation caused her to suffer the damage?
40. The minority view in *Chappel v Hart* was that the defendant had not increased the risk to which the claimant was exposed. That may have been debatable, in that there was some evidence from which it might be inferred that the risk would have been less at the hands of a more experienced surgeon. But the risk was in any event so small that the difference must have been minuscule. However, if it were only appropriate to focus attention on the risks of having the operation whenever it took place, the claimant would never succeed, even when she could show that she would never have had the operation. The risks were always the same and the defendant did not increase them. But Mr Spencer accepts that *McAllister* was rightly decided. In our view he is correct to do so. The defendant does change the risk in a material way: he causes the patient to have an operation which she would not otherwise have had then and there and possibly not at all. Logically, the correct comparison of risk is between having that operation on that occasion and not having it.
41. Miss Perry put it in this way to the judge in her closing speech, 'All she has to do is to satisfy my Lord that, given the appropriate advice, she would have gone elsewhere. Unless my Lord is satisfied that, going elsewhere, will inevitably or on the balance of probabilities have produced exactly the same result for her . . . then . . . the claimant must succeed.' If it is more likely than not that the same damage would have been sustained in any event, then all the defendant has done is bring forward the date when she suffers it. If it is more likely than not that the same damage would not have been suffered, then by causing her to have the operation that day he has caused her to sustain it. There is no problem of remoteness because the risk was clearly foreseeable: it was the fact that it was a foreseeable risk, albeit a small one, that gave rise to the duty to warn which was broken. Indeed, in each of these cases, it can be said that he has caused some damage, the question of acceleration being one of quantum rather than causation.
42. If that is the correct approach, then causation is established in this case. The judge made a clear finding that the claimant would not have had the operation when she did. The defendant therefore caused her to have the operation. The judge did not expressly find that the likelihood was that she would not have suffered the same injury on a different occasion. But the

evidence both as to the general and the particular risks of this procedure was such that such a finding was strongly arguable if not inevitable when damages come to be assessed. At the trial it was not suggested that the well-known risk of cauda equina damage resulting from the type of surgery advised and performed by the defendant was greater than 1 to 2%. Nor do we think that there was any evidence to show that the claimant's constitution made her abnormally vulnerable to this type of surgery. But this will be a matter for the court assessing damages. On the assessment it will be open to the defendant to argue (and prove so far as he may be able to do so) that

(i) it is more likely than not that the claimant would have undergone an operation with the same or similar risks in the future; and

(ii) it is more likely than not that the same risk would have eventuated.

43. Several further considerations help us to conclude that the correct approach goes at least this far. We accept that the 'but for' test is necessary but not always sufficient to establish causation in law. Even if the claimant would not have been on the operating table that day if the defendant had given her a proper warning, the defendant is not liable for coincidences which have nothing to do with him, such as the anaesthetic failure referred to by Gummow J or lightning striking the operating theatre. The classic example of this point was given by Lord Hoffmann in *Banque Bruxelles SA v Eagle Star* [1997] AC 191, at 213D-E:

"A mountaineer about to undertake a difficult climb is concerned about the fitness of his knee. He goes to a doctor who negligently makes a superficial examination and pronounces the knee fit. The climber goes on the expedition, which he would not have undertaken if the doctor had told him the true state of his knee. He suffers an injury which is an entirely foreseeable consequence of mountaineering but has nothing to do with his knee."

44. In cases such as the present, however, it simply cannot be said that the injury suffered had nothing to do with the problem which had taken the claimant to the doctor. It was a consequence of that very problem and the doctor's attempt to put it right. Furthermore it was a consequence about which the claimant had expressed her concern to the doctor and been wrongly reassured. The closer analogy is with the mountaineer who consults his doctor because he is afraid that his knee will give way under the strain of mountain climbing, is wrongly reassured that it will not, and who is injured because his knee does give way. The doctor was not to blame for the knee giving way, any more than the doctor (if the first operation was not negligently performed) was to blame for the cauda equina syndrome in this case, but he was to blame for the mountaineer being on the mountain at all.
45. What if the mountaineer would not have taken the risk immediately but cannot rule out the possibility that his love of mountaineering was such that he would have been prepared to run it at some later date? Logic would again suggest that this should only make a difference if it was more

likely than not that he would do so: the mere possibility that his feelings would eventually get the better of him does not break the chain. Furthermore, by causing him to go up the mountain when he would not have done so the doctor had caused him to suffer the injury earlier than he would otherwise have done. He has therefore lived for longer with the consequences of a broken leg (or whatever) than he would otherwise have done. The question then becomes one of quantification rather than causation, as the judge held in this case.

