[1985] 1 All ER 643

HOUSE OF LORDS

21 February 1985.

SIDAWAY (A.P.) (APPELLANT)

V

BETHLEM ROYAL HOSPITAL AND THE MAUDESLEY HOSPITAL HEALTH AUTHORITY AND OTHERS

(RESPONDENTS)

Lord Scarman
Lord Diplock
Lord Keith of Kinkel
Lord Bridge of Harwich
Lord Templeman

LORD SCARMAN

My Lords,

The state of the evidence in this case compels me to the conclusion that the appellant has not made out a case of negligence against her surgeon, the late Mr. Murray A. Falconer. I regret profoundly that after a trial in the course of which the judge listened with great care to a substantial and complex volume of medical evidence and delivered a meticulous and detailed judgment, and after two appellate hearings (by the Court of Appeal and your Lordships' House), the conclusion should be that the plaintiff has failed to prove her case.

Such a result is, I believe, inevitable for a number of reasons. The issue is whether Mr. Falconer failed to exercise due care (his skill was not challenged) in the advice which he gave his patient when recommending an operation: I use the word advice to cover information as to risk and the options of alternative treatment. Whatever be the correct formulation of the applicable law, the issue cannot be settled positively for or against the doctor without knowing what advice, including any warning of inherent risk in the operation, he gave his patient before she decided to undergo it and what was his assessment of the mental, emotional, and physical state of his patient. The trial judge derived no help on these two vital matters from the evidence of the appellant. Mr. Falconer was not an available witness, having died before trial, and the medical records afforded no sure guide on either matter. Regrettable though a "non-proven" verdict is, it is not, therefore, surprising. Where the court lacks direct evidence as to the nature and extent of the advice and warning (if any) given by the doctor and as to his assessment of his patient the court may well have to conclude that the patient has failed to prove her case.

This lack of evidence is unsatisfactory also from a purely legal point of view. I am satisfied, for reasons which I shall develop, that the trial judge and the Court of Appeal erred in law in holding that in a case where the alleged negligence is a failure to warn the patient of a risk inherent in the treatment proposed, the "Bolam test", to which I shall refer in detail at a later stage of my speech, is to be applied. In my view the question whether or not the omission to warn constitutes a breach of the doctor's duty of care towards his patient is to be determined not exclusively by reference to the current state of responsible and

competent professional opinion and practice at the time, though both are, of course, relevant considerations, but by the court's view as to whether the doctor in advising his patient gave the consideration which the law requires him to give to the right of the patient to make up her own mind in the light of the relevant information whether or not she will accept the treatment which he proposes. This being my view of the law, I have tested the facts found by the trial judge by what I believe to be the correct legal

criterion. In my view the appellant has failed to prove that Mr. Falconer was in breach of the duty of care which he owed to her in omitting to disclose the risk which the trial judge found as a fact he did not disclose to her.

I turn now to the detailed facts and issues in the case.

This is an appeal by the plaintiff, Mrs. Sidaway, from the dismissal by the Court of Appeal of her appeal from the judgment of Skinner J. given on 19 February 1982 whereby he dismissed her action for damages in respect of the personal injuries which she suffered as a result of a surgical operation performed upon her by a neuro-surgeon on 29 October 1974. The first defendants are the governing body of the Maudsley Hospital where she was treated and where she underwent the operation. The second defendants are the executors of Mr. Falconer, the distinguished neuro-surgeon who advised and performed the operation. Mr. Falconer died in August 1977, some five years before the trial of the action. Mrs. Sidaway does not allege negligence in the performance of the operation. Her case is that she was not informed of a risk inherent in the operation, that the risk materialised with the result that she suffered, and continues to suffer, serious personal injury, and that, had she been warned, she would not have consented to the operation. Damages are agreed at £67,500 subject to liability.

The case is plainly of great importance. It raises a question which has never before been considered by your Lordships' House. Has the patient a legal right to know, and is the doctor under a legal duty to disclose, the risks inherent in the treatment which the doctor recommends? If the law recognises the right and the obligation, is it a right to full disclosure or has the doctor a discretion as to the nature and extent of his disclosure? And, if the right be qualified, where does the law look for the criterion by which the court is to judge the extent of the disclosure required to satisfy the right? Does the law seek guidance in medical opinion or does it lay down a rule which doctors must follow, whatever may be the views of the profession? There is further a question of law as to the nature of the cause of action. Is it a cause of action in negligence, i.e. a breach of the duty of care, or is it based on a breach of a specific duty to inform the patient which arises not from any failure on the part of the doctor to exercise the due care and skill of his profession but directly from the patient's right to know?

Before attempting to answer these questions it is necessary to set out the facts of the case. At once a formidable difficulty arises. Mr. Falconer was dead before the trial. The judge was not prepared to accept Mrs. Sidaway's evidence that he gave no warning. The judge was, therefore, without any direct evidence as to the extent of the warning given. Further, the judge lacked evidence which Mr. Falconer alone could have given as to his

assessment of his patient with especial reference to his view as to what would be the effect upon her of a warning of the existence of a risk, albeit slight, of serious personal injury arising from the operation however skilfully and competently it was performed. Such being the limitations upon the availability of critically important evidence, I confess that I find it surprising that the trial judge felt able to reach the detailed findings as to the extent of the warning given which are a striking feature of his judgement. There is, however, no appeal against his findings; and I have no doubt that your Lordships' House must proceed upon the basis of the facts as found. Nevertheless, the lack of knowledge of Mr. Falconer's assessment of his patient reduces to some extent the guidance which your Lordships can give for the assistance of judges in future cases. It also presents difficulties for the appellant.

Mrs. Sidaway was 71 years of age at the time of the trial in 1982. She was severely disabled by a partial paralysis resulting from her operation. The relationship of doctor and patient between Mr. Falconer and herself had been long-standing prior to the operation. In 1958 she had injured an elbow at work and as a result had suffered persistent pain. Treatment failed to relieve pain. In July 1960, she was referred to the Maudsley Hospital where Mr. Falconer discovered that the second and third cervical vertebrae were congenitally fused and that there was a significant narrowing of the spinal column between the fifth and sixth vertebrae. Mr. Falconer diagnosed the deformity in this area as the cause of her pain. He decided to operate. He removed the disc between the fifth and sixth vertebrae of the neck and fused the two vertebrae by a bone graft. Although pain persisted for another two years, it eventually disappeared. Mr. Falconer's

diagnosis was proved correct and his operation ultimately succeeded in relieving his patient's pain.

Mr. Falconer annually reviewed his patient's progress between I960 and 1970. In 1973, he wrote to Mrs. Sidaway asking how she was. She replied, complaining of very persistent pain "in the right arm and shoulder," which was the same area as before, and now also of pain in the left forearm. Mr. Falconer saw her in the early months of 1974. After some delays, she was admitted to hospital on 11 October 1974. Her pain in the meantime had got progressively worse.

On admission, Mrs. Sidaway was thoroughly examined by Dr. Goudarzi, a junior member of Mr. Falconer's team. On 17 October, she underwent a myelogram which revealed a partial block at the level of the C4/5 disc space, a posterior ridge in the same area which appeared to have, at least in part, a bony structure, and a narrowing of the subarachnoid space in the same area. Mr. Falconer diagnosed that pressure on a nerve root was the cause of her pain and decided to operate. The operation, which he performed on 29 October 1974, and its risks were, if I may respectfully say so, admirably and lucidly described by the trial judge, from whose judgment I take the following description:

> "The operation consisted of a laminectomy of the fourth cervical vertebra and a facetectomy or foraminectomy of the disc space between the fourth and fifth cervical vertebrae. A laminectomy is an excision of the posterior

> arch of the vertebra. It gives the surgeon access to the foramen or channel through which nerves travel from the spine laterally. Randomly placed in the foramina, running alongside the nerves, are small blood vessels known as the radicular arteries. These supply blood to the cord and are extremely vulnerable because of (a) their size and (b) the unpredictable nature of their siting. In one foramen, there may be one, two or more radicular arteries. Their rupture or blockage may cause damage to the cord by depriving it temporarily or permanently of its blood supply at the relevant level. At the operation, Mr. Falconer freed the fourth cervical nerve root by removing the facets, or small

bony protuberances, from the fourth verbebra and used a dental drill to free the nerve within the foramen."

It was common ground between ail the neuro-surgeons who gave evidence that the operation involved specific risks beyond those inherent in all operations under general anaesthetic. So far as the general risks are concerned, the judge commented that Mrs. Sidaway was a healthy woman apart from her cervical spine, and no medical witness had suggested that any special warning as to the existence of those risks needed to be given.

