It is almost fifty years since Mr Bolam was injured when receiving ECT and he unsuccessfully sued the hospital for damages. However, while the world and Medicine have moved on, the principles set out by McNair J in his clear and simple direction to the jury are still in force today (though with a little gloss and froth added by successive judgments). In a nutshell, a doctor is not negligent if his advice and/or treatment accords with any practice(s) considered acceptable by his peers at the relevant time. *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582. The House of Lords judgment in *Bolitho v City and Hackney Health Authority* [1998] AC 232 implies that a judge may reject a purportedly acceptable medical practice if it is demonstrably not reasonable and logical.

Consent is not vitiated to the extent the treatment becomes a battery if the patient understands the nature of the treatment she is accepting even though she may prove she would have refused it had she been appropriately warned of the risks. (*Chatterton v Gerson* [1981] QB 432.) And if she can prove that **but for the negligent failure to warn her of the complication that occurred** she would have avoided the injury she may recover damages. In a clear cut (but alas rare) case this would be because she can convince a judge that she would never at any time or place in the future have undergone that treatment at all. But this may not be the end of the matter. Her condition may be progressive so that without treatment it would worsen and some future intervention, though different, may have been needed with the outcome uncertain. Thus even if liability and causation are established, calculating quantum may be very difficult as it will be based on educated speculation of what the future may have held for the claimant - on the balance of probabilities.

Obviously, whether you will be able to persuade a sympathetic or sceptical judge that the defendant’s failure to warn of the risk was negligent and caused the claimant to suffer an otherwise avoidable injury will depend on the evidence available. It will depend heavily on the claimant and defendant clinician’s credibility as witnesses and the contemporaneous notes and attitudes displayed. We are off to a flying start if the defendant doctor admits he should have warned of the risk that occurred but failed on this occasion to warn the claimant. This is not a very likely scenario, alas. Not quite so good is when the defendant doctor agrees he should have warned of
the risk but says *this precisely what he did* as it is his standard practice. Can he produce a leaflet that was always handed out or a supportive contemporary note or a colleague as witness to what was said? Can the claimant produce a witness who was present at the consultation? Is the picture that either party is presenting consistent and credible? The more anxious or desperate the patient was to have treatment to alleviate a painful or deteriorating condition, the more difficult for her/him to prove that a warning of a small risk (albeit of a serious complication) would have deterred her/him. If the treatment was private (and in return for a hefty fee) this may be a real or a subtle influencing factor woven into the bigger picture.

Causation is frequently a major hurdle in a clinical negligence claim, but this may be a particular problem when the claim is based lack of informed consent. The claimant may allege a number of alternatives - eg no injury because she would (a) never have had this treatment at all at any time (b) not have had the treatment at that time – it may have been years later by which time etc… (c) delayed during which time she may have been helped by other treatments or the condition remitted (d) have only accepted the treatment at a later stage either performed by the same doctor and/or his team in the same hospital, or (e) selected or more skilled clinician in a different hospital, etc. Whether or not to proceed with a claim all the way to trial or try to settle it (and the Part 36 offer needs to be very carefully calculated) will obviously depend on the evidence as perceived by both parties. Crucial in consent cases will be the consistency and fluency of the parties’ key witnesses, their experts, the pre-treatment picture which must take account of the severity of any underlying illness and prognosis if left untreated, any alternative treatment options that were or should have been offered – this may include doing nothing.

What were the risks and benefits that the claimant would have taken into account when deciding how to proceed? How far will her/his evidence or that of the defendant be discounted to allow for the impact of 20:20 retrospective vision?

Despite their flaws- the Woolf procedural reforms have created a climate of much earlier and fuller exchange of information and evidence between the parties. Defendants have to produce their records promptly and can no longer hide behind a stone wall of denial. So, despite serious worries about future funding of cases and while litigation remains a lottery for lawyers and
claimants alike, I offer you hope and a touch of optimism – even when faced with a claim founded on alleged lack of informed consent and consequential causation of injury and quantum.

