HOUSE OF LORDS SESSION 2003–04
[2004] UKHL 41

on appeal from:[2002] EWCA Civ 724

OPINIONS

OF THE LORDS OF APPEAL

FOR JUDGMENT IN THE CAUSE

Chester (Respondent)
v.
Afshar (Appellant)

ON
THURSDAY 14 OCTOBER 2004

The Appellate Committee comprised:

Lord Bingham of Cornhill
Lord Steyn
Lord Hoffmann
Lord Hope of Craighead
Lord Walker of Gestingthorpe

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LORD BINGHAM OF CORNHILL

My Lords,

1. The central question in this appeal is whether the conventional approach to causation in negligence actions should be varied where the claim is based on a doctor's negligent failure to warn a patient of a small but unavoidable risk of surgery when, following surgery performed with due care and skill, such risk eventuates but it is not shown that, if duly warned, the patient would not have undergone surgery with the same small but unavoidable risk of mishap. Is it relevant to the outcome of the claim to decide whether, duly warned, the patient probably would or probably would not have consented to undergo the surgery in question?

2. I am indebted to my noble and learned friend Lord Hope of Craighead for his detailed account of the facts and the history of these proceedings, which I need not repeat.

3. For some six years beginning in 1988 the claimant, Miss Chester, suffered repeated episodes of low back pain. She was conservatively treated by Dr Wright, a consultant rheumatologist, who administered epidural and sclerosant injections. An MRI scan in 1992 showed evidence of disc protrusions. In 1994, on the eve of a professional trip abroad, Miss Chester suffered another episode of pain and disability: she could "hardly walk", and had reduced control of her bladder. Dr Wright gave another epidural injection, and Miss Chester was able to make the trip, using a wheelchair at Heathrow. But after the trip the pain returned. A further MRI scan revealed marked protrusion of discs into the spinal canal. After further conservative treatment which proved ineffective, Dr Wright referred Miss Chester to Mr Afshar, a distinguished consultant neurosurgeon with much experience of disc surgery, although Miss

Chester was understandably reluctant to undergo surgery if this could be avoided.

4. On accepting Miss Chester as a patient, Mr Afshar became subject to a legal as well as a professional duty to exercise reasonable care and skill in examining her; in assessing her case; and in advising on the need for surgery to alleviate her condition. If surgery was advised and accepted, he was bound to exercise reasonable care and skill in operating and in supervising her post-operatively. Mr Afshar did examine Miss Chester, did advise and did undertake surgery. All these duties Mr Afshar duly performed. Miss Chester contended at trial that Mr Afshar had performed the operation negligently, but the judge rejected this complaint and in the event the Court of Appeal was not asked to rule on that question.

5. Mr Afshar was however subject to a further, important, duty: to warn Miss Chester of a small (1%–2%) but unavoidable risk that the proposed operation, however expertly performed, might lead to a seriously adverse result, known in medical parlance as cauda equina syndrome. The existence of such a duty is not in doubt. Nor is its rationale: to enable adult patients of sound mind to make for themselves decisions intimately affecting their own lives and bodies. There was a conflict of evidence at trial on what was said by Mr Afshar about the risk of an adverse outcome, but the judge resolved this conflict against him, holding that he had not given the warning which he should have given, and the Court of Appeal did not give him leave to challenge that conclusion. So it must be accepted that Mr Afshar did not give Miss Chester the warning which he should have given of the small but unavoidable risk that surgery might not improve Miss Chester's condition but might affect it adversely. As it was, the surgery, although skilfully performed, led to her suffering the cauda equina syndrome.

6. Had the evidence entitled the judge to conclude, and had he concluded, that Miss Chester, if warned as she should have been, would probably not have agreed to surgery, she would on conventional principles have been entitled to recover damages. The measure of damages would have reflected the difference between Miss Chester's condition following surgery and the condition she would probably have been in without surgery, but there would have been no problem of causation. Had the warning been given, Miss Chester would (on such a finding) have acted differently, and her additional injury would be directly attributable to the absence of warning. The same would be true if the evidence had entitled the judge to conclude, and if he had

concluded, that Miss Chester, if properly warned as she should have been, could and would have minimised the risk of surgery by entrusting herself to a different surgeon, or undergoing a different form of surgery, or (in another kind of case) losing weight or giving up smoking.

7. But the judge made none of these findings. He concluded that, if duly warned, Miss Chester would not have undergone surgery three days after her first consultation with Mr Afshar, but would, very understandably, have wished to discuss the matter with others and explore other options. But he did not find (and was not invited to find) that she would probably not have undergone the surgery or that there was any way of minimising the small degree of risk inherent in surgery. As my noble and learned friend Lord Hope observes in paragraph 61 of his opinion, the risk

> "was also liable to occur at random, irrespective of the degree of care and skill with which the operation was conducted by the surgeon. This means that the risk would have been the same whenever and at whoever's hands she had the operation … it is difficult to say that his failure was the effective cause of the injury."

8. It is now, I think, generally accepted that the "but for" test does not provide a comprehensive or exclusive test of causation in the law of tort. Sometimes, if rarely, it yields too restrictive an answer, as in *Fairchild v Glenhaven Funeral Services Ltd* [2002] UKHL 22, [2003] 1 AC 32. More often, applied simply and mechanically, it gives too expansive an answer: "But for your negligent misdelivery of my luggage, I should not have had to defer my passage to New York and embark on *SS Titanic*". But, in the ordinary run of cases, satisfying the "but for" test is a necessary if not a sufficient condition of establishing causation. Here, in my opinion, it is not satisfied. Miss Chester has not established that but for the failure to warn she would not have undergone surgery. She has shown that but for the failure to warn she would not have consented to surgery on Monday 21 November 1994. But the timing of the operation is irrelevant to the injury she suffered, for which she claims to be compensated. That injury would have been as liable to occur whenever the surgery was performed and whoever performed it.

9. Thus the question arises whether Miss Chester should be entitled to recover even though she cannot show that the negligence proved

against Mr Afshar was, in any ordinary sense, a cause of her loss. I am of course impressed by the weight and distinction of the academic opinion supporting the decisions of the judge and the Court of Appeal in this case. But if failure to warn and the occurrence of injury which should have been the subject of the warning are, without more, enough to found a successful claim, the claimant would presumably succeed even in a case like *Smith v Barking, Havering and Brentwood Health Authority* [1994] 5 Med LR 285, where it is found on the balance of probabilities that the claimant would have consented to the operation even if properly advised. That seems to me, with respect to those who hold otherwise, to be a substantial and unjustified departure from sound and established principle. It is trite law that damage is the gist of the action in the tort of negligence. It is not suggested that it makes any difference whether a claim such as the present is framed in tort or in contract. A claimant is entitled to be compensated for the damage which the negligence of another has caused to him or her. A defendant is bound to compensate the claimant for the damage which his or her negligence has caused the claimant. But the corollaries are also true: a claimant is not entitled to be compensated, and a defendant is not bound to compensate the claimant, for damage not caused by the negligence complained of. The patient's right to be appropriately warned is an important right, which few doctors in the current legal and social climate would consciously or deliberately violate. I do not for my part think that the law should seek to reinforce that right by providing for the payment of potentially very large damages by a defendant whose violation of that right is not shown to have worsened the physical condition of the claimant. I would respectfully adopt the reasoning of McHugh J in his dissenting judgment in *Chappel v Hart* (1998) 195 CLR 232.

10. For these reasons, and also those given by my noble and learned friend Lord Hoffmann, I would allow this appeal.

LORD STEYN

My Lords,

11. The facts of this case can be simplified. The claimant suffered from low back pain. A neurosurgeon advised her to undergo an elective lumbar surgical procedure. The procedure entails a 1%-2% chance of serious neurological damage arising from the operation. The claimant

was entitled to be informed of this fact. In breach of the common law duty of care the surgeon failed to inform the claimant of the risk. The claimant reluctantly agreed to the operation. Three days after her consultation with the surgeon the claimant underwent the surgery. The claimant sustained serious neurological damage. In the result the very injury about which she should have been warned occurred. The surgeon had not been negligent in performing the operation: he did not increase the risks inherent in the surgery. On the other hand, if the claimant had been warned she would not have agreed to the operation. Instead she would have sought further advice on alternatives. The judge found that if the claimant had been properly warned the operation would not have taken place when it did, if at all. The judge was unable to find whether if the claimant had been duly warned she would with the benefit of further medical advice have given or refused consent to surgery. What is clear is that if she had agreed to surgery at a subsequent date, the risk attendant upon it would have been the same, ie 1%-2%. It is therefore improbable that she would have sustained neurological damage.