46. Kirby J also referred to the observations of Lord Hoffmann in *Environment Agency (formerly National Rivers Authority) v Empress Car Co (Abertillery) Ltd* [1999] 2 AC 22, at pp 29 – 31:

"The first point to emphasise is that common sense answers to questions of causation will differ according to the purpose for which the question is asked. Questions of causation often arise for the purpose of attributing responsibility to someone, for example, so as to blame him for something which has happened . . . one cannot give a common sense answer to a question of causation for the purpose of attributing responsibility under some rule without knowing the purpose and scope of the rule."

A somewhat similar point was made by Laws LJ in *Rahman v Arearose* [2001] QB 351, at p 367, albeit in the different context of sharing responsibility between two different tortfeasors:

"33. So in all these cases the real question is, what is the damage for which the defendant under consideration should be held *responsible*. The nature of his duty (here the common law duty of care) is relevant; causation, certainly will be relevant – but it will fall to be viewed, and in truth can only be understood, in the light of the answer to the question: from what kind of harm was it the defendant's duty to guard the claimant?"

In principle there seems to be little difficulty in attributing causative responsibility to a doctor who has in breach of duty failed to draw a particular risk to his patient's attention if in the event that particular risk materialises.

47. The purpose of the rule requiring doctors to give appropriate information to their patients is to enable the patient to exercise her right to choose whether or not to have the particular operation to which she is asked to give her consent. English law has rejected the proposition that a failure to give adequate warning vitiates the patient's consent, thus turning the operation into an assault: see *Chatterton v Gerson* [1981] QB 432. Liability lies in negligence rather than trespass. But the patient does still have the right to choose what will and will not be done with her body and the doctor must take the care expected of a reasonable doctor in the circumstances in giving her the information relevant to that choice. The law is designed to require doctors properly to inform their patients of the risks attendant on their treatment and to answer questions put to them as to that treatment and its dangers, such answers to be judged in the context of good professional practice, which has tended to a greater

degree of frankness over the years, with more respect being given to patient autonomy. The object is to enable the patient to decide whether or not to run the risks of having that operation at that time. If the doctor's failure to take that care results in her consenting to an operation to which she would not otherwise have given her consent, the purpose of that rule would be thwarted if he were not to be held responsible when the very risk about which he failed to warn her materialises and causes her an injury which she would not have suffered then and there. As Adrian Whitfield QC pointed out in his comment on *Chappel v Hart* [1999] Lloyd's Law Reports (Medical) 253, at p 255:

"The view of the minority of the High Court, that the 'but for' test works injustice and that the effective cause should be taken not as the defendant's failure to warn, but rather the random occurrence of an inherent risk, runs counter to the whole basis of informed consent cases, which are designed to protect patients against negligent failure to advise against just such risks."

It would in our judgment be unjust to hold that the effective cause of the claimant's injury was the random occurrence of the 1 to 2% risk referred to above rather than the defendant's failure to bring such risk to her attention.

48. In the end, therefore, all these considerations lead us to the same conclusion: that the conclusion of the majority in *Chappel v Hart* was right and that the judge reached the right conclusion in this case. We therefore reject the grounds of appeal which argue that the judge adopted the wrong test, failed to adopt the correct test, and therefore failed to make the necessary findings of fact to support his conclusions. We have already indicated that we see no reason to disturb the judge's factual findings on the issue of whether or not an adequate warning was given and would refuse permission to appeal on that ground.

49. That leaves the first ground of appeal, for which the defendant would also require permission. This is a pleading point. From issue of the Statement of Claim on 9 April 1998 until trial of the action in December 2000, the claimant's pleading was in the form complained of, paragraph 11 of which read:

"In breach of his said duty and/or negligently, the Defendant wholly failed to advise, explain or otherwise counsel the Plaintiff as to the real risks attached to the said surgical procedure thereby depriving the Plaintiff of an opportunity to reflect, consider and/or seek alternative medical or other opinion in respect of options which may be open to her which, it is averred, the Plaintiff would have done and so sought had the Defendant acted in accordance with reasonably medical practice in the course of his said consultation and thereafter at the London Bridge Hospital."

At the beginning of the trial Mr Spencer sought to strike out the issue on the ground that it was inadequately pleaded in terms of causation. He was unsuccessful. The defendant had had more than two years to obtain whatever particulars he wanted. So far as we are aware he did nothing

effective to do so. The judge held that it was too late to do so on the eve of trial. We cannot say that the exercise of his discretion was plainly wrong. In any event, the pleading was adequate to allege that the claimant would not have consented to the operation which was in fact performed upon her and would at the very least have postponed the decision. That, on the law as we have held it to be, was sufficient.

50. The defendant's appeal is dismissed.