This is partly because although the Bolam test propounded in 1957 still holds pretty much sway in the UK, medical practice itself along with the courts’ attitudes to the evidence have shifted to reflect the public’s wish and expectation for greater openness and increased professionalism from its medics. Medical practice has altered as it is battered by the ever-rising tide of litigation and what is sometimes described as the blame culture. It is interesting to compare Sidaway [1984] QB 493 (HL) with the recent landmark Court of Appeal case of Chester v Afshar [2002] 3 All ER 552. Mrs Sidaway unsuccessfully alleged that she should have been, but was not, warned of the risk of nerve damage in spinal surgery. Her case was that if she had been so warned she would have refused the operation that left her disabled. It was accepted by the courts in Sidaway that in 1974 there was a “responsible body of opinion” who would not have warned about the risk of nerve damage arising from spinal/lumbar surgery. The prudent patient test proposed by Lord Scarman was rejected outright by the majority and there was no suggestion that the test had altered by 1983 when judgment was given.

By contrast in Chester v Afshar, the defendant surgeon accepted that he had a duty to warn of the small risk of cauda equina (nerve root) damage in the context of spinal surgery and said he had warned the claimant – who denied this. (see further, below).

Before considering the potential impact of Chester v Afshar on causation, I want to consider a couple of cases in which I was personally instructed and the claimant recovered damages for (inter alia) the consequences of lack of informed consent.

rummitt. This case was settled before trial for £145,000 including CRU). The solicitor was Sue Jarvis then of Pictons now of Linnells. Mrs Grummitt claimed on behalf of her infant son who was injured in utero in consequence of a vaginal pre-natal screening procedure. It was claimed that she had not been warned of the risks of this procedure (which were greater than average in her case due to an extra long cervix) and she was not advised of or offered other lower risk procedures that should have been available. She said that if she had been properly informed she would never have undergone the vaginal
screening and so avoided the damage to her uterus. This damage caused a devastating loss of amniotic fluid procedure and resulted in her baby developing two club feet and an abnormal knee joint. This was not a straightforward case. Mrs Grummitt (40 odd), was a very anxious lady. She had paid privately for prenatal screening and advice which was inconclusive. She had children from a previous marriage and had recently remarried a man who had no children. Her position was that she would never have had an abortion but she wanted to know in advance of delivery if she was carrying an abnormal child.

While investigating the case, Sue Jarvis – alias Sherlock Holmes, discovered the consultant concerned only offered the vaginal screening technique which he never again performed after he realised what had happened to Mrs Grummitt. The Defendant contended Mrs Grummitt had been given adequate information – the notes were inconclusive.

In *Linda Kennedy v Queen’s Medical Centre, Nottingham* (my solicitor was Andrew Pattison of Nelsons) the Claimant was a black woman who suffered from alopecia universalis. Before undergoing the treatment with DCP she had been variously described as “desperate” and had suffered from bouts of depression but her case was that although she had been very distressed over time she had learned to come to terms with her distressing condition and was coping quite well. She was offered treatment with Diphenycypro (DCP) and was advised that there was a reasonable chance of it stimulating hair growth but was not warned there was a risk she could develop vitiligo (loss of pigmentation) where the DCP had been applied. Vitiligo is particularly noticeable on black skin. The DCP was applied to her scalp. It did not cure or alleviate her alopecia but caused severe blistering and then vitiligo. At trial the Claimant wore a wig. She had worn a wig quite a bit before DCP. Her evidence was that she had been willing to leave her wig off at times before the treatment with DCP and the vitiligo developed. She was horrified by her appearance and plunged into a severe depressive episode but was starting to emerge from this by the hearing. The Claimant’s case was that the treatment was “experimental” by an unlicensed product and that this had not been explained to her and that she had not been warned it could cause vitiligo. Her case was that if she had been properly counselled and warned she would have refused the treatment and avoided developing vitiligo and the severe depression and some loss of earnings.
Again this case was very far from a push over and was not straightforward. Our expert, we learned 2 days before trial, had never himself used DCP (it was not available in a District General Hospital where he used to work). However, this fact turned out to be something of an asset after all – it emphasised DCP was not a mainstream treatment. It transpired that everybody who did use DCP in the UK had been introduced to it by the Defendant’s expert, who was a very keen advocate and who had based her thesis on its application. She had decided what information should be in all the patient leaflets - and instructed pretty much every doctor who used DCP including the one who had prescribed it to Linda Kennedy, who was a close personal friend.