12. On these facts the judge found that the claimant had established a causal link between the breach and the injury she had sustained and held that the defendant was liable in damages. In a detailed and careful judgment the Court of Appeal (Hale LJ, Sir Christopher Slade and Sir Denis Henry) upheld the conclusion of the judge: *Chester v Afshar* [2002] EWCA Civ 724; [2003] QB 356.

13. Counsel for the surgeon submitted that it is contrary to general principles of tort law to award damages when a defendant's wrong has not been proved to have increased the claimant's exposure to risk. He argued that in order to establish causation in a case of a surgeon's failure to warn a patient of a significant risk of injury, the patient must prove both that she would not have consented to run the relevant risk then and there, and that she would not, ultimately, have consented to run the relevant risk. The only qualification was the case where a claimant could prove an accelerated onset of injury. That the claimant could not do on the facts of the case. On analysis it was an all or nothing case. Counsel said that the injury that the claimant sustained was just a coincidence, a piece of abominable bad luck, like lightning striking a person. This was a powerful argument and persuasively presented.

14. The legal context requires consideration of a number of other relevant factors. First, the nature of the correlative rights and duties of the patient and surgeon must be kept in mind. The starting point is that every individual of adult years and sound mind has a right to decide

what may or may not be done with his or her body. Individuals have a right to make important medical decisions affecting their lives for themselves: they have the right to make decisions which doctors regard as ill advised. Surgery performed without the informed consent of the patient is unlawful. The court is the final arbiter of what constitutes informed consent. Usually, informed consent will presuppose a general warning by the surgeon of a significant risk of the surgery.

15. In the case before the House a single cause of action is under consideration, viz the tort of negligence. How a surgeon's duty to warn a patient of a serious risk of injury fits into the tort of negligence was explained by Lord Woolf MR, with the agreement of Roch and Mummery LJJ, in *Pearce v United Bristol Healthcare NHS Trust* [1999] PIQR P53. After reviewing a trilogy of decisions in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582; *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871 and *Bolitho v City and Hackney Health Authority* [1998] AC 232, Lord Woolf observed, at P59:

> "In a case where it is being alleged that a plaintiff has been deprived of the opportunity to make a proper decision as to what course he or she should take in relation to treatment, it seems to me to be the law, as indicated in the cases to which I have just referred, that if there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or she should adopt."

16. A surgeon owes a legal duty to a patient to warn him or her in general terms of possible serious risks involved in the procedure. The only qualification is that there may be wholly exceptional cases where objectively in the best interests of the patient the surgeon may be excused from giving a warning. This is, however, irrelevant in the present case. In modern law medical paternalism no longer rules and a patient has a prima facie right to be informed by a surgeon of a small, but well established, risk of serious injury as a result of surgery.

17. Secondly, not all rights are equally important. But a patient's right to an appropriate warning from a surgeon when faced with surgery

ought normatively to be regarded as an important right which must be given effective protection whenever possible.

18. Thirdly, in the context of attributing legal responsibility, it is necessary to identify precisely the protected legal interests at stake. A rule requiring a doctor to abstain from performing an operation without the informed consent of a patient serves two purposes. It tends to avoid the occurrence of the particular physical injury the risk of which a patient is not prepared to accept. It also ensures that due respect is given to the autonomy and dignity of each patient. Professor Ronald Dworkin (*Life's Dominion: An Argument about Abortion and Euthanasia*, 1993) explained these concepts at p 224:

> "The most plausible [account] emphasizes the integrity rather than the welfare of the choosing agent; the value of autonomy, on this view, derives from the capacity it protects: the capacity to express one's own character – values, commitments, convictions, and critical as well as experiential interests – in the life one leads. Recognizing an individual right of autonomy makes self-creation possible. It allows each of us to be responsible for shaping our lives according to our own coherent or incoherent – but, in any case, distinctive – personality. It allows us to lead our lives rather than be led along them, so that each of us can be, to the extent a scheme of rights can make this possible, what we have made of ourselves. We allow someone to choose death over radical amputation or a blood transfusion, if that is his informed wish, because we acknowledge his right to a life structured by his own values."

19. Fourthly, it is a distinctive feature of the present case that but for the surgeon's negligent failure to warn the claimant of the small risk of serious injury the actual injury would not have occurred when it did and the chance of it occurring on a subsequent occasion was very small. It could therefore be said that the breach of the surgeon resulted in the very injury about which the claimant was entitled to be warned.

20. These factors must be considered in combination. But they must also be weighed against the undesirability of departing from established principles of causation, except for good reasons. The collision of competing ideas poses a difficult question of law.

21. That such problems do not necessarily have a single right answer is illustrated by the judgment of the Australian High Court in *Chappel v Hart* (1998) 195 CLR 232. A surgeon failed to warn a patient of a small risk of an operation. She underwent the operation. In the result the very injury of which she should have been warned took place. As in the present case the position was that the patient would not have had the operation at the time and place when she did. If the patient had the operation on a subsequent occasion, the outcome would probably have been uneventful. On these facts the court decided by a majority of three (Gaudron, Gummow and Kirby JJ) to two (McHugh and Hayne JJ) that the patient was entitled to recover substantial damages from the surgeon for the physical injuries suffered as a result of the operation performed on her. The judgments are illuminating. For my part I found the dissenting judgment of McHugh J particularly powerful, and rightly counsel for the surgeon relied heavily on it. *Chappel v Hart* mirrors the issues and arguments in the present case. It will not serve any useful purpose to cite at length from the judgments. I also do not think a process of counting heads in a case such as *Chappel v Hart* is a particularly helpful exercise in regard to the issue before the House. At the very least, however, this Australian case reveals two fundamentally different approaches, the one favouring firm adherence to traditionalist causation techniques and the other a greater emphasis on policy and corrective justice.

22. The House was referred to a valuable body of academic literature which discusses problems such as arose in *Chappel v Hart*, and in the present case, in some detail. Not surprisingly, the authors approach the matter from slightly different angles. It is, however, fair to say that there is general support for the majority decision in *Chappel v Hart*, and for the view which prevailed in the Court of Appeal in the present case: see Cane, "A Warning about Causation" (1999) 115 LQR 21; Grubb, "Clinical Negligence: Informed Consent and Causation" (2002) 10 Med LRev 322; Honoré, "Medical non-disclosure: causation and risk: *Chappel v Hart*" (1999) 7 Torts LJ 1; Jones, 'But for' causation in actions for non-disclosure of risk", (2002) 18 PN 192; Stapleton, "Cause-in-Fact and Scope of Liability for Consequences" (2003) 119 LQR 388; Stauch, "Taking the Consequences for Failure to Warn of Medical Risks" (2000) 63 MLR 261. The case note by the co-author of the seminal treatise on causation is particularly interesting. Professor Honoré said, at p 8:

> "Does it follow that Mrs Hart should not recover ? Or is this a case where courts are entitled to see to it that justice is done despite the absence of causal connection? I think it

> is the latter and for the following reason. The duty of a surgeon to warn of the dangers inherent in an operation is intended to help minimise the risk to the patient. But it is also intended to enable the patient to make an informed choice whether to undergo the treatment recommended and, if so, at whose hands and when. Dr Chappel violated Mrs Hart's right to choose for herself, even if he did not increase the risk to her. Judges should vindicate rights that have been violated if they can do so consistently with the authority of statutes and decided cases. In this case the High Court did just this, in effect by making Dr Chappel, when he operated on Mrs Hart, strictly liable for any injury he might cause of the type against which he should have warned her. For Dr Chappel *did* cause the harm that Mrs Hart suffered, though not by the advice he failed to give her. He did so by operating on her and, though he operated with due care, he slit open her oesophagus with disastrous consequences. Morally he was responsible for the outcome of what he did. … All the High Court has therefore done is to give legal sanction to an underlying moral responsibility for causing injury of the very sort against the risk of which the defendant should have warned her.
>
> Do the courts have power in certain cases to override causal considerations in order to vindicate a plaintiff's rights? I believe they do though the right must be exercised with great caution."

In my view Professor Honoré was right to face up to the fact that *Chappel v Hart* – and therefore the present case – cannot neatly be accommodated within conventional causation principles. But he was also right to say that policy and corrective justice pull powerfully in favour of vindicating the patient's right to know.