The two specific risks of injury were: (1) damage to a nerve root in the area of the operation; and (2) damage to the spinal cord either by direct contact or by some interference, which might be slight and of short duration or very much more serious, of the radicular arteries running through a foramen.

The risk of either sort of damage occurring was not great: one surgeon estimated the degree of risk at between one and two per cent. But, if either risk materialised, the injury could be severe. Mr. Uttley, the distinguished surgeon called on behalf of Mrs. Sidaway, said that the possible effects of the damage ranged from a sensation of pins and needles in the hand to paraplegia, i.e. a partial paralysis. All the surgeons who were called as expert witnesses accepted that the risk of damage, though slight, was a real one. They distinguished between the two categories of specific risk, the effect of damage to a nerve root being in all probability that the operation would fail to relieve and might increase pain, while damage to the spinal cord might cause a partial paralysis. The risk of damage to the spinal cord was, however, in their opinion less that one per cent.

There is no challenge to the judge's findings: (1) that Mr. Falconer's diagnosis was correct; and (2) that his recommendation in favour of operative treatment was one which he could reasonably and properly have made to his patient; and (3) that he performed the operation with due care and skill.

The issue between the parties arises solely in respect of the warning, if any, which Mr. Falconer gave his patient of the specific risks inherent in the operation. None of the medical witnesses suggested that his decision to recommend the operation was itself wrong. And no one has ever suggested that the operation was carried out otherwise than competently and skilfully.

The one criticism, made and pursued on behalf of Mrs. Sidaway throughout this litigation, is that Mr. Falconer was in breach of his duty as her medical adviser in failing to warn her of the risk of damage to the spinal cord.

Mrs. Sidaway consented to the operation. She signed the usual consent form, in which she declared that the nature and purpose of the operation had been explained to her by Dr. Goudarzi. Dr. Goudarzi confirmed that he had given her this explanation: but he made it clear in his evidence that he would have left warning of the risks to Mr. Falconer. And we know from the hospital records that Mr. Falconer saw his patient before he operated. It would have been his practice to give a warning: but a finding as to what warning he gave faces the formidable difficulty to which I have already referred, that Mr Falconer was not available to give evidence. Nevertheless, the judge, while refusing to accept Mrs. Sidaway's evidence that she was given no warning, made the following findings upon the balance of probabilities. He said:

> "on the evidence . . . the probabilities are that ... on the day before the operation he [Mr. Falconer] followed his usual practice ... It is probable that he explained the nature of the operation [to his patient] ... in simple terms. ... As to the risks, I think it is probable that he mentioned the possibility of disturbing a nerve root and the consequences of doing so, but I am satisfied that he did not refer to the danger of cord damage or to the fact that this was an operation of choice rather than necessity."

The medical witnesses were agreed that they would give a patient some warning of the specific risks involved before performing an operation of this kind. They would explain the nature and purpose of the operation, and that there was a small risk of untoward consequences and of an increase of pain instead of relief. Mr. Uttley would go further: he would warn of the possible risk of some weakness of the legs resulting from the operation. Two answers in his cross-examination were of great importance. When asked whether he would question the judgment of a surgeon that it was not in his patient's interest to frighten

her by talking about death or paralysis, he replied "not at all:" and he agreed that such a judgment would be in accordance with a practice accepted as proper by a responsible body of competent neuro-surgeons. The existence of such a practice was also recognised by the other medical witnesses. Their view may be summarised as being that the extent of the warning is a matter for medical judgment with especial importance attached to the doctor's assessment of his patient.

This being the state of the evidence, the question for the House is whether the omission by Mr. Falconer to warn his patient of the risk inherent in the operation of damage to the spinal cord with the possible result of a partial paralysis was a breach of duty owed by him to his patient. The duty of a doctor to warn was considered in Bolam v. Friern Hospital Management Committee [1957] 1 W.L.R. 582, where it was treated as one to be answered within the context of the duty of care and skill owed by a doctor to his patient. In that case, the plaintiff, a voluntary patient in the defendants' mental hospital, sustained fractures in the course of electro-convulsive therapy. The plaintiff claimed damages alleging negligence (1) in failing to administer a relaxant drug prior to the treatment: (2) in failing to provide some form of manual restraint during the passing of electric current through his

brain: and (3) in failing to warn him of the risks involved in the treatment. The case was heard by McNair J. and a jury. The judge included in his summing-up to the jury a number of directions as to the standard of care required of a doctor in advising and treating his patient. He said at p. 586:

> "The test is the standard of the ordinary skilled man exercising and professing to have that special skill . . .it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art."

He referred at p. 587, without any critical comment, to the defence submission that the jury had to make up its mind on each of the three major topics" (these included the duty to warn of the risks of treatment) whether the defendants were acting in accordance with a [emphasis added] practice of competent respected professional opinion." And he concluded by directing the

jury that a doctor is not guilty of negligence if he acts in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art." When the judge dealt with the facts, he reminded the jury of the differing evidence of the doctors as to the extent of warning which they believed to be proper before a patient decided to undergo a surgical operation. They all treated the question as one for medical judgment. There was, however, at p. 590, this difference of opinion among them: the doctor who recommended the E.C.T. said that he did not agree that a patient should be warned of all the risks of the operation: he should be told that "there are some slight risks, but I do not tell him of the catastrophe risk." Others who were called to give independent expert evidence gave it as their opinion that a warning should be given, but its extent was a matter of medical judgment with especial importance attached to the character of the patient: "every patient has to be considered as an individual" (Dr. Page) and "Giving the full details may drive a patient away" (Dr. Baker). McNair J. put the issue thus to the jury, at p. 590:

> "Having considered the evidence on this point, you have to make up your minds whether it has been proved to your satisfaction that when the defendants adopted the practice they did (namely, the practice of saying very little and waiting for questions from the patient), they were falling below a proper standard of competent professional opinion on this question of whether or not it is right to warn."

The jury found for the defendants. The judge clearly directed the jury to treat the test of negligence which he formulated as exclusively applicable in medical cases. The Bolam principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care: but the standard of care is a matter of medical judgment.

The Bolam principle has been accepted by your Lordships' House as applicable to diagnosis and treatment: Whitehouse v. Jordan [1981] 1 W.L.R. 246 (treatment), and Maynard v. West Midland Regional Health Authority [1984] 1 W.L.R. 634 (diagnosis). It is also recognised in Scots law as applicable to diagnosis and

treatment: indeed, McNair J. in the Bolam case cited a Scots decision to that effect, Hunter v. Hanley 1955 S.L.T. 213 (Lord President Clyde at p. 217.)

But was the judge correct in treating the "standard of competent professional opinion" as the criterion in determining whether a doctor is under a duty to warn his patient of the risk, or risks, inherent in the treatment which he recommends? Skinner J. and the Court of Appeal have in the instant case held that he was correct. Bristow J. adopted the same criterion in Chatterton v. Gerson [1981] Q.B. 432. The implications of this view of the law are disturbing. It leaves the determination of a legal duty to the judgment of doctors. Responsible medical judgment may, indeed, provide the law with an acceptable standard in determining whether a doctor in diagnosis or treatment has complied with his duty. But is it right that medical judgment should determine whether there exists a duty to warn of risk and its scope? It would be a strange conclusion if the courts should be led to conclude that our law, which undoubtedly recognises a right in the patient to decide whether he will accept or reject the treatment proposed, should permit the doctors to determine whether and in what circumstances a duty arises requiring the doctor to warn his patient of the risks inherent in the treatment which he proposes.

The right of "self-determination" - the description applied by some to what is no more and no less than the right of a patient to determine for himself whether he will or will not accept the doctor's advice - is vividly illustrated where the treatment recommended is surgery. A doctor who operates without the consent of his patient is, save in cases of emergency or mental disability, guilty of the civil wrong of trespass to the person: he is also guilty of the criminal offence of assault. The existence of the patient's right to make his own decision, which may be seen as a basic human right protected by the common law, is the reason why a doctrine embodying a right of the patient to be informed of the risks of surgical treatment has been developed in some jurisdictions in the U.S.A. and has found favour with the Supreme Court of Canada. Known as the "doctrine of informed consent," it amounts to this: where there is a "real" or a "material" risk inherent in the proposed operation (however competently and skilfully performed) the question whether and to

what extent a patient should be warned before he gives his consent is to be answered not by reference to medical practice but by accepting as a matter of law that, subject to all proper exceptions (of which the court, not the profession, is the judge), a patient has a right to be informed of the risks inherent in the treatment which is proposed. The profession, it is said, should not be judge in its own cause: or, less emotively but more correctly, the courts should not allow medical opinion as to what is best for the patient to override the patient's right to decide for himself whether he will submit to the treatment offered him. It will be necessary for the House to consider in this appeal what is involved in the doctrine and whether it, or any modification of it, has any place in English law.