There were problems with the changing by her of conclusions reached at the expert meetings so that two different versions were produced to the judge. Notwithstanding, the Defendant, whom we must assume was confident of success, ignored our Part 36 offer and paid nothing into court. After three days (with an inconvenient break) the judge gave a reserved judgment in which he found for the Claimant on all point. He awarded her £25,000.00. (Leicester County Court, June/July 2000.)

Now for the Court of Appeal decision in Chester v Afshar [2002] 3 All ER 552 which apparently adopts and extends the rationale of the majority of the High Court in the Australian case of Chappel v Hart [1993] MLR 223. Mrs Hart the Claimant/respondent, had a pharyngeal pouch – a progressive condition which sooner or later required surgery. The surgery carried an inherent risk of perforation of the oesophagus which could lead to infection and damage the voice. Dr Chappel, an ENT surgeon, failed to advise Mrs Hart of the risk. She consented to the surgery and suffered damage to her laryngeal nerves, paralysis of her right vocal cord and voice loss. She sued Dr Chappel for damages claiming that she should have been warned of the risks and she had been she would “not have had surgery when she did. And she would have taken steps to have it performed by ‘the most experienced [surgeon] with a record and reputation in the field.’” The majority, Gaudron J, Gummow and Kirby JJ held that Mrs Hart’s claim was for damages and not loss of a chance, but for physical injury. That injury resulted from an operation which, but for Dr Chappel’s breach of duty, would not have taken place. It was an injury within the scope of foreseeable risk against which it was the appellant’s duty to warn and the respondent had not consented to run that risk. Therefore causation was proved.
This simple conclusion was reached only after a prolonged battle through the Australian courts. Fierce differences of judicial opinions are evident. Is it a triumph for logical deduction or the defeat of plain commonsense? As the judgment stands in Australia at least, the door has been opened to claimants who cannot put hand on heart and say (or convince a judge) that they would never have consented to the same surgery at any time in the future.

In *Chappel v Hart*, Mrs Hart contended that she would have had the operation done by a different and more expert surgeon, in whose hands the risks of injury would have been less. Dr Chappel had in any event conceded that if the surgery had been performed at a different time, then in all likelihood Mrs Hart would not have suffered the random chance of injury. She was very worried about her voice being damaged and the consequences of this for her were more significant than the statistical risk.

But is this in itself not something of a red herring, given that the risk of injury from the surgery even when performed by Dr Chappel was very small in percentage terms – far below 50% and the balance of probability. Mrs Hart was claiming not the “loss of a chance” of a better outcome (though some simple-minded souls might approach things this way) but damages to compensate her for the actual injury she suffered. Mrs Hart’s injury resulted from an unbroken chain of causation which started with the defendant surgeon’s negligent failure to warn her of a small risk of a serious complication. But even supposing Mrs Hart could not have found a more experienced surgeon in whose hands the risks of the same injury would have been still smaller, how should this have affected calculation of any damages payable? If her chances of suffering an injury at a later date were miniscule and far, far below 50% should she not recover the whole sum? Or should any sum be discounted by the percentage - assuming the risk was greater than the minimum of 1% with which the court would be concerned?

This appears to be the rationale behind the landmark decision in the Court of Appeal in *Chester v Afshar* (which may yet go to the House of Lords).