23. It is true that there is no direct English authority permitting a modification of the approach to the proof of causation in a case such as the present. On the other hand, there is the analogy of *Fairchild v Glenhaven Funeral Services Ltd* [2003] 1 AC 32 which reveals a principled approach to such a problem. The facts were that claimants had developed mesothelioma after exposure to asbestos dust while employed by different and entirely separate employers. Breach of duty was established against all the employers. But on a balance of probabilities the employees could not prove the onset of the disease due to any particular or cumulative exposure. Given that each employer's

wrongdoing had materially increased the risk of contracting the disease, the House of Lords held that a modified approach to proof of causation was justified. Lord Bingham of Cornhill ended his opinion by observing (para 35, p 68) "I prefer to recognise that the ordinary approach to proof of causation is varied than to resort to the drawing of legal inferences inconsistent with the proven facts." Similarly, Lord Nicholls of Birkenhead expressly proceeded on the basis that the ordinary "but for" standard of causation was not satisfied. He said (para 45, p 71) that "Instead the court is applying a different and less stringent test". Relying on "the justice and the policy of common law and statute", Lord Hoffmann arrived at the same conclusion: para 63, p 75. Relying on policy reasons Lord Rodger of Earlsferry concluded that on policy grounds a lower threshold test was justified: para 168, p 118. The *Fairchild* case is, of course, very different from the facts of the present case. A modification of causation principles as was made in *Fairchild* will always be exceptional. But it cannot be restricted to the particular facts of *Fairchild.* Lord Bingham of Cornhill observed in *Fairchild* that "It would be unrealistic to suppose that the principle here affirmed will not over time be the subject of incremental and analogical development": para 34, p 68. At the very least *Fairchild* shows that where justice and policy *demand* it a modification of causation principles is not beyond the wit of a modern court.

24. Standing back from the detailed arguments, I have come to the conclusion that, as a result of the surgeon's failure to warn the patient, she cannot be said to have given informed consent to the surgery in the full legal sense. Her right of autonomy and dignity can and ought to be vindicated by a narrow and modest departure from traditional causation principles.

25. On a broader basis I am glad to have arrived at the conclusion that the claimant is entitled in law to succeed. This result is in accord with one of the most basic aspirations of the law, namely to right wrongs. Moreover, the decision announced by the House today reflects the reasonable expectations of the public in contemporary society.

26. The result ought to come as no surprise to the medical profession which has to its credit subscribed to the fundamental importance of a surgeon's duty to warn a patient in general terms of significant risks: Royal College of Surgeons: "Good Surgical Practice" (2002) chap 4, guidelines on consent.

27. For these reasons as well as the reasons given by my noble and learned friends Lord Hope of Craighead and Lord Walker of Gestingthorpe I would dismiss the appeal.

LORD HOFFMANN

My Lords,

28. The purpose of a duty to warn someone against the risk involved in what he proposes to do, or allow to be done to him, is to give him the opportunity to avoid or reduce that risk. If he would have been unable or unwilling to take that opportunity and the risk eventuates, the failure to warn has not caused the damage. It would have happened anyway.

29. The burden is on a claimant to prove that the defendant's breach of duty caused him damage. Where the breach of duty is a failure to warn of a risk, he must prove that he would have taken the opportunity to avoid or reduce that risk. In the context of the present case, that means proving that she would not have had the operation.

30. The judge made no finding that she would not have had the operation. He was not invited by the claimant to make such a finding. The claimant argued that as a matter of law it was sufficient that she would not have had the operation at that time or by that surgeon, even though the evidence was that the risk could have been precisely the same if she had it at another time or by another surgeon. A similar argument has been advanced before this House.

31. In my opinion this argument is about as logical as saying that if one had been told, on entering a casino, that the odds on No 7 coming up at roulette were only 1 in 37, one would have gone away and come back next week or gone to a different casino. The question is whether one would have taken the opportunity to avoid or reduce the risk, not whether one would have changed the scenario in some irrelevant detail. The judge found as a fact that the risk would have been precisely the same whether it was done then or later or by that competent surgeon or by another.

32. It follows that the claimant failed to prove that the defendant's breach of duty caused her loss. On ordinary principles of tort law, the defendant is not liable. The remaining question is whether a special rule should be created by which doctors who fail to warn patients of risks should be made insurers against those risks.

33. The argument for such a rule is that it vindicates the patient's right to choose for herself. Even though the failure to warn did not cause the patient any damage, it was an affront to her personality and leaves her feeling aggrieved.

34. I can see that there might be a case for a modest solatium in such cases. But the risks which may eventuate will vary greatly in severity and I think there would be great difficulty in fixing a suitable figure. In any case, the cost of litigation over such cases would make the law of torts an unsuitable vehicle for distributing the modest compensation which might be payable.

35. Nor do I agree with Professor Honoré's moral argument for making the doctor an insurer, namely that his act caused the damage. That argument seems to me to prove both too much and too little. Too much, because it is an argument for making a doctor the insurer of any damage which he causes, whether the patient knew of the risk or not. Too little, because it would excuse the doctor in a case in which he had a duty to warn but the actual operation was perfectly properly performed by someone else, for example, by his registrar.

36. For these reasons and those given by my noble and learned friend Lord Bingham of Cornhill, I would allow the appeal and dismiss the action.

LORD HOPE OF CRAIGHEAD

My Lords,

37. The appellant, Mr Fari Afshar, is an eminent consultant neurosurgeon. He carries on his practice both under the National Health Service and privately. The respondent, Miss Carole Chester, was

formerly a working journalist specialising in travel writing. On 18 November 1994 she attended a consultation with Mr Afshar as a private patient in his consulting rooms in Harley Street. She had suffered for several years from back pain and had been referred to him by another medical practitioner with a view to surgery. Three days later, on 21 November 1994, Mr Afshar conducted an operation on Miss Chester's back, with her consent. It resulted in significant nerve damage and left her partially paralysed.

38. Miss Chester's case that the operation was performed negligently was rejected by the trial judge (Judge Robert Taylor). He held that she had failed to establish that Mr Afshar was in any way negligent in his conduct of her surgery. But Miss Chester also claimed that Mr Afshar failed to advise her of the risks that were inherent in the operation and that this breach of duty too entitled her to damages. The trial judge found that the injury which she had sustained during surgery was caused by Mr Afshar's negligence in failing adequately to advise her of the risks of surgery and that on this ground she had established liability. The Court of Appeal (Hale LJ, Sir Christopher Slade and Sir Denis Henry) dismissed Mr Afshar's appeal against this finding by the trial judge: [2002] EWCA Civ 724; [2003] QB 356.

39. The issue of law of general public importance which has brought this case before your Lordships rests upon two findings of fact by the trial judge. The first is his finding that Miss Chester was not told pre-operatively of the risk of nerve damage possibly resulting in paralysis. Mr Afshar said that, while he could not remember verbatim what he said to her, he thought that he spent a good deal of time spelling out what the risks were. But the trial judge was satisfied that she was not given adequate or proper advice about the risk of nerve damage possibly resulting in paralysis and that, despite her requests for information about such risks, she was given to understand in effect that there were none. He found that in this respect Mr Afshar was negligent under the principle which was established in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582. The second was his finding that, if she had known of the actual risks of the proposed surgery, Miss Chester would not have consented to the operation taking place on 21 November 1994 and that before deciding what to do she would have sought a second, or possibly, a third opinion.

40. The question of law which arises from these findings is whether it was sufficient for Miss Chester to prove that, if properly warned, she would not have consented to the operation which was in fact performed

and which resulted in the injury, or whether it was necessary for her to prove also that she would never have had that operation. The issue is essentially one of causation. It is not disputed that the failure to warn could be said to have caused the injury if Miss Chester's position had been that she would never have undertaken the operation at all if that warning had been given. But, as the trial judge observed, it was one of the signs of her truthfulness that Miss Chester did not attempt to go that far, as she had never claimed that, if adequately advised of the risks, she would never at any time have consented to surgery. Can it then be said on these facts that the test for causation is satisfied?

The facts

41. Miss Chester had been referred to Mr Afshar by a consultant rheumatologist, Dr Wright. He had been treating her for back trouble since 1988. His approach had been to treat it conservatively. This treatment had included a series of injections, but the pain and backache were not permanently relieved by them. In 1992 she had a MRI scan of her lumbar spine. It showed that there was an element of congenital stenosis between L2 and L5 and that there were degenerative changes and some fairly marked instances of disc protusion in this area. In September 1994 she had a recurrence of her back trouble, following which she had a second MRI scan in October 1994. This showed that her condition had worsened since 1992. She now had a very substantial central-lateral variation at L2/3 and central canal stenosis at L3 and L4/L5. Dr Wright advised Miss Chester that in the light of this report the time had come for her to consider surgery. She told him that she wished to avoid this if at all possible, as she had a general aversion to surgery. He agreed to treat her condition once again by injection, but this effected no clear improvement. So he repeated his advice about surgery. He mentioned Mr Afshar as one of the surgeons to whom she might go for this.