The appellant's submissions

The appellant's first submission is that, even if (which she does not accept) the Bolam principle determines whether a warning

of risk should or should not be given, the facts found establish liability. My Lords, the submission is untenable. It is not possible to hold that the appellant has shown negligence in the Bolam sense on the part of Mr. Falconer in advising or treating her. His decision not to warn her of the danger of damage to the spinal cord and of its possible consequences was one which the medical witnesses were agreed to be in accordance with a practice accepted as proper by a responsible body of opinion among neuro-surgeons. Further, the medical evidence also emphasised that in reaching a decision whether or not to warn his patient a competent and careful surgeon would attach especial importance to his assessment of the character and emotional condition of his patient, it being accepted that a doctor acting in the best interests of his patient would be concerned lest a warning might frighten the patient into refusing an operation which in his view was the best treatment in the circumstances. Nobody knows what Mr. Falconer's assessment of Mrs. Sidaway's character, state of mind and emotion was before her operation. There is no evidence to justify an inference that this careful and compassionate man (the history of the case, which I have related, shows that he merited both adjectives) would have failed to consider what was in the best interests of his patient. He could well have concluded

that a warning might have deterred her from agreeing to an operation which he believed to be the best treatment for her.

The appellant's second submission is that she has a cause of action which is independent of negligence in the Bolam sense. The submission is based on her right to decide for herself whether she should submit to the operation proposed. In effect, she invokes the transatlantic doctrine of informed consent.

The law

The doctrine is new ground in so far as English law is concerned. Apart from the judgment of Bristow J. in Chatterton v. Gerson [1981] Q.B. 432 I know of only one case prior to the present appeal in which an English court has discussed it. In Hills v. Potter [1984] 1 W.L.R. 641 Hirst J. followed Skinner J. in this case, adding a comment with which I respectfully agree, that it would be deplorable to base the law in medical cases of this kind on the torts of assault and battery. He did, however, carefully and helpfully devote part of his judgment to a consideration of the transatlantic cases which accept a doctrine of informed consent. He was, if I may say so, right to refuse to follow them: he was sitting at first instance and was faced with formidable English authority accepting the Bolam test (Skinner J. in the present case and Bristow J. in respect of advice: and this House in respect of diagnosis and treatment.) But the circumstance that this House is now called upon to explore new ground is no reason why a rule of informed consent should not be recognised and developed by our courts. The common law is adaptable: it would not otherwise have survived over the centuries of its existence. The concept of negligence itself is a development of the law by the judges over the last hundred years or so. The legal ancestry of the tort of negligence is to be found in the use made by the judges of the action on the case. Damage is the gist of the action. The action on the case was sufficiently flexible to enable the judges to extend it to cover situations where damage was suffered in circumstances which they judged to call for a remedy. It would

be irony indeed if a judicial development for which the opportunity was the presence in the law of a flexible remedy should result

now in rigidly confining the law's remedy to situations and relationships already ruled upon by the judges.

Counsel for the appellant referred to Nocton v. Lord Ashburton [1914] A.C. 932 in an attempt to persuade your Lordships that the relationship between doctor and patient is of a fiduciary character entitling a patient to equitable relief in the event of a breach of fiduciary duty by the doctor. The attempt fails: there is no comparison to be made between the relationship of doctor and patient with that of solicitor and client, trustee and cestui qui trust or the other relationships treated in equity as of a fiduciary character. Nevertheless the relationship of doctor and patient is a very special one, the patient putting his health and his life in the doctor's hands. Where Nocton v. Lord Ashburton does throw light is upon the approach of our law to new or special situations and relationships not previously considered by the judges. In that case the House had to consider the field covered by Perry v. Peek (1889) 14 App.Cas. 337, the famous case in which the House had held that in an action of deceit it is necessary to prove actual fraud. Lord Haldane had this to say at [1914] A.C. 932; 947:

> "My Lords, the discussion of the case by the noble and learned Lords who took part in the decision appears to me to exclude the hypothesis that they considered any other question to be before them than what was the necessary foundation of an ordinary action for deceit. They must indeed be taken to have thought that the facts proved as to the relationship of the parties in Perry v. Peek were not enough to establish any special duty arising out of that relationship other than the general duty of honesty. But they do not say that where a different sort of relationship ought to be inferred from the circumstances the case is to be concluded by asking whether an action for deceit will lie. I think that the authorities subsequent to the decision of the House of Lords shew a tendency to assume that it was intended to mean more than it did. In reality the judgment covered only a part of the field in which liabilities may arise. There are other obligations besides that of honesty the breach of which may give a right to damages. These obligations depend on principles which the judges have worked out in the fashion that is characteristic of a system

where much of the law has always been judge-made and unwritten."

This remains the approach of the judges to new or as yet unconsidered situations. Unless statute has intervened to restrict the range of judge-made law, the common law enables the judges, when faced with a situation where a right recognised by law *is* not adequately protected, either to extend existing principles to cover the situation or to apply an existing remedy to redress the injustice. There is here no novelty: but merely the application of the principle "ubi jus ibi remedium." If, therefore, the failure to warn a patient of the risks inherent in the operation which is recommended does constitute a failure to respect the patient's right to make his own decision, I can see no reason in principle why, if the risk materialises and injury or damage is caused, the

law should not recognise and enforce a right in the patient to compensation by way of damages.

For the reasons already given, the Bolam principle does not cover the situation. The facts of this very case expose its limitation. Mr. Falconer lacked neither care for his patient's health and well-being nor professional skill in the advice and treatment which he offered. But did he overlook or disregard his patient's right to determine for herself whether or not to have the operation? Did he fail to provide her with the information necessary for her to make a prudent decision? There is, in truth, no evidence to answer these questions. Mrs. Sidaway's evidence was not accepted: and Mr. Falconer was dead. Assume, however, that he did overlook this aspect of his patient's situation. Since neither his advice nor his treatment could be faulted on the Bolam test, his patient may have been deprived of the opportunity to exercise her right of decision in the light of information which she, had she received it, might reasonably have considered to be of importance in making up her mind. On the Bolam view of the law, therefore, even if she established that she was so deprived by the lack of a warning, she would have no remedy in negligence unless she could also prove that there was no competent and respected body of medical opinion which was in favour of no warning. Moreover, the tort of trespass to the person would not

provide her with a remedy: for Mrs. Sidaway did consent to the operation. Her complaint is that her consent resulted from ignorance of a risk, known by the doctor but not made known by him to her, inherent in the operation. Nor would the law of contract offer her a sure way forward. Medical treatment, as in her case, is frequently given today under arrangements outside the control of the law of contract.

One point is clear, however. If failure to warn of risk is actionable in English law, it must be because it is in the circumstances a breach of the doctor's duty of care: in other words, the doctor must be shown to be negligent. English law has not accepted a "no-fault" basis for the liability of a doctor to compensate a patient for injury arising in the course of medical treatment. If, however, the Bolam principle is to be applied to the exclusion of any other test to advice and warning, there will be cases in which a patient who suffers injury though ignorance of a risk known to the doctor has no remedy. Is there any difficulty in holding that the doctor's duty of care is sufficiently extensive to afford a patient in that situation a remedy, if as a result she suffers injury or damage? I think not. The root principle of common law negligence is to "take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour": Donoghue v. Stevenson [1932] A.C. 562, per Lord Atkin at p.580. If it be recognised that a doctor's duty of care extends not only to the health and well-being of his patient but also to a proper respect for his patient's rights, the duty to warn can be seen to be a part of the doctor's duty of care.

It is, I suggest, a sound and reasonable proposition that the doctor should be required to exercise care in respecting the patient's right of decision. He must acknowledge that in very many cases factors other than the purely medical will play a significant part in his patient's decision-making process. The

doctor's concern is with health and the relief of pain. These are the medical objectives. But a patient may well have in mind circumstances, objectives, and values which he may reasonably not make known to the doctor but which may lead him to a different

decision from that suggested by a purely medical opinion. The doctor's duty can be seen, therefore, to be one which requires him not only to advise as to medical treatment but also to provide his patient with the information needed to enable the patient to consider and balance the medical advantages and risks alongside other relevant matters, such as, for example, his family, business or social responsibilities of which the doctor may be only partially, if at all, informed.

I conclude, therefore, that there is room in our law for a legal duty to warn a patient of the risks inherent in the treatment proposed, and that, if such a duty be held to exist, its proper place is as an aspect of the duty of care owed by the doctor to his patient. I turn, therefore, to consider whether a duty to warn does exist in our law and, if it does, its proper formulation and the conditions and exceptions to which it must be subject.