The appeal was from a split trial dealing only with issues of liability and causation but not quantum. The decision may extend quite considerably the circumstances in which claimants can claim damages on a but for ticket which goes beyond claims based on a lack of informed consent.
Miss Chester, was a journalist who had a history of miserable back pain. From the judgment she appears to be an intelligent and educated woman who, prior to the index events, was very strongly opposed to the idea of spinal surgery. She was receiving treatment from a rheumatologist that did not relieve her pain. He urged her to consider undergoing surgery and inter alia recommended Mr Afshar. Miss Chester saw him in November 1994. He advised her that she needed 3 bulging discs removed and that in his hands the operation (microdiscectomy L2/3, L3/4 and L4/5 would be straightforward and gave her the impression that it was virtually risk-free. She accepted his advice and he fitted her in for surgery only three days later, Monday at 7pm. Unfortunately, Miss Chester suffered both motor and sensory impairment. Further investigations were done and a second operation promptly performed. Mr Afshar recorded in his note: “My only explanation for the current situation is one of cauda equina contusion that may have occurred on the routine medial retraction of L3 root and cauda equinal dura during the L2/3 disc removal at the first procedure. Although Miss Chester recovered near normal function of her right leg, progress on her left side was much slower and she was six years later, still seriously disabled by the surgery.

Miss Chester sued for damages. She claimed Mr Afshar failed to warn her of the small risk (he put it at 0.9%) of cauda equina (nerve root) damage, infection and bleeding and its consequences. She claimed that his negligent failure to warn had deprived “her of an opportunity to reflect, consider and/or seek alternative medical or other opinion as to the options which might be open to her”. She further alleged the surgery was negligently performed. This part of the case did not succeed at trial..

However, the judge found in favour of Miss Chester’s claim based on lack of information – he held that Mr Afshar had negligently failed to warn Miss Chester of the risks of nerve damage. That had he warned her, Miss Chester would not have had the surgery performed by Mr Afshar three days later.

The pleadings were rather vague about the claimant’s alleged “but for” situation and it was not until two years after they were served and just before trial that the Defendant asked for further and better particulars – this request was refused. It was not alleged in evidence (nor was it pleaded) that Miss Chester would never at some time in the future have undergone the surgery performed either by Mr Afshar or a different surgeon. Beyond this, the “but for” scenario is rather vague. But if the rationale is that there is an unbroken
chain of causation and a miniscule chance that such an injury would have occurred in the future, how far is this material when assessing quantum?

The trial judge concluded the causal link had been established (at page 563g and earlier at e: said “while it is impossible to say what the probable outcome would have been if the claimant had sought a further opinion or further opinions – I think it improbable that any surgery she might eventually undergo would have been identical in circumstances (including the nature of the surgery, procedure and surgeon) to the operation she actually underwent on 21.11.94.” (But is that the test?)

Giving the leading judgment, Sir Denis Henry in the C A concluded: “What might happen in future was relevant to quantum. He reviewed the key English and Australian authorities, (noting that English law does not impose quite such a rigorous standard upon doctors as that in Rogers v Whitaker). In particular the arguments and judgment in *Chappel v Hart*, (‘which the trial judge had found extremely persuasive’) were carefully considered.

Miss Chester had been very worried and reluctant to undergo spinal surgery. Sir Denis Henry concluded (page 572 at e)

“In principle there seems to be little difficulty in attributing causative responsibility to a doctor who has in breach of duty failed to draw a particular risk to his patient’s attention in the event that the particular risk materialises. …The law is designed to require doctors properly to inform their patients of the risks attendant on their 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. 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. (See commentary by Adrien Whitfield QC on Chappel v Hart Lloyds Medical Report 223 at 255.)

“It would in our judgment be unjust to hold that the effective cause of the claimant’s injury was the random occurrence of a 1% to 2% risk rather than
the defendant’s failure to bring the risk to her attention.” The Court was satisfied that the majority reasoning in Chappel v Hart was correct and that the judge reached the right conclusion in this case.

The appeal was dismissed and leave to appeal refused.

Assuming this case will not be reversed by the House of Lords, it would seem that Miss Chester is entitled to recover damages which compensate her for the extent of the injury caused by Mr Afshar’s surgery but having regard for her “but for” likely prognosis with appropriate treatment.

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3.10.02.
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