42. Miss Chester said that she did not know when she went to see Mr Afshar on 18 November 1994 that only surgery was going to help her. She was looking for advice from him, not only about surgery but also as to whether any alternatives to surgery were possible. Dr Wright had mentioned in his letter of referral, at her request, that she was anxious to avoid surgery if possible, so there is no doubt that Mr Afshar was aware of this. He examined her for about 15 minutes and then spent about 30 minutes in conversation and discussion with her. He advised her that three intravertebral discs were the cause of her trouble and that they should be removed surgically.

43. There was a conflict of evidence as to the detail of their conversation. Mr Afshar said that he discussed with Miss Chester the outcomes of having surgery and not having surgery, that he showed her where the disc was and what it was doing to the nerve roots and why he recommended surgery. He said that he explained that there was a small risk of disturbance to the cauda equina nerve root which could mean sensory disturbance leading to reduction in power in her legs and alterations in touch, temperature and position sense. Cauda equina syndrome can lead, at one end of the spectrum, to minor disturbance of nerve roots or, at the other end, to paralysis. He said that he thought that he told her about these risks and the problems which she would experience if she did not have surgery.

44. Miss Chester's account, which was the version which the trial judge accepted, was that she told Mr Afshar that she had heard a lot of horror stories about surgery and that she wanted to know about the risks, but that none of this was explained to her. She did not mention paralysis specifically as one of the risks that she wanted to be told about, and this was not mentioned as a risk of surgery by Mr Asfar. The reply which she got from him, as a throw away line, was that he had not crippled anybody yet. She agreed to the surgery because he made it all sound so simple. She said if she had been told of the risks as she now knew them to be she would not have had the operation the next Monday. She would have spoken to various journalist friends as to who to go and see, would have spoken also to the BMA and would have wanted at least two further opinions as to whether an operation was necessary.

45. The operation to which Miss Chester gave her consent was carried out by Mr Afshar on Monday 21 November 1994. It involved a microdiscectomy at all three disc levels, and it lasted just under two hours. There was no complication during the operation. When it was over Mr Afshar was satisfied that his objectives had been fully met by the techniques which he used. But as soon as Miss Chester recovered consciousness it was found that she had suffered both motor and sensory impairment below the level of L2. After an hour she had developed some knee extension and flexion and sensation to pain. But there was no real improvement of limb function, so Mr Afshar arranged for an urgent MRI scan which suggested that there was still some compression at the L2/L3 level.

46. In the light of this finding Mr Afshar embarked on a second operation shortly after midnight on 22 November 1994. On this occasion he carried out a laminectomy. This meant that he was able to

see the whole spinal canal. There was no sign of nerve root damage or of a break in the neural sac or of any fluid escaping. He was unable to find any explanation for Miss Chester's condition to his satisfaction. To make sure that nothing had escaped his attention a second post-operative scan was carried out. The only thing that was found was a small fragment which Mr Afshar did not think could have contributed to the profound change that had occurred. His conclusion was that the only explanation that could be given for it was one of cauda equina contusion during the routine medial retraction of the L3 root and cauda equinal dura during the L2/L3 disc removal during the first procedure. He told the trial judge at the end of his evidence that what happened to Miss Chester was a profound surprise to him and also a profound disappointment, as in all the years he had done neurosurgery he had never before or since had the same outcome.

47. Miss Chester made some progress after the operation. Within about two or three weeks her right leg function had returned virtually to normal. But progress on her left side was much slower. Six years later, when her case came to trial, she was still suffering from disability in a number of areas. The extent of her disability and its consequences have yet to be determined, as that part of the trial was adjourned by the trial judge pending resolution of the dispute on liability.

The duty to warn

48. It was not in dispute that cauda equina damage was a known risk of the surgery which was performed by Mr Afshar. Mr Afshar said that the risk of such damage was about 0.9%. Mr Findlay, who gave expert evidence for the defence, said that nerve root injury or injury to the cauda equina was a recognised risk of lumbar surgery and that operation at three levels carried a higher overall risk because there was a risk at each level. He explained that, while the likelihood of risk of damage was no greater when operating at L3 level than when operating lower down the spine, the magnitude of the damage could be increased if it was suffered at the upper level. "Most of us," he said, "would put a figure of 1 to 2% on the risk of nerve damage (including both single and multiple nerves) and other serious risks."

49. It was also common ground at the trial that it was Mr Afshar's duty, in accordance with good medical practice, to warn Miss Chester of the risk of damage involved in the surgery to which she was giving her consent and its possible consequences, including the risk of paralysis.

The Court of Appeal was asked to give permission to appeal against the judge's factual findings on the issue as to whether she was told of these risks. But the court was of the opinion that the judge had given detailed and compelling reasons for preferring the claimant's account of her conversation with Mr Afshar. It held that there were no grounds that would justify interfering with his findings of fact: [2003] QB 356, 368, para 18.

50. The trial judge explained his finding that Mr Afshar did not warn Miss Chester about the risks in this way in para 65 of his judgment:

> "As has been recognised in many cases (including *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871) it is often a difficult and delicate matter for a consultant to advise a patient about what he regards as comparatively minor risks, particularly when that patient is already suffering from stress, pain and anxiety. He will naturally be anxious to avoid alarming or confusing the patient unnecessarily. In the present case, as the defendant indicated in 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 damages in the many hundreds of operations he had carried out over 20 to 25 years. It may well be that he considered the claimant over-anxious or over-preoccupied with 'horror stories' and the possibility of being crippled. In these circumstances I do not find it improbable that, in an attempt to reassure, he deflected her inquiries by answering them in the light-hearted terms which she has described - and which he accepts that 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*."

51. The issue which is in dispute is now confined to the issue of causation. But the duty which, as is now accepted, was breached forms an essential part of the background to a discussion of that issue. Damage is the gist of the action of negligence, as Lord Scarman put it in *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871, 883H. But damages can only be awarded if the loss which the claimant has sustained was within the

scope of the duty to take care. And the issue of causation cannot be properly addressed without a clear understanding of the scope of that duty. So it is appropriate to reflect for a moment, before addressing the issue of causation, on the scope of the duty that was found to have been breached in this case and on the rationale for it that was established in *Sidaway*.

52. The question of principle that was decided in *Sidaway* was that English law measures the doctor's duty of care to his patient when he is giving advice with respect to a proposed course of treatment by applying the standard of competent professional opinion. The test which was described by McNair J in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, 586 and approved in *Maynard v West Midlands Regional Health Authority* [1984] 1 WLR 634, 638 by Lord Scarman, is the standard of the ordinary skilled man exercising and professing to have that special skill. Lord Bridge of Harwich described the background to the issue of law which was before the House in *Sidaway*, which was whether this test should be replaced by an objective one, in this way, at p 897D-F :

> "It is clearly right to recognise that a conscious adult patient of sound mind is entitled to decide for himself whether or not he will submit to a particular course of treatment proposed by the doctor, most significantly surgical treatment under general anaesthesia. This entitlement is the foundation of the doctrine of 'informed consent' which has led in certain American jurisdictions to decisions, and in the Supreme Court of Canada, to dicta, on which the appellant relies, which would oust the *Bolam* test and substitute an 'objective' test of a doctor's duty to advise the patient of the advantages and disadvantages of undergoing the treatment proposed and more particularly to advise the patient of the risks involved."

53. The decision that was mainly relied on in favour of an objective test which could be applied by the court independently of any medical opinion or practice was *Canterbury v Spence* (1972) 464 F 2d 772, in which Robinson J, delivering the judgment of the District of Columbia Circuit Court of Appeals, said, at p 784:

> "Respect for the patient's right of self-determination on particular therapy demands a standard set by law for

> physicians rather than one which physicians may or may not impose upon themselves."

The logical force of this approach was recognised by the majority in *Sidaway*, but it was rejected in favour of the *Bolam* test. Lord Diplock said, at p 893H, that no convincing reason had been advanced which would justify treating the *Bolam* test as doing anything less than laying down a principle of English law that was comprehensive and applicable to every aspect of the duty of care owed by the doctor to his patient. As he put it, at p 895E-F, to decide what risks the existence of which a patient should be voluntarily warned and the terms in which such warning, if any, should be given, having regard to the effect that a warning might have, was as much an exercise of professional skill and judgment as any other part of the doctor's comprehensive duty of care to the individual patient, and expert medical evidence on that matter should be treated in just the same way. Lord Bridge, with whose speech Lord Keith of Kinkel agreed, drew attention, at p 899E-F, to several reasons why the *Canterbury* doctrine was impractical in its application.