Some American courts have recognised such a duty. They have seen it as arising from the patient's right to know of material risks, which itself is seen to arise from the patient's right to decide for himself whether or not to submit to the medical treatment proposed. This is the doctrine of informed consent, to which I have already briefly referred. The landmark case is a decision of the U.S. Court of Appeals, District of Columbia Circuit, Canterbury v. Spence (1972) 464 F. 2d 772. This case, which has now been approved by the District of Columbia Appeal Court in Grain v. Allison (1982) 443 A. 2d 558, is discussed learnedly and lucidly in an article published in the Law Quarterly Review, upon which I have drawn extensively in reaching my opinion in this appeal. I wish to put on record my deep appreciation of the help I have derived from the article, the author of which is Mr. Gerald Robertson: the reference of the article is "Informed Consent to Medical Treatment", (1981) 97 L.Q.R. 102. The author deals so comprehensively with the American, Canadian, and other countries' case law that I find it unnecessary to refer to any of the cases to which our attention has been drawn, interesting and instructive though they are, other than Canterbury v. Spence and a case in the Supreme Court of Canada, Reibl v. Hughes (1980) 114 D.L.R. (3d) 1, in which the judgment of the Supreme Court came too late to be considered by Mr. Robertson in his article. I have also been greatly assisted by the note on the present case by Professor Ian Kennedy in the Modern Law Review, (1984) 47 M.L.R. 454.

It is necessary before discussing the doctrine to bear in mind that it is far from being universally accepted in the U.S.A., or indeed elsewhere. Speaking of the position as it was in 1981 Mr. Robertson said at p. 108:

> "The present position in the United States is one of contrast between the minority of States which have chosen to follow the lead given by Canterbury by adopting the objective 'prudent patient' test . . . and the majority of States which have been content to adopt the traditional test and determine the question of disclosure of risks by applying the 'reasonable doctor' test."

There can be little doubt that policy explains the divergence of view. The prolification of medical malpractice suits in the U.S.A. has led some courts and some legislatures to curtail or even to reject the operation of the doctrine in an endeavour to restrict the liability of the doctor and so discourage the practice of "defensive medicine" - by which is meant the practice of doctors advising and undertaking the treatment which they think is legally safe even though they may believe that it is not the best for their patient.

The danger of defensive medicine developing in this country clearly exists - though the absence of the lawyer's "contingency tee" (a percentage of the damages for him as his fee if he wins the case but nothing if he loses) may make it more remote. However that may be, in matters of civil wrong or tort, courts are concerned with legal principle: if policy problems emerge, they are best left to the legislature: McLoughlin v. O'Brian [1983] 1 A.C. 410.

In Canterbury v. Spence the court enunciated four propositions: (1) the root premise is the concept . . . that every human being of adult years and of sound mind has a right to determine what shall be done with his own body. (2) the consent is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each: (1972) 464 F. 2d 772; (3) the doctor must, therefore, disclose all "material risks"; what risks are "material"

is determined by the "prudent patient" test, which was formulated by the court at p.787:

> "a risk is ... material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy." (Emphasis supplied).

(4) the doctor, however, has what the court called a "therapeutic privilege." This exception enables a doctor to withhold from his patient information as to risk if it can be shown that a reasonable medical assessment of the patient would have indicated to the doctor that disclosure would have posed a serious threat of psychological detriment to the patient.

In Canada, in Reibl v. Hughes (1980) 114 D.L.R. (3d) 1, Laskin C.J.C. expressed broad approval of the doctrine as enunciated in Canterbury v. Spence, though it would seem that approval of the doctrine was not necessary to a decision in the case. I find no difficulty in accepting the four propositions enunciated in Canterbury's case. But with two notable exception they have not yet been considered, so far as I am aware, by an English court. In Chatterton v. Gerson [1981] Q.B. 432, Bristow J. did consider whether there is any rule in English law comparable with the doctrine of informed consent. At p. 444 he held that a doctor ought to warn of what may happen by misfortune however well the operation may be carried out "if there is a real risk of a misfortune inherent in the procedure" (emphasis supplied). He held that whether or not a warning should have been given depended upon what a reasonable doctor would have done in the

circumstances: and he applied the Bolam test to determine the reasonableness of what the doctor did. In Hills v. Potter [1984] 1 W.L.R. 641 Hirst J., after discussing the doctrine, also applied the Bolam test.

In my judgment the merit of the propositions enunciated in Canterbury v. Spence (1972) 464 F. 2d 772 is that without excluding medical evidence they set a standard and formulate a test of the doctor's duty the effect of which is that the court

determines the scope of the duty and decides whether the doctor has acted in breach of his duty. This result is achieved first by emphasis on the patient's "right of self-determination" and secondly by the "prudent patient" test. If the doctor omits to warn where the risk is such that in the court's view a prudent person in the patient's situation would have regarded it as significant, the doctor is liable.

The Canterbury propositions do indeed attach great importance to medical evidence, though judgment is for the court. First, medical evidence is needed in determining whether the risk is material, i.e. one which the doctor should make known to his patient. The two aspects of the risk, namely the degree of likelihood of it occurring and the seriousness of the possible injury if it should occur, can in most, if not all, cases be assessed only with the help of medical evidence. And secondly, medical evidence would be needed to assist the court in determining whether the doctor was justified on his assessment of his patient in withholding the warning.

My Lords, I think the Canterbury propositions reflect a legal truth which too much judicial reliance on medical judgment tends to obscure. In a medical negligence case where the issue is as to the advice and information given to the patient as to the treatment proposed, the available options, and the risk, the court is concerned primarily with a patient's right. The doctor's duty arises from his patient's rights. If one considers the scope of the doctor's duty by beginning with the right of the patient to make his own decision whether he will or will not undergo the treatment proposed, the right to be informed of significant risk and the doctor's corresponding duty are easy to understand: for the proper implementation of the right requires that the doctor be under a duty to inform his patient of the material risks inherent in the treatment. And it is plainly right that a doctor may avoid liability for failure to warn of a material risk if he can show that he reasonably believed that communication to the patient of the existence of the risk would be detrimental to the health (including, of course, the mental health) of his patient.

Ideally, the court should ask itself whether in the particular circumstances the risk was such that this particular patient would think it significant if he was told it existed. I would think that, as a matter of ethics, this is the test of the doctor's duty. The

law, however, operates not in Utopia but in the world as it is: and such an inquiry would prove in practice to be frustrated by the subjectivity of its aim and purpose. The law can, however, do the next best thing, and require the court to answer the question, what would a reasonably prudent patient think significant if in the situation of this patient. The "prudent patient" cannot, however, always provide the answer for the obvious reason that he is a

norm (like the man on the Clapham omnibus), not a real person: and certainly not the patient himself. Hence there is the need that the doctor should have the opportunity of proving that he reasonably believed that disclosure of the risk would be damaging to his patient or contrary to his best interest. This is what the Americans call the doctor's "therapeutic privilege." Its true analysis is that it is a defence available to the doctor which, if he invokes it, he must prove. On both the test and the defence medical evidence will, of course, be of great importance.

The "prudent patient" test calls for medical evidence. The materiality of the risk is a question for the court to decide upon all the evidence. Many factors call for consideration. The two critically important medical factors are the degree of probability of the risk materialising and the seriousness of possible injury, if it does. Medical evidence will be necessary so that the court may assess the degree of probability and the seriousness of possible injury. Another medical factor, upon which expert evidence will also be required, is the character of the risk. In the event of an operation is the risk common to all surgery, e.g. sepsis, cardiac arrest, and the other risks associated with surgery and the administration of an anaesthetic? Or is it specific to the particular operation under consideration? With the world-wide development and use of surgical treatment in modern times the court may well take the view that a reasonable person in the patient's situation would be unlikely to attach significance to the general risks: but it is not difficult to foresee circumstances particular to a patient in which even the general risks of surgery should be the subject of a warning by his doctor: e.g. a heart or lung or blood condition. Special risks inherent in a recommended operational procedure are more likely to be material. The risk of

partial paralysis, as in this case where the purpose of the operation was not to save life but merely to relieve pain, illustrates the sort of question which may face first the doctor and later the court. Clearly medical evidence will be of the utmost importance in determining whether such a risk is material: but the question for the court is ultimately legal, not medical in character.

If the doctor admits or the court finds that on the prudent patient test he should have disclosed the risk, he has available the defence that he reasonably believed it to be against the best interest of his patient to disclose it. Here also medical evidence, including the evidence of the doctor himself, will be vital. The doctor himself will normally be an essential witness: and the reasonableness of his assessment may well need the support of independent medical testimony.