54. Common however to all the speeches in *Sidaway* was a recognition of the fundamental importance that must be attached to the right of the patient to decide whether he will accept or reject the treatment which is being proposed by the doctor. Lord Scarman, in his dissenting speech at p 882D, said that the patient's right to make his own decision might be seen as a basic human right protected by the common law. At p 897D-E, in the passage which I have already quoted, Lord Bridge recognised that a conscious adult patient of sound mind was entitled to decide for himself whether or not he would submit to a particular course of treatment. Later in his speech, at p 900F-G, he referred to what was necessary for an informed choice on the part of the patient and to the patient's right of decision. Lord Templeman said, at p 904A-B, that he did not subscribe to the theory that the patient is entitled to know everything. Some information might confuse and other information might alarm the patient. So it was for the doctor to decide in the light of his training and experience what needed to be said, and how it should be said. But he went on to add these words, at p 904D-E:

> "At the same time the doctor is not entitled to make the final decision with regard to treatment which may have disadvantages or dangers. Where the patient's health and future are at stake, the patient must make the final decision."

55. Thus the right to make the final decision and the duty of the doctor to inform the patient if the treatment may have special disadvantages or dangers go hand in hand. In this case there is no dispute that Mr Afshar owed a duty to Miss Chester to inform her of the risks that were inherent in the proposed surgery, including the risk of paralysis. The duty was owed to her so that she could make her own decision as to whether or not she should undergo the particular course of surgery which he was proposing to carry out. That was the scope of the duty, the existence of which gave effect to her right to be informed before she consented to it. It was unaffected in its scope by the response which Miss Chester would have given had she been told of these risks.

56. There were three possibilities. She might have agreed to go ahead with the operation despite the risks. Or she might have decided then and there not to have the operation then or at any time in the future. Or she might have decided not to have the operation then but to think the matter over and take further advice, leaving the possibility of having the operation open for the time being. The choice between these alternatives was for her to take, and for her alone. The function of the law is to protect the patient's right to choose. If it is to fulfil that function it must ensure that the duty to inform is respected by the doctor. It will fail to do this if an appropriate remedy cannot be given if the duty is breached and the very risk that the patient should have been told about occurs and she suffers injury.

57. In his article 'Informed Consent and Other Fairy Stories' (1999) 7 Med LRev 103 Professor Michael A Jones drew attention to the problems which had been focussed in the debate about informed consent that followed the decision of this House in *Sidaway* to prefer what he described, at p 104, as the reasonable doctor standard (the *Bolam* test) in contrast to the prudent patient standard adopted in the American cases, which has been accepted also in Canada. Liability for the non-disclosure of risks is judged by reference to the tort of negligence which looks to the nature of the doctor's duty and applies the *Bolam* test to it, rather than the validity of the consent of the patient to what would otherwise be a trespass. There are then two problems that face a patient who brings a claim for non-disclosure of risk: that of proving breach of duty and that of proving causation. The greater the difficulties that stand in the way of the patient on these issues, the more difficult it is to say that the law of informed consent works as a means of protecting patient autonomy.

58. Commenting on a perceived imbalance of power in the doctor-patient relationship, Professor Jones said, at p 129:

> "Part of the imbalance between doctor and patient is due to the patient's lack of information, and, on one view, it is the function of the law to redress the imbalance by providing patients with the 'right' to be given that information, or perhaps more accurately imposing a duty on doctors to provide it. There are some within the medical profession who appear to resent the notion that informed consent is part and parcel of 'patient rights' – a patient with rights is a lawsuit waiting to happen. On the other hand, a patient with no rights is a citizen who is stripped of his or her individuality and autonomy, as well as her clothes, as soon as she walks into the surgery or the hospital."

At p 133 he observed that the law cannot play a direct role in setting out detailed rules by way of guidance to doctors, but that it can have a powerful symbolic and galvanising role and that this is its major strength. The message that he was seeking to convey was that, while the case law provided little guidance to doctors and even less comfort to patients, litigation on informed consent could provide a stimulus to the broader debate about the nature of the doctor-patient relationship. The "happy ending" of his title would be found if the iterative process between case law and professional guidance were to lead to the creation of a more substantive "right" to truly informed consent for patients.

59. That is the background to the problem of causation that has been posed in this case. The scope of the duty brings within its ambit all the consequences of the risks that the patient ought to be informed about. It is unaffected by the response which the patient may give on being told of these risks.

Causation

60. It is not in doubt that a patient who claims that she has suffered injury as the result of a doctor's failure to inform her of the risk of injury must show that the damage was caused by the doctor's breach of duty. In this respect the present action is no different from any action that is brought in negligence. But how can causation be established when, as

in this case, the patient would not have refused absolutely there and then and for ever to undergo the operation if told of the risks but would have postponed her decision until later?

61. The problem is rendered all the more acute in this case by the fact that the failure to warn cannot be said in any way to have increased the risk of injury. The risk was inherent in the operation itself. It was described by Miss Chester's expert witness, Mr Firth, as "the terror of neurosurgery." The evidence indicated that it was also liable to occur at random, irrespective of the degree of care and skill with which the operation was conducted by the surgeon. This means that the risk would have been the same whenever and at whoever's hands she had the operation. It can be said that Miss Chester would not have suffered her injury "but for" Mr Afshar's failure to warn her of the risks, as she would have declined to be operated on by him on 21 November 1994. But it is difficult to say that his failure was the effective cause of the injury.

62. On the other hand, there is no doubt that the injury which Miss Chester sustained when she was operated on by Mr Afshar was within the scope of his duty to warn. It was his duty to warn her of the risks of the operation that he was proposing to perform, and it was in the course of that same operation that she sustained the very kind of injury that he ought to have warned her about. If she had been given the warning she would have avoided that risk, and the chances of her being injured in that way if she had had the operation later would have been very small – between 1 and 2% on Mr Findlay's evidence.

63. None of the four cases in which claims for a failure to warn have come before the courts in this country, all of which were decided at first instance, raised the issue of causation in this form. In *Smith v Barking, Havering and Brentwood Health Authority* [1994] 5 Med LR 285 Hutchison J found on the balance of probabilities that the claimant would have consented to the operation even if she had been properly advised about the risk of tetraplegia. The consequence of this decision was that the lack of a warning could not have caused the injury, as she would have gone ahead with the operation anyway. In *Smith v Salford Health Authority* [1994] 5 Med LR 321 Potter J decided the case against the doctor on other grounds. But he would not have found him liable for a failure to warn, because he was not satisfied that the claimant would not have had the operation if he had been properly advised. In *McAllister v Lewisham and North Southwark Health Authority* [1994] 5 Med LR 343, on the other hand, Rougier J was confident that the

claimant would not have had the operation if she had been properly warned and that on balance of probabilities she would have continued to decline it. So he held that the necessary causal connection was established in her case. And in *Smith v Tunbridge Wells Health Authority* [1994] 5 Med LR 334 the claim succeeded because Morland J was satisfied that the claimant would have declined the operation if he had been properly advised of the risk of impotence and bladder malfunction from rectal surgery.

64. But the issue of causation in the form that has arisen in this case was present in *Chappel v Hart* (1998) 195 CLR 232, a decision of the High Court of Australia. In that case Gaudron, Gummow and Kirby JJ held, on facts which were similar to those of this case, that there was a causal connection between the failure to warn and the claimant's injury. The minority, McHugh and Hayne JJ, held that causation had not been established, as the defendant did not increase the risk to which the claimant was exposed when she underwent the operation.

65. The Court of Appeal in this case, having examined that decision, came to the conclusion that the majority in *Chappel v Hart* were right and that for the same reasons the decision of the trial judge in this case was right also. Sir Denis Henry, delivering the judgment of the court, explained the reasoning which had guided its decision in this way: [2003] QB 356, 379, para 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…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."

66. In view of the importance which the Court of Appeal attached to the opinions of the majority in *Chappel v Hart* it is necessary to look more closely at the guidance which is offered by the views that were expressed in that case on both sides of the argument.