My conclusion as to the law is therefore this. To the extent that I have indicated I think that English law must recognise a duty of the doctor to warn his patient of risk inherent in the treatment which he is proposing: and especially so, if the treatment be surgery. The critical limitation is that the duty is confined to material risk. The test of materiality is whether in the circumstances of the particular case the court is satisfied that a reasonable person in the patient's position would be likely to attach significance to the risk. Even if the risk be material, the doctor will not be liable if upon a reasonable assessment of his patient's condition he takes the view that a warning would be detrimental to his patient's health.

Conclusion

Applying these principles to the present case, I ask first: has the appellant shown the risk of damage to the spinal cord to have been a material risk? The risk was slight - less than one per cent: but, if it were to materalise, it could result in severe injury. It was for the appellant, as plaintiff, to establish that the risk was so great that the doctor should have appreciated that it would be considered a significant factor by a prudent patient in the appellant's situation deciding whether or not to have the operation. The medical evidence even of Mr. Uttley, the

appellant's expert witness, gets nowhere near establishing the materiality of the risk in the sense just outlined. It is, of course, possible that Mr. Uttley's evidence was not directed to anything other than negligence in the Bolam sense. If so, the appellant, who now relies on the principle of informed consent, must accept the consequences: - it was up to her to prove such a case, if she were seeking to establish it. Further, we do not know Mr. Falconer's assessment of his patient. It is possible that, had he lived, he could have enlightened the court on much that would have been relevant. After an anxious consideration of the evidence I do not find it possible to say that it has been proved that Mr. Falconer failed in his duty when he omitted - as we must assume that he did - to warn his patient of the risk of injury to the spinal cord.

At the end of the day, therefore, the substitution of the Canterbury propositions for the Bolam test of duty and breach of duty does not avail the appellant because the evidence does not enable her to prove that Mr. Falconer was in breach of his duty when he omitted the warning. Lack of evidence was always her difficulty; and it remains so, even though, contrary to the submission of the respondents, the law, in my view, recognises a right of a patient of sound understanding to be warned of material risks save in the exceptional circumstances to which I have referred. Accordingly, I would dismiss the appeal.

LORD DIPLOCK

My Lords,

Such facts as emerged in evidence at the trial of the action that is the subject of this appeal have been set out by my noble and learned friend, Lord Scarman. They are characterised by their extreme paucity. We know nothing of the emotional idiosyncracies of the plaitiff, Mrs. Sidaway ("the patient"), even in ordinary health let alone under stress of ill-health and the prospects of waiting for surgical treatment at the hands of Mr. Falconer ("the neuro-surgeon"); and yet a doctor's duty of care, whether he be general practitioner or consulting surgeon or physician is owed to that patient and none other, idiosyncracies and all. Inevitably all treatment, medical or surgical, involves some degree of risk that

the patient's condition will be worse rather than better for undergoing it. Statistically, the chances of any risk of the proposed treatment going awry at all may be small – but

particularly if surgery is involved (though this is by no means confined to surgery) it is never totally absent and the degree of possible worsening involved may cover a whole spectrum of disabilities from mild occasional discomfort to what might justify the epithet catastrophic. All these are matters which the doctor will have taken into consideration in determining, in the exercise of his professional skill and judgment, that it is in the patient's interest that he should take the risk involved and undergo the treatment recommended by the doctor.

There is no evidence in the instant case that the patient asked the neuro-surgeon a single question about whether there were any risks involved in undergoing the operation that he was proposing for her, or if there were, what were the consequences of those risks or the chances of their occurring. So there are eliminated from our consideration matters of clinical judgment of the neuro-surgeon as to how to conduct a bilateral discussion with the patient in terms best calculated not to scare her off from undergoing an operation which, in the exercise of the paramount duty of care he owed to her individually to exercise his skill and judgment in endeavouring to heal her, he is satisfied that it is in her interests to undergo despite such risks as may be entailed.

Likewise we do not know save in vaguest terms which amount to little more than speculation but which the trial judge was prepared to hold on balance of probabilities to be a fact, what risks the neuro-surgeon did mention to the patient. The risks which it is contended the neuro-surgeon ought to have drawn to the attention of the patient, even though unasked, were damage to the nerve roots and damage to the spinal cord. The occurrence of these were possible however skilfully the intended operation was carried out; and the consequences of such damage might cover a whole spectrum of mishaps ranging from localised numbness or pins and needles to, in the worst cases, some degree of paraplegia - as unfortunately happened in the patient's case. Because of the physical area of the body in which the operation takes place, these

are closely related risks, one or other of which may occur. The combined chance of one or other occurring was put by the neurological experts at something below two per cent., of which injury to the spinal cord was rather more likely to have serious consequences if it were to happen, but the chances of its happening were was less than half the chance of damage to the nerve roots, i.e. less than one in a hundred.

These two risks are specific to operations on the spinal column; but in addition there are involved the risks inherent in any general surgery especially if conducted under anaesthesia. As in the case of spinal column surgery, the consequences of these other risks may be minor and evanescent or may be gravely and permanently disabling or even result in death itself. I find it significant that no common law jurisdiction either American or Canadian which has espoused the doctrine of "informed consent" appears to have suggested that the surgeon was under a duty to warn his patient of such general risks which, rare though they may be, do happen and they are real risks.

We are dealing in the present appeal with a patient who has expressed to the neuro-surgeon no anxiety about any risks of the proposed operation going wrong; and we are likewise confronted

with a neuro-surgeon whose practice, in the absence of specific questioning, was to mention to patients to whom he recommended such an operation for relief of pain as he was proposing to undertake on the patient in the instant case the risk of damage to the nerve roots with deleterious effect of varying degrees of discomfort or more serious disability, if the one in fifty chance occurred and despite the utmost operating skill something went wrong.

What we do know, however, and this is in my view determinative of this appeal, is that all the expert witnesses specialising in neurology (including the patient's own expert witness, Mr. Uttley who would not himself have undertaken a similar operation without waiting a period of time, after October 1974, to see what developed as to the persistence of the patient's pain) agreed that there was a responsible body of medical opinion

which would have undertaken the operation at the time the neuro-surgeon did and would have warned the patient of the risk involved in the operation in substantially the same terms as the trial judge found on the balance of probabilities the neuro-surgeon had done, i.e. without specific reference to risk of injuring the spinal cord.

My Lords, it is the very paucity of facts in evidence that makes it possible, in my view, to treat this appeal as raising a naked question of legal principle. It falls within a pattern of frequently occurring cases, which involve no consideration of the idiosyncracies of an exceptional patient. For the last quarter-of-a-century the test applied in English law as to whether a doctor has fulfilled his duty of care owed to his patient has been that set out in the summing-up to the jury by McNair J. in Bolam v. Friern Hospital Management Committee [1957] 1 W.L.R. 582. I will call this the Bolam test. At any rate so far as disgnosis and treatment is concered, the Bolam test has twice received the express approval of this House.

The Bolam test is far from new, its value is that it brings up to date and re-expresses in the light of modern conditions in which the art of medicine is now practised, an ancient rule of common law. The original rule can be traced to the maxim spondet peritiam artis et imperitia culpae admuneratur. It goes back to the origin of assumpsit; it applied to all articifers and was firmly founded in "case" (moderniter negligence) although it may be of interest to note that as long ago as 1767 in Slater v. Baker 2 Wils. 359, a suggestion that where injury was caused by surgery the form of action lay in trespass vi et armis was rejected with scant sympathy by the Court of King's Bench.

The standard of skill and judgment in the particular area of the art of medicine in which the doctor practised that was called for by the expression peritia was the standard of ordinary skill and care that could be expected to be shown by a doctor who had successfully completed the training to qualify as a doctor, whether as general practitioner or as consultant in a speciality if he held himself out as practising as such, as the case might be. But unless the art in which the articifer claims to have acquired skill and judgment is stagnant so that no improvement in methods or knowledge is sought - and of few is this less true than medicine and surgery over the last half-century - advances in the ability to heal resulting from the volume of research, clinical as

well as technological, will present doctors with alternative treatments to adopt and a choice to select that treatment (it may be one of several) that is in their judgment likely at the time to prove most efficacious or ameliorating to the health of each particular patient committed to their care.

Those members of the public who seek medical or surgical aid would be badly served by the adoption of any legal principle that would confine the doctor to some long-established, well-tried method of treatment only, although its past record of success might be small, if he wanted to be confident that he would not run the risk of being held liable in negligence simply because he tried some more modern treatment, and by some unavoidable mischance it failed to heal but did some harm to the patient. This would encourage "defensive medicine" with a vengeance. The merit of the Bolam test is that the criterion of the duty of care owed by a doctor to his patient is whether he has acted in accordance with a practice accepted as proper by a body of responsible and skilled medical opinion. There may be a number of different practices which satisfy this criterion at any particular time. These practices are likely to alter with advances in medical knowledge. Experience shows that, to the great benefit of human kind, they have done so, particularly in the recent past. That is why fatal diseases such as smallpox and tuberculosis have within living memory become virtually extinct in countries where modern medical care is generally available.

In English jurisprudence the doctor's relationship with his patient which gives rise to the normal duty of care to exercise his skill and judgment to improve the patient's health in any particular respect in which the patient has sought his aid, has hitherto been treated as single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment in the improvement of the physical or mental condition of the patient for which his services either as a general practitioner or specialist have been engaged. This general duty is not subject to dissection into a number of component parts to which different criteria of what satisfy the duty of care apply, such as diagnosis, treatment, advice (including warning of any risks of something going wrong however skilfully the treatment advised is carried out.) The Bolam case itself embraced failure to advise the patient of the risk

involved in the electric shock treatment as one of the allegations of negligence against the surgeon as well as negligence in the actual carrying out of treatment in which that risk did result in injury to the patient. The same criteria were applied to both these aspects of the surgeon's duty of care. In modern medicine and surgery such dissection of the various things a doctor has to do in the exercise of his whole duty of care owed to his patient is neither legally meaningful nor medically practicable. Diagnosis .itself may involve exploratory surgery, the insertion of drugs by 'injection (or vaccination) involves intrusion upon the body of the patient and oral treatment by drugs although it involves no physical intrusion by the doctor on the patient's body may in the case of particular patients involve serious and unforeseen risks.

My Lords, no convincing reason has in my view been advanced before your Lordships that would justify treating the Bolam test as doing anything less than laying down a principle of English law that is comprehensive and applicable to every aspect

of the duty of care owed by a doctor to his patient in the exercise of his healing functions as respects that patient. What your Lordships have been asked to do - and it is within your power to do so - is to substitute a new and different rule for that part only of the well established Bolam test as comprises a doctor's duty to advise and warn the patient of risks of something going wrong in the surgical or other treatment that he is recommending.

The juristic basis of the proposed substitution which originates in certain state court jurisdictions of the United States of America and has found some favour in modified form by the Supreme Court of Canada, appears to me, with great respect, to be contrary to English law. Its foundation is the doctrine of "informed consent" which was originally based on the assumption made in U.S. Court of Appeals, District of Columbia Circuit, in Canterbury v. Spence (1972) 464 F. 2d 772, where the cynic might be forgiven for remarking it enabled a defence under the State Statute of Limitations to be outmanoeuvred, that, prima facie, the cause of action in a case of surgery was trespass to the person unless "informed consent" to the particular battery involved in the

surgical operation could be proved. From a period long before American independence this, as I have pointed out, has never been so in English law. The relevant form of action has been based in negligence, i.e. in assumpsit, alone.

The Supreme Court of Canada, after some initial vaccilation, rejected trespass to the person, i.e. battery, as the cause of action in cases of surgery but endeavoured to transfer the concept of "informed consent" to a patient's cause of action in negligence, into which, in my opinion, it simply cannot be made to fit. Consent to battery is a state of mind personal to the victim of the battery and any information required to make his consent qualify as informed must be relevant information either actually possessed by him or which he is estopped from denying he possessed, because he so acted towards the defendant as to lead to the latter reasonably to assume the relevant information was known to him. There is no room in the concept of informed consent for the "objective" patient (as he is referred to at one point by the Supreme Court of Canada) to whom the doctor is entitled, without making any inquiry whether it is the fact or not, to attribute knowledge of some risks but not of others. It may be that most patients, though not necessarily all, have a vague knowledge that there may be some risk in any form of medical treatment: but it is flying in the face of reality to assume that all patients from the highest to the lowest standard of education or intelligence are aware of the extent and nature of the risks which, notwithstanding the exercise of skill and care in carrying out the treatment, are inevitably involved in medical treatment of whatever kind it be but particularly surgical. Yet it is not merely conceded but specifically asserted in the Canadian cases that it is no part of the duty of care on the part of the doctor to go out of his way to draw the attention of his patient to these. On what logical or juristic basis can the need for informed consent be confined to some risks and not extended to others that are also real - and who decides which risk falls into which class?

My Lords, I venture to think that in making this separation between that part of the doctor's duty of care that he owes to

each individual patient, which can be described as a duty to advise upon treatment and warn of its risks, the courts have misconceived their functions as the finders of fact in cases depending upon the negligent exercise of professional skill and judgment. In matters of diagnosis and the carrying out of treatment the court is not tempted to put itself in the surgeon's shoes; it has to rely upon and evaluate expert evidence, remembering that it is no part of its task of evaluation to give effect to any preference it may have for one responsible body of professional opinion over another, provided it is satisfied by the expert evidence that both qualify as responsible bodies of medical opinion. But when it comes to warning about risks, the kind of training and experience that a judge will have undergone at the bar makes it natural for him to say (correctly) it is my right to decide whether any particular thing is done to my body, and I want to be fully informed of any risks there may be involved of which I am not already aware from my general knowledge as a highly educated man of experience, so that I may form my own judgment as to whether to refuse the advised treatment or not.

No doubt if the patient in fact manifested this attitude by means of questioning, the doctor would tell him whatever it was the patient wanted to know; but we are concerned here with volunteering unsought information about risks of the proposed treatment failing to achieve the result sought or making the patient's physical or mental condition worse rather than better. The only effect that mention of risks can have on the patient's mind, if it has any at all, can be in the direction of deterring the patient from undergoing the treatment which in the expert opinion of the doctor it is in the patient's interest to undergo. 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 the warning may have, is as 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 this matter should be treated in just the same way. The Bolam test should be applied.

I agree with your Lordships that this appeal should be dismissed.

LORD KEITH OF KINKEL

My Lords,

I have had the advantage of reading in draft the speech to be delivered by my noble and learned friend, Lord Bridge of Harwich. I agree with it, and for the reason which he gives would dismiss the appeal.

LORD BRIDGE OF HARWICH

My Lords,

The facts giving rise to this appeal have been fully recounted by my noble and learned friend, Lord Scarman. I draw attention in briefest summary only to those which seem to me central to the issue of law arising for decision.

The appellant underwent at the hospital for which the first respondents are the responsible authority an operation on her cervical vertebrae performed by a neuro-surgeon, since deceased, whose executors are the second respondents. The nature of the operation was such that, however skilfully performed, it involved a risk of damage to the nerve root at the site of the operation or to the spinal cord. The trial judge described that risk as "best expressed to a layman as a one to two per cent. risk of ill effects ranging from the mild to the catastrophic." The appellant in fact suffered, without negligence on the surgeon's part in the performance of the operation, a degree of damage to the spinal cord of which the effects, if not catastrophic, were certainly severe. Damages have been agreed, subject to liability, in the sum of £67,500.

The appellant denied that she had seen the surgeon at all before the operation was performed. This evidence the judge rejected. He found that, before the appellant consented to undergo the operation, the surgeon explained the nature of the operation to her in simple terms and warned her of the possibility

and likely consequences of damage to the nerve root, but did not refer to the risk of damage to the spinal cord. Most unfortunately, the surgeon who performed the operation died before these proceedings were instituted. Accordingly the trial judge, the Court of Appeal, and your Lordships' House have ail been denied the advantage of what would clearly have been vital evidence on the issue of liability, not only the surgeon's own account of precisely of what he had told this appellant, but also his explanation of the reasons for his clinical judgment that, in her case, the information he gave her about the operation and its attendant risks was appropriate and sufficient. The judge was thus driven to base the finding to which I have earlier referred in part on inference from documents, but mainly on the evidence of other doctors as to what they knew of the deceased surgeon's customary practice when discussing with patients an operation of the kind the appellant was to undergo. The result is that liability falls to be considered, in effect, in relation to that customary practice, independently of the vitally important individual doctor/patient relationship which must play so large a part in any discussion of a proposed operation with a patient. That introduces an element of artificiality into the case which we may deplore but cannot avoid.

There was a difference of opinion between the neuro-surgeons called as expert witnesses as to whether they themselves would, in the circumstances, have warned the appellant specifically of the risk of damage to the spinal cord. But the one expert witness called for the appellant agreed readily and without reservation that the deceased surgeon, in omitting any such warning, would have been following a practice accepted as proper by a responsible body of competent neuro-surgeons.