Chappel v Hart

67. Mrs Hart underwent surgery for the removal of a pharyngeal pouch in her oesophagus at the hands of Dr Chappel who was an ear, nose and throat specialist. During this surgery the oesophagus was perforated and an infection set in which damaged a laryngeal nerve. This resulted in damage to Mrs Hart's vocal chords and loss of vocal strength which affected her employment as a teacher librarian. She was assessed as medically unfit and had to retire from her employment. A claim that the operation had been performed negligently was not pursued. Mrs Hart's case was that she had not been warned of the risk, however slight, that perforation of the oesophagus might occur and of the laryngeal damage that might result from this. The trial judge found that no such warning had been given and that, if she had been warned of the risk of vocal damage, Mrs Hart would have postponed the operation and made further inquiries to minimise the risk.

68. The case is complicated by the fact that Mrs Hart maintained that if she had been warned of the risk she would have deferred the operation and had it performed instead by the most experienced surgeon in the field then available. That additional factor is not present in this case. There was no suggestion here that Miss Chester was more at risk at the hands of Mr Afshar due to any lack of experience on his part than she would have been at the hands of anyone else. It is necessary to bear in mind too that the law of Australia favours the objective rather than the subjective, or *Bolam*, approach to the duty to warn: *Rogers v Whitaker* (1992) 175 CLR 479, 490. Nevertheless there is obviously much common ground between the two cases.

69. In *Chappel v Hart* McHugh J, who was in the minority, took as his starting point the proposition that in principle, if the act or omission by the defendant has done no more than expose the plaintiff to a class of risk to which he or she would have been exposed irrespective of the

defendant's act or omission, the law of torts should not require the defendant to pay damages: para 28. He developed this theme, drawing upon examples from the negligent acts in *Monarch Steamship Co Ltd v Karlshamns Oljefabriker (A/B)* [1949] AC 196 and *Carslogie Steamship Co Ltd v Royal Norwegian Government* [1952] AC 292, by considering how a causal connection might be established in the case of omissions such as the defendant's failure to warn the plaintiff that a particular route was liable to landslides. In para 32 he restated his proposition that a defendant is not causally liable, and therefore legally responsible, for wrongful acts or omissions if those acts or omissions would not have caused the plaintiff to alter his or her course of action, adding these sentences:

> "The inquiry as to what the plaintiff would have done if warned is necessarily hypothetical. But if the evidence suggests that the acts or omissions of the defendant would have made no difference to the plaintiff's course of action, the defendant has not caused the harm which the plaintiff has suffered."

70. In para 34 McHugh J set out his conclusions as to whether a causal connection existed between a defendant's failure to warn of a risk of injury and the subsequent suffering of injury by the plaintiff as a result of the risk eventuating. Among these were the following:

> "(1) a causal connection will exist between the failure and the injury if it is probable that the plaintiff would have acted on the warning and desisted from pursuing the type of activity or course of conduct involved;
>
> (2) no causal connection will exist if the plaintiff would have persisted with the same course of action in comparable circumstances even if a warning had been given;
>
> (3) no causal connection will exist if every alternative means of achieving the plaintiff's goal gave rise to an equal or greater probability of the same risk of injury and the plaintiff would probably have attempted to achieve that goal notwithstanding the warning…"

71. In para 35 McHugh J said that in his opinion the defendant would escape liability only if the plaintiff did not prove that his failure to warn

resulted in her consenting to a procedure that involved a higher risk of injury than would have been the case if the procedure had been carried out by another surgeon. He then reviewed the evidence. In para 41 he said that it was all one way, that perforation of the oesophagus was an inherent risk of the procedure which could occur even when reasonable skill and care were exercised. In para 42 he drew the conclusion that, on this approach, was inevitable. The plaintiff's claim must fail. The defendant's failure to warn did not increase the risk of injury involved in the procedure, and her claim that a causal connection existed between that failure and the injury had to be rejected.

72. Hayne J, the other justice who was in the minority, pointed out in para 116 that the "but for" test was neither a comprehensive nor exclusive test of causation. In his view the only connection between the failure to warn and the harm to the plaintiff was that but for the failure to warn she would not have been in harm's way: para 121. It was not enough to show that the subject matter of the failure to warn was the very subject matter of the damage: para 124. Important as this was, it was not determinative: para 125. Nor was the ambit of the liability to be decided only according to whether enlarging that ambit would promote careful conduct, as the question of causation had still to be answered: para 126. He rejected the plaintiff's case that she had lost the chance of better treatment, and he agreed with McHugh J that there was insufficient evidence to say that the defendant's failure to warn exposed the plaintiff to a greater risk of injury: para 146.

73. The approach of the minority is strong on logic and, so far as it goes, may be said to be impeccable in its reasoning. It is plain that the "but for" test is not in itself a sufficient test of causation. It is also plain that the requirements of causation would have been satisfied if Mrs Hart had been able to show that the failure to warn had exposed her to an increased risk of injury or that she would not have had the operation at all if she had been warned of the risk. But if the application of logic is to provide the answer, the consequences for a case where those elements are absent, as they are here, are stark. A duty was owed, the duty was breached and an injury was suffered that lay within the scope of the duty. Yet the patient to whom the duty was owed is left without a remedy.

74. Gaudron J, who was one of the three justices in the majority, observed that causation was to be approached as a question of fact to be answered by applying common sense to the facts of the particular case: para 6. She pointed out that questions of causation are not answered in a

legal vacuum. Rather, they are answered in the legal framework in which they arise and for present purposes that framework was the law of negligence: para 7. It was not disputed that the defendant was under a duty to inform his patient of the risk. The duty was called into existence because of the foreseeability of that risk, it was not performed and the risk eventuated. That was often the beginning and the end of the inquiry whether breach of duty materially caused or contributed to the harm suffered: para 8. She accepted that where there is a duty to inform it is necessary for the plaintiff to give evidence as to what would or would not have happened if the information had been provided. But it was 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 question, 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: para 9. The physical injury having occurred, breach of the duty was treated as materially causing or contributing to that injury unless there was sufficient reason to the contrary: para 10.

75. Gummow J began his discussion by quoting the following passage from the Mason CJ's highly influential judgment in *March v E & MH Stramare Pty Ltd* (1991) 171 CLR 506, 509:

> "In philosophy and science, the concept of causation has been developed in the context of explaining phenomena by reference to the relationship between conditions and occurrences. In law, on the other hand, problems of causation arise in the context of ascertaining or apportioning legal responsibility for a given occurrence."

He referred also to Mason CJ's observation in that case at p 514 that, 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. He then introduced his approach to the case with these words, in para 68:

> "Here, the injury to Mrs Hart occurred within an area of foreseeable risk. In the absence of evidence that the breach had no effect or that the injury would have occurred even if Dr Chappel had warned her of the risk of injury to the laryngeal nerve and of the consequent risk of partial or total voice loss, the breach of duty will be taken to have caused the injury."

In his opinion it was for Dr Chappel to demonstrate some good reason for denying to Mrs Hart recovery in respect of injury which she would not have suffered at his hands but for his failure to advise her, and he had failed to do so: para 69. To make good her case and obtain damages, Mrs Hart was not required to negative the proposition that any later treatment would have been attended with the same or a greater degree of risk: para 76.

76. Kirby J, the third justice in the majority, said in para 95 that for a time he was attracted by Dr Chappel's arguments, which had laid emphasis upon a logical examination of the consequences which would have flowed had he not breached his duty to warn his patient, but that ultimately he had 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."

In para 96 he said that the standards which the court had set in *Rogers v Whitaker* (1992) 175 CLR 479, 490 as to the doctor's duty to warn the patient of a material risk inherent in the proposed treatment had fairly been described as onerous, but that they were the law and they had been 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."

77. Academic comment on *Chappel v Hart* favours the view that was taken of the case by the majority. Peter Cane, "A Warning about Causation" (1999) 115 LQR 21, 23 said that the effect of adopting the central sense of "cause", which was that favoured by the minority, as appropriate to determining liability and compensation for breach of the duty to inform and warn would be very much to weaken the force and importance of that duty. At p 25 he said that, so far as Dr Chappel's role

in the causal chain was concerned, it seemed to him that the majority view was correct. The desirable rule was that a doctor might be held liable for injury about the risk of which he had a duty to inform the patient, but not for injury the risk of which fell outside the duty to warn. Marc Stauch, "Taking the Consequences for Failure to Warn of Medical Risks" (2000) 63 MLR 261, 267, suggests that the High Court reached the correct conclusion in favour of liability, but not necessarily for the right reasons. The rationale which he favours is based on the special nature of the doctor's duty to advise his patient of risks of treatment. The principal reason for imposing this duty is to promote the patient's decision making autonomy. The law should deem the doctor to have assumed the risk of injury as though, in failing to mention it, he had warranted that it would not materialise. Or one could say that the doctor is estopped from pointing to the existence and unavoidable nature of the risk.