Broadly, a doctor's professional functions may be divided into three phases: diagnosis, advice, and treatment. In performing his functions of diagnosis and treatment, the standard by which English law measures the doctor's duty of care to his patient is not open to doubt. "The test is the standard of the ordinary skilled man exercising and professing to have that special skill." These are the words of McNair J. in Bolam v. Friern Hospital Management Committee [1957] 1 W.L.R. 582, at p. 586, approved

by this House in Whitehouse v. Jordan [1981] 1 W.L.R. 246 (per Lord Edmund-Davies at p. 258) and in Maynard v. West Midland Regional Health Authority [1984] 1 W.L.R. 634 (per Lord Scarman at p. 638.) The test is conveniently referred to as the Bolam test. In Maynard's case, Lord Scarman, with whose speech the other four members of the Appellate Committee agreed, further cited with approval the words of Lord President Clyde in Hunter v. Hanley, 1955 S.L.T. 213, 217:

> "In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men . . . The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care . . ."

The language of the Bolam test clearly requires a different degree of skill from a specialist in his own special field than from a general practitioner. In the field of neuro-surgery it would be necessary to substitute for Lord President Clyde's phrase "no doctor of ordinary skill," the phrase "no neuro-surgeon of ordinary skill." All this is elementary and, in the light of the two recent decisions of this House referred to, firmly established law.

The important question which this appeal raises is whether the law imposes any, and if so what, different criterion as the measure of the medical man's duty of care to his patient when giving advice with respect to a proposed course of treatment. 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.

There are, it appears to me, at least theoretically, two extreme positions which could be taken. It could be argued that, the patient's consent is to be fully informed, the doctor must specifically warn him of all risks involved in the treatment offered, unless he has some sound clinical reason not to do so. Logically, this would seem to be the extreme to which a truly objective criterion of the doctor's duty would lead. Yet this position finds no support from any authority, to which we have

been referred, in any jurisdiction. It seems to be generally accepted that there is no need to warn of the risks inherent in all surgery under general anaesthesia. This is variously explained on the ground that the patient may be expected to be aware of such risks or that they are relatively remote. If the law is to impose on the medical profession a duty to warn of risks to secure "informed consent" independently of accepted medical opinion of what is appropriate, neither of these explanations for confining the duty to special as opposed to general surgical risks seems to me wholly convincing.

At the other extreme it could be argued that, once the doctor has decided what treatment is, on balance of advantages and disadvantages, in the patient's best interest, he should not alarm the patient by volunteering a warning of any risk involved, however grave and substantial, unless specifically asked by the patient. I cannot believe that contemporary medical opinion would support this view, which would effectively exclude the patient's right to decide in the very type of case where it is most important that he should be in a position to exercise that right and, perhaps even more significantly, to seek a second opinion as to whether he should submit himself to the significant risk which has been drawn to his attention. I should perhaps add at this point, although the issue does not strictly arise in this appeal, that, when questioned specifically by a patient of apparently sound mind about risks involved in a particular treatment proposed, the doctor's duty must, in my opinion, be to answer both truthfully and as fully as the questioner requires.

The decision mainly relied on to establish a criterion of the doctor's duty to disclose the risks inherent in a proposed treatment

which is prescribed by the law and can be applied independently of any medical opinion or practice is that of the District of Columbia Circuit Court of Appeals in Canterbury v. Spence (1972) 464 F. 2d 772. The judgment of the Court (Wright, Leventhal and Robinson JJ.), delivered by Robinson J., expounds the view that an objective criterion of what is a sufficient disclosure of risk is necessary to ensure that the patient is enabled to make an intelligent decision and cannot be left to be determined by the doctors. He 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."

In an attempt to define the objective criterion it is said at p. 787 that "the issue on non-disclosure must be approached from the viewpoint of the reasonableness of the physician's divulgence in terms of what he knows or should know to be the patient's informational needs." A risk is required to be disclosed "when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy": (1972) 464 F. 2d 772; 787. The judgment adds at p. 788: "Whenever non-disclosure of particular risk information is open to debate by reasonable-minded men, the issue is for the finder of facts."

The court naturally recognises exceptions from the duty laid down in the case of an unconscious patient, an immediate emergency, or a case where the doctor can establish that disclosure would be harmful to the patient.

Expert medical evidence will be needed to indicate the nature and extent of the risks and benefits involved in the treatment (and presumably of any alternative course.) But the court affirms at p. 792: "Experts are unnecessary to a showing of the materiality of a risk to a patient's decision on treatment, or to the reasonably, expectable effect of risk disclosure on the decision." In English law, if this doctrine were adopted, expert

medical opinion as to whether a particular risk should or should not have been disclosed would presumably be inadmissible in evidence.

I recognise the logical force of the Canterbury doctrine, proceeding from the premise that the patient's right to make his own decision must at ail costs be safeguarded against the kind of medical paternalism which assumes that "doctor knows best." But, with all respect, I regard the doctrine as quite impractical in application for three principal reasons. First, it gives insufficient weight to the realities of the doctor/patient relationship. A very wide variety of factors must enter into a doctor's clinical judgment not only as to what treatment is appropriate for a particular patient, but also as to how best to communicate to the patient the significant factors necessary to enable the patient to make an informed decision whether to undergo the treatment. The doctor cannot set out to educate the patient to his own standard of medical knowledge of all the relevant factors involved. He may take the view, certainly with some patients, that the very fact of his volunteering, without being asked, information of some remote risk involved in the treatment proposed, even though he describes it as remote, may lead to that risk assuming an undue significance in the patient's calculations. Secondly, it would seem to me quite unrealistic in any medical negligence action to confine the expert medical evidence to an explanation of the primary medical factors involved and to deny the court the benefit of evidence of medical opinion and practice on the particular issue of disclosure which is under consideration. Thirdly, the objective test which Canterbury propounds seems to me to be so imprecise as to be almost meaningless. If it is to be left to individual judges to decide for themselves what "a reasonable person in the patient's position" would consider a risk of sufficient significance that he should be told about it, the outcome of litigation in this field is likely to be quite unpredictable.

I note with interest from a learned article entitled Informed Consent to Medical Treatment by Mr. Gerald Robertson, Lecturer in Law, University of Leicester, (1981) 97 L.Q.R. 102, 108, that only a minority of states in the United States of America have chosen to follow Canterbury and that since 1975 "there has been a growing tendency for individual states to enact legislation which severely curtails the operation of the doctrine of informed consent." I should also add that I find particularly cogent and

convincing the reasons given for declining to follow Canterbury by the Supreme Court of Virginia in Bly v. Rhoads (1976) 222 S.E. 2d 783.

Having rejected the Canterbury doctrine as a solution to the problem of safeguarding the patient's right to decide whether he will undergo a particular treatment advised by his doctor, the question remains whether that right is sufficiently safeguarded by the application of the Bolam test without qualification to the determination of the question what risks inherent in a proposed treatment should be disclosed. The case against a simple application of the Bolam test is cogently stated by Laskin C.J.C., giving the judgment of the Supreme Court of Canada in Reibl v. Hughes (1980) 114 D.L.R. (3d) 1; 13:

> "To allow expert medical evidence to determine what risks are material and, hence, should be disclosed and, correlatively, what risks are not material is to hand over to the medical profession the entire question of the scope of the duty of disclosure, including the question whether there has been a breach of that duty. Expert medical evidence is, of course, relevant to findings as to the risks that reside in or are a result of recommended surgery or other treatment. It will also have a bearing on their materiality but this is not a question that is to be concluded on the basis of the expert medical evidence alone. The issue under consideration is a different issue from that involved where the question is whether the doctor carried out his professional activities by applicable professional standards. What is under consideration here is the patient's right to know what risks are involved in undergoing or foregoing certain surgery or other treatment."

I fully appreciate the force of this reasoning, but can only accept it subject to the important qualification that a decision what degree of disclosure of risks is best calculated to assist a particular patient to make a rational choice as to whether or not to undergo a particular treatment must primarily be a matter of clinical judgement. It would follow from this that the issue

whether non-disclosure in a particular case should be condemned as a breach of the doctor's duty of care is an issue to be decided primarily on the basis of expert medical evidence, applying the Bolam test. But I do not see that this approach involves the necessity "to hand over to the medical profession the entire question of the scope of the duty of disclosure, including the question whether there has been a breach of that duty." Of course, if there is a conflict of evidence as to whether a responsible body of medical opinion approves of non-disclosure in a particular case, the judge will have to resolve that conflict. But even in a case where, as here, no expert witness in the relevant medical field condemns the non-disclosure as being in conflict with accepted and responsible medical practice, I am of opinion that the judge might in certain circumstances come to the conclusion that disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it. The kind of case I have in mind would be an operation involving a substantial risk of grave adverse consequences, as, for example, the ten per cent. risk of a stroke from the operation which was the subject of the Canadian case of Reibl v. Hughes (1980) 114 D.L.R. (3d) 1. In such a case, in the absence of some cogent clinical reason why the patient should not be informed, a doctor, recognising and respecting his patient's right of decision, could hardly fail to appreciate the necessity for an appropriate warning.