78. Professor Andrew Grubb, "Clinical Negligence: Informed Consent and Causation" (2002) 10 Med LRev 322, in his commentary on the decision of the Court of Appeal in this case (see also his *Principles of Medical Law*, 2nd ed (2004), p 200, para 3.161-3.162, where the same comments are repeated), referred, at p 324, to the fact that it had approved and applied the majority view in *Chappel v Hart*. After quoting part of the passage from para 47 of the Court of Appeal's judgment which I have set out above he said:

> "It is difficult to argue with this reasoning. It would undermine the rule and be unjust for a doctor to require a patient to show that she would never have a particular procedure in the future (see also *Chappel v Hart* [195 CLR 232] per Kirby J especially at paras 95-96). It is also counterintuitive to think that because the patient may run the risk in the future – by agreeing to and having the procedure – the negligence is not connected to her injury. At worst, she will be exposed to a small risk of injury which is unlikely *then* to eventuate – exceptional circumstances aside … She had in a real and immediate sense suffered injury that she would not otherwise have suffered. That should be sufficient to establish a causal link."

79. In "Medical non-disclosure, causation and risk: *Chappel v Hart*" (1999) 7 Torts LJ 1, Professor Tony Honoré said, at p 7, that at first sight the argument which commended itself to the minority in *Chappel v*

Hart was cogent. Dr Chappel's advice related to a risk which Mrs Hart was bound, sooner or later, to run. On the assumption that the risk to her would have been the same whenever she had the operation (for reasons given earlier in this case note, he was proceeding on the assumption that the risk would have been exactly the same if she had been operated on by a surgeon more experienced in that type of operation than Dr Chappel), Dr Chappel neither exposed her to a risk that she need never run nor increased the risk she was bound to run in any case. So his failure to warn was not, on that assumption, a cause of the injury that she suffered.

80. But he was not content to leave the matter there. At p 8 he asked himself these questions:

> "Does it follow that Mrs Hart should not recover? Or is this a case where courts are entitled to see to it that justice is done despite the absence of causal connection?

His answer was that the latter proposition was the right one, for the following reason:

> "The duty of a surgeon to warn of the dangers inherent in an operation is intended to help minimise the risk to the patient. But it is also intended to enable the patient to make an informed choice whether to undergo the treatment recommended and, if so, at whose hands and when. Dr Chappel violated Mrs Hart's right to choose for herself, even if he did not increase the risk to her…All the High Court has therefore done is to give legal sanction to an underlying moral responsibility for causing injury of the very sort against the risk of which the defendant should have warned her."

In his concluding remarks on the case he explained that, while he believed that the courts have power in certain cases to override causal considerations in order to vindicate a plaintiff's rights, this right must be exercised with great caution. He saw *Chappel v Hart* as an illustration of one of the types of case that he had in mind, where a plaintiff is entitled to recover from a defendant who has without negligence caused the sort of injury the risk of which the defendant should have warned the plaintiff. These, he said, were very unusual types of case in which

causal principles have to be overridden so that a defendant bears the risk of harm that the defendant did not cause.

The answer to the problem of causation in this case

81. I would accept that a solution to this problem which is in Miss Chester's favour cannot be based on conventional causation principles. The "but for" test is easily satisfied, as the trial judge held that she would not have had the operation on 21 November 1994 if the warning had been given. But the risk of which she should have been warned was not created by the failure to warn. It was already there, as an inevitable risk of the operative procedure itself however skilfully and carefully it was carried out. The risk was not increased, nor were the chances of avoiding it lessened, by what Mr Afshar failed to say about it. As Professor Honoré in his note "Medical non-disclosure, causation and risk: *Chappel v Hart"* (1999) 7 Torts LJ 1, 4 has pointed out, to expose someone to a risk to which that person is exposed anyhow is not to cause anything.

82. Nor does it seem to me that an appeal to common sense alone will provide a satisfactory answer to the problem. In *Stapley v Gypsum Mines Ltd* [1953] AC 663, 681 Lord Reid said that the question as to what caused an accident must be determined as a properly instructed and reasonable jury would decide it, by applying common sense to the facts of each particular case. The problem that had to be resolved in that case was whether the fault of the deceased's fellow workman, they both having disobeyed their foreman's instructions, was to be regarded as having contributed to the accident. Lord Reid's dictum was referred to by Mason CJ in *March v E & MH Stramare Pty Ltd*, 171 CLR 506, 515 in a passage which laid the basis for the approach to the issue of causation in Australia and was much referred to in *Chappel v Hart*.

83. An appeal to common sense when determining issues of causation is valuable in the right context. But out of its proper context, and without more, it may pull in two or more directions. This can be seen in *Chappel v Hart* where, following the guidance of Mason CJ in *March*, common sense was referred to and relied upon by justices on either side of the argument: Gaudron J at para 6; McHugh J, paras 23, 24; Kirby J, para 93; Hayne J, para 148. On its own common sense, and without more guidance, is no more reliable as a guide to the right answer in this case than an appeal to the views of the traveller on the London Underground. As I survey my fellow passengers on my twice weekly

journeys to and from Heathrow Airport on the Piccadilly Line – such a variety in age, race, nationality and languages – I find it increasingly hard to persuade myself that any one view on anything other than the most basic issues can be said to be typical of all of them.

84. As Lord Hoffmann sought to emphasise in *Environment Agency (formerly National Rivers Authority) v Empress Car Co (Abertillery) Ltd* [1999] 2 AC 22, 29F, common sense answers to questions of causation will differ according to the purpose for which the question is asked. He supported this proposition by examples. He then said, at p 31H, that before answering questions about causation it was first necessary to identify the scope of the relevant rule and that this is a question of law, not of common sense fact. But even with this guidance, with which I agree, I find myself back at the same answer. The relevant rule is the duty which the law has imposed on the doctor – the duty to warn. Did the doctor's breach of that duty cause the patient's injury? It would appear that this question can only be answered in the negative. He did nothing which increased the risk to the patient, or even altered it. It was a risk to which she was exposed anyway. It was the same risk, irrespective of when or at whose hands she had the operation.

85. But the issue of causation cannot be separated from issues about policy. As Hart and Honoré point out in the Preface to *Causation in the Law*, 2nd ed (1985), pp xxxiv -xxxv, questions about causation which lie beyond the simple issue as to whether the harm could have occurred in the absence of the wrongful conduct tend to be issues of legal policy in disguise. They are better answered by asking whether, all things considered, the defendant should be held liable for the harm which ensued, or, on another view, whether the harm was foreseeable as within the risk, or was within the scope of the rule violated by the defendant. I would prefer to approach the issue which has arisen here as raising an issue of legal policy which a judge must decide. It is whether, in the unusual circumstances of this case, justice requires the normal approach to causation to be modified.

86. I start with the proposition that the law which imposed the duty to warn on the doctor has at its heart the right of the patient to make an informed choice as to whether, and if so when and by whom, to be operated on. Patients may have, and are entitled to have, different views about these matters. All sorts of factors may be at work here – the patient's hopes and fears and personal circumstances, the nature of the condition that has to be treated and, above all, the patient's own views about whether the risk is worth running for the benefits that may come if

the operation is carried out. For some the choice may be easy – simply to agree to or to decline the operation. But for many the choice will be a difficult one, requiring time to think, to take advice and to weigh up the alternatives. The duty is owed as much to the patient who, if warned, would find the decision difficult as to the patient who would find it simple and could give a clear answer to the doctor one way or the other immediately.

87. To leave the patient who would find the decision difficult without a remedy, as the normal approach to causation would indicate, would render the duty useless in the cases where it may be needed most. This would discriminate against those who cannot honestly say that they would have declined the operation once and for all if they had been warned. I would find that result unacceptable. The function of the law is to enable rights to be vindicated and to provide remedies when duties have been breached. Unless this is done the duty is a hollow one, stripped of all practical force and devoid of all content. It will have lost its ability to protect the patient and thus to fulfil the only purpose which brought it into existence. On policy grounds therefore I would hold that the test of causation is satisfied in this case. The injury was intimately involved with the duty to warn. The duty was owed by the doctor who performed the surgery that Miss Chester consented to. It was the product of the very risk that she should have been warned about when she gave her consent. So I would hold that it can be regarded as having been caused, in the legal sense, by the breach of that duty.

88. The reasoning of Kirby J in *Chappel v Hart*, 195 CLR 232, para 95, which I would respectfully endorse, supports this approach. I am encouraged too by the answer which Professor Honoré gave to the question which he posed for himself in his case note on that case at p 8: "is this a case where courts are entitled to see to it that justice is done despite the absence of causal connection?" I would hold that justice requires that Miss Chester be afforded the remedy which she seeks, as the injury which she suffered at the hands of Mr Afshar was within the scope of the very risk which he should have warned her about when he was obtaining her consent to the operation which resulted in that injury.

89. For these reasons, and those which have been given by my noble and learned friends Lord Steyn and Lord Walker of Gestingthorpe, I would dismiss the appeal.

LORD WALKER OF GESTINGTHORPE

My Lords,

90. I have had the great advantage of reading in draft the opinions of my noble and learned friends Lord Steyn and Lord Hope of Craighead. I agree with them, and for the reasons which they give I would dismiss this appeal. But because of the general interest and difficulty of the issue of causation that arises in the appeal, and in view of the differences of opinion between your Lordships on that issue, I add some brief comments of my own.

91. In his opinion (para 51) Lord Hope rightly emphasises that the issue of causation cannot be properly addressed without a clear understanding of the scope of the defendant's duty: in this case, the surgeon's duty to warn his patient of the risk, small though it was, of nerve damage occurring during lumbar surgery. This is a point which your Lordships' House has noted in several recent decisions, including *Banque Bruxelles Lambert SA v Eagle Star Insurance Co Ltd* [1997] AC 191, 212-213; *Environment Agency (formerly National Rivers Authority) v Empress Car Co (Abertillery) Ltd* [1999] 2 AC 22, 29-32; *Kuwait Airways Corpn v Iraqi Airways Co (Nos 4 and 5)* [2002] 2 AC 883, 1091, 1106.

92. The surgeon's duty to advise his patient (and in particular, to warn of unavoidable risks of surgery) is a very important part of his professional duty. In *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871, 882, Lord Scarman described the patient's right to make his own decision as a basic human right. Lord Scarman was delivering a dissenting speech, but the whole House recognised this right (see Lord Diplock, at p 895, Lord Bridge of Harwich, at pp 897 and 900, and Lord Templeman, at p 904); and during the twenty years which have elapsed since *Sidaway* the importance of personal autonomy has been more and more widely recognised.

93. The surgeon's duty to advise and warn his patient is closely connected with the need for the patient's consent to submit, under anaesthesia, to invasive surgery which would (in the absence of consent) be an assault. The advice is the foundation of the consent. That is why it is so important. And for that reason I derive very little assistance from

analogies based on quite different facts (such as a landowner's duty to warn of the remote risk of a hiker being injured by a landslide or a falling tree). In this case the surgeon failed to warn of the risk of the very calamity which occurred in the course of the operation which he performed three days later. As Kirby J said in *Chappel v Hart* (1998) 195 CLR 232, 277, para 96,

> "It is true to say that the inherent risks of injury from rare and random causes arise 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 of 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 a 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".

94. If a patient in the position of Miss Chester or Mrs Hart had been injured by some wholly unforeseeable accident of anaesthesia (the scenario suggested by Gummow J in *Chappel v Hart* at para 66) or because the operating theatre was struck by lightning (Hayne J's more fanciful scenario at para 129) the injury could have been described as coincidental in the sense indicated by Mason CJ in *March v E & MH Stramare Pty Ltd* (1991) 171 CLR 506, 516,

> "A factor which secures the presence of the plaintiff at the place where and at the time where he or she is injured is not causally connected with the injury, unless the risk of the accident occurring at that time was greater."

When a traveller was delayed through a railway company's fault and a lamp exploded in the hotel where she was compelled to spend the night (the well-known case of *Central of Georgia Railway v Price* (1898) 32 SE 77) that was simply an unfortunate coincidence. Similarly, if a taxi-driver drives too fast and the cab is hit by a falling tree, injuring the passenger, it is sheer coincidence. The driver might equally well have avoided the tree by driving too fast, and the passenger might have been injured if the driver was observing the speed limit. But to my mind the present case does not fall into that category. Bare "but for" causation is

powerfully reinforced by the fact that the misfortune which befell the claimant was the very misfortune which was the focus of the surgeon's duty to warn.

95. Against this must be set the cogent argument, lucidly developed by McHugh J in his minority judgment in *Chappel v Hart*, that the surgeon's failure to warn did not increase the patient's risk (para 27, footnotes omitted):

> "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. That being so, whether the claim is in contract or tort, the fact that the risk eventuated at a particular time or place by reason of the conduct of the defendant does not itself materially contribute to the plaintiff's injury unless the fact of that particular time or place increased the risk of the injury occurring".

That argument has even more force on the facts of this appeal, since in the Australian case Mrs Hart would have gone to another surgeon, the most experienced who could be found, whereas in this case no one has suggested that Mr Afshar was not a leading expert in this type of surgery.

96. The judge carefully considered what would have happened if Mr Afshar had given his patient an adequate warning at the consultation held three days before the operation. The judge made such findings of fact as he could (para 69) and summarised his limited findings (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 have agreed to undergo would have been *identical* in circumstances (including nature of surgery, procedure and surgeon) to the operation she actually underwent on 21 November 1994."

97. Was this enough to justify the judge in finding a sufficient causal link between the surgeon's omission to warn and the nerve damage which ensued? My noble and learned friend Lord Hoffmann would reject that view. He puts forward a vivid analogy from roulette. But the 1 in 37 chance of a particular number coming up (assuming the roulette wheel to be properly made and operated) is a matter of simple and precise mathematical calculation. By contrast the chance of nerve damage occurring (without negligence) during lumbar surgery can be calculated only with hindsight, as a more or less accurate approximation, by compiling and analysing statistics as to the outcome of that type of surgery. The risk no doubt varies with the skill and experience of the surgeon, the severity of the patient's condition, and the precise type of surgery undertaken (for instance whether there is an operation on only one disc level, a point on which the judge made a detailed review of the expert evidence). There may be other less easily identifiable factors which also affect the risk.

98. I would not accept, on the strength of the roulette analogy, that these should be regarded as changing the scenario only in some irrelevant detail. Nor, I suspect, would anyone who was suffering the same pain and distress as Miss Chester was suffering, and who was faced with the same dilemma as she faced (a dilemma which would have been even more anxious if she had been told of the risk of nerve damage). In making a decision which may have a profound effect on her health and well-being a patient is entitled to information and advice about possible alternative or variant treatments.

99. I accept that (as Kirby J said in *Chappel v Hart* at para 94) a surgeon should not be penalised for chance alone. It would be irrational superstition to suppose that Mr Afshar, who had performed hundreds of similar operations without mishap, was somehow fated to meet with cauda equina syndrome, ("the terror of neurosurgery" as one of the experts put it) during the operation which he performed on Miss Chester on 21 November 1994; and that a postponement of the operation by a

month (or even a day) would somehow have completely averted the risk. It was no more "in the stars" that it would happen on that particular day than it was "in the stars" that the delayed vessel in *Associated Portland Cement Manufacturers (1900)Ltd v Houlder Brothers & Co Ltd* (1917) 86 LJKB 1495 would be torpedoed on 25 May 1916, but would not have been torpedoed if making the same voyage two or three days earlier.

100. That is to my mind a criticism of the reasoning of the Court of Appeal [2003] QB 356, 377, paras 40-41:

> "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 … 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."

In this passage the words "*possibly* not at all" (emphasis supplied) are difficult to reconcile, on normal principles of causation, with the requirement that it is for the claimant to prove her case, including loss caused by the defendant's negligence; and the last sentence quoted seems to stack the odds against the surgeon, since it compares a random misfortune which has actually and unexpectedly occurred with the statistical improbability of its occurring on one particular occasion in the future.

101. Nevertheless there are real difficulties (especially, perhaps, for a conscientious claimant aware of the fallibility of hindsight) in a claimant asserting that (if warned of the risks) she would never in any circumstances have submitted to surgery. There would be a danger, as Lord Hope points out, of an honest claimant finding herself without a remedy in circumstances where the surgeon has failed in his professional duty, and the claimant has suffered injury directly within the scope and focus of that duty. I agree with Lord Steyn and Lord Hope that such a claimant ought not to be without a remedy, even if it involves some extension of existing principle, as in *Fairchild v Glenhaven Funeral Services Ltd* [2003] 1 AC 32 (see especially the speech of my noble and learned friend Lord Bingham of Cornhill at paras 8-13). Otherwise the surgeon's important duty would in many cases be drained of its content.