In the instant case I can see no reasonable ground on which the judge could properly reject the conclusion to which the unchallenged medical evidence led in the application of the Bolam test. The trial judge's assessment of the risk at one to two per cent. covered both nerve root and spinal cord damage and covered a spectrum of possible ill effects "ranging from the mild to the catastrophic." In so far as it is possible and appropriate to measure such risks in percentage terms - some of the expert medical witnesses called expressed a marked and understandable reluctance to do so - the risk of damage to the spinal cord of such severity as the appellant in fact suffered was, it would appear, certainly less than one per cent. But there is no yardstick either in the judge's findings or in the evidence to measure what fraction of one per cent. that risk represented. In these

circumstances, the appellant's expert witness's agreement that the non-disclosure complained of accorded with a practice accepted as proper by a responsible body of neuro-surgical opinion afforded the respondents a complete defence to the appellant's claim.

I would dismiss the appeal.

LORD TEMPLEMAN

My Lords,

The appellant patient Mrs. Sidaway claims £67,500 damages against the estate of the deceased neuro-surgeon Mr. Murray A. Falconer for his failure to warn her of the risk that the operation which he recommended and performed with the consent of Mrs. Sidaway might cause the damage to her spinal cord which in fact occurred and the disability from which she is now suffering.

Between 1958 and 1960 Mrs. Sidaway suffered pain as a result of deformity in the region of her fifth and sixth cervicle vertebrae. Conservative treatment, including collar, traction and manipulation failed to effect a cure. In 1960 Mr. Falconer removed the disc between the affected vertebrae and fused them with a bone graft. After some time the pain disappeared. Mrs. Sidaway's condition was reviewed annually until 1970 and in 1973 Mr. Falconer's secretary wrote to Mrs. Sidaway enquiring after her health. The evidence is that Mr. Falconer was experienced, competent, conscientious and considerate in his practice and in his attitude to his patients including Mrs. Sidaway. In 1973 Mrs. Sidaway complained again of persistent pain. She was examined by Mr. Falconer, went into hospital on 11 October, and was operated upon by Mr. Falconer on 29 October. Mr. Falconer has since died. Mrs. Sidaway said that during her 18 days in hospital prior to the operation Mr. Falconer did not examine or speak to her. The trial judge rightly assumed that Mrs. Sidaway's recollection was understandably at fault and that she was seen and advised by Mr. Falconer.

Mrs. Sidaway was suffering increasing pain as a result of pressure on the fourth cervicle nerve root. The operation proposed and carried out by Mr. Falconer required the excision of part of a

vertebra in order to obtain access to the channel through which the affected nerve travelled. This would enable the removal of boney excrescencies from the fourth vertebra and the freeing of the nerve within its channel by the use of a dental drill. The operation involved working within three millimetres of the spinal cord, exposing the cord and interfering with the nerve root

Basing himself on evidence of the usual practice of Mr. Falconer and apparently assuming that Mr. Falconer's explanation to every patient followed the same practice, the trial judge, without the benefit of any direct evidence from Mr. Falconer or Mrs. Sidaway, made the confident finding that Mr. Falconer probably explained the nature of the operation to Mrs. Sidaway in simple terms and the reasons for performing the operation and mentioned the possibility of damage to a nerve root and the consequences of doing so but the judge was "satisfied that he did not refer to the danger of cord damage or to the fact that this was an operation of choice rather than necessity." The judge was also satisfied that "even if the surgeon exercised proper care and skill, the spinal cord might be damaged causing weakness or paralysis . . . and that the nerve root might be damaged causing pain and/or weakness . . ." Mrs. Sidaway's spinal cord was in fact damaged inadvertently without negligence on the part of Mr. Falconer, the performer of the operation.

In my opinion a simple and general explanation of the nature of the operation should have been sufficient to alert Mrs. Sidaway to the fact that a major operation was to be performed and to the possibility that something might go wrong at or near the site of the spinal cord or the site of the nerve root causing serious injury. If, as the judge held, Mr. Falconer probably referred expressly to the possibility of damage to a nerve root and to the consequences of such damage, this warning could only have reinforced the possibility of something going wrong in the course of a delicate operation performed in a vital area with resultant damage. In view of the fact that Mr, Falconer recommended the operation, Mrs. Sidaway must have been told or could have assumed that Mr. Falconer considered that the possibilities of damage were sufficiently remote to be ignored. Mrs. Sidaway could have asked questions. If she had done so, she could and should have been informed that there was an aggregrate risk of

between one per cent. and two per cent. risk of some damage either to the spinal cord or to a nerve root resulting in injury which might vary from irritation to paralysis. But to my mind this further information would only have reinforced the obvious, with the assurance that the maximum risk of damage, slight or serious, did not exceed two per cent. Mr. Falconer may reasonably have taken the view that Mrs. Sidaway might be confused, frightened or misled by more detailed information which she was unable to evaluate at a time when she was suffering from stress, pain and anxiety. A patient may prefer that the doctor should not thrust too much detail at the patient. We do not know how Mr. Falconer explained the operation to Mrs. Sidaway and we do not know the reasons for the terms in which he couched his explanation.

On the assumption that Mr. Falconer explained that it was necessary to remove bone and free a nerve root from pressure near the spinal cord, it seems to me that the possibility of

damage to a nerve root or to the spinal cord was obvious. The operation was skilfully performed but by mishap the remote risk of damage to the spinal cord unfortunately caused the disability from which Mrs. Sidaway is now suffering. However much sympathy may be felt for Mrs. Sidaway and however much in hindsight the operation may be regretted by her, the question now is whether Mr. Falconer was negligent in the explanation which he gave.

In my opinion if a patient knows that a major operation may entail serious consequences, the patient cannot complain of lack of information unless the patient asks in vain for more information or unless there is some danger which by its nature or magnitude or for some other reason requires to be separately taken into account by the patient in order to reach a balanced judgment in deciding whether or not to submit to the operation. To make Mr. Falconer liable for damages for negligence, in not expressly drawing Mrs. Sidaway's attention to the risk of damage to the spinal cord and its consequences, Mrs. Sidaway must show and fails to show that Mr. Falconer was not entitled to assume, in the absence of questions from Mrs. Sidaway, that his explanation of the nature of the operation was sufficient to alert Mrs. Sidaway

to the general danger of unavoidable and serious damage inherent in the operation but sufficiently remote to justify the operation. There is no reason to think that Mr. Falconer was aware that, as Mrs. Sidaway deposed, a specific warning and assessment of the risk of spinal cord damage would have influenced Mrs. Sidaway to decline the operation although the general explanation which she was given resulted in her consenting to the operation.

There is no doubt that a doctor ought to draw the attention of a patient to a danger which may be special in kind or magnitude or special to the patient. In Reibl v. Hughes (1980) 114 D.L.R (3d) 1, a surgeon advised an operation on the brain to avoid a threatened stroke. The surgeon knew or ought to have known that there was a four per cent. chance that the operation might cause death and a ten per cent. chance that the operation might precipitate the very stroke which the operation was designed to prevent. The patient ought to have been informed of these specific risks in order to be able to form a balanced judgment in deciding whether or not to submit to the operation.

When a patient complains of lack of information, the court must decide whether the patient has suffered harm from a general danger inherent in the operation or from some special danger. In the case of a general danger the court must decide whether the information afforded to the patient was sufficient to alert the patient to the possibility of serious harm of the kind in fact suffered. If the practice of the medical profession is to make express mention of a particular kind of danger, the court will have no difficulty in coming to the conclusion that the doctor ought to have referred expressly to this danger as a special danger unless the doctor can give reasons to justify the form or absence of warning adopted by him. Where the practice of the medical profession is divided or does not include express mention, it will be for the court to determine whether the harm suffered is an example of a general danger inherent in the nature of the operation and if so whether the explanation afforded to the patient was sufficient to alert the patient to the general dangers of which the harm suffered is an example. If a doctor conscientiously

endeavours to explain the arguments for and against a major operation and the possibilities of benefiting and the dangers, the court will be slow to conclude that the doctor has been guilty of a breach of duty owed to the patient merely because the doctor omits some specific item of information. It is for the court to decide, after hearing the doctor's explanation, whether the doctor has in fact been guilty of a breach of duty with regard to information.

A doctor offers a patient diagnosis, advice and treatment. The objectives, sometimes conflicting, sometimes unattainable, of the doctor's services are the prolongation of life, the restoration of the patient to full physical and mental health and the alleviation of pain. Where there are dangers that treatment may produce results, direct or indirect, which are harmful to the patient, those dangers must be weighed by the doctor before he recommends the treatment. The patient is entitled to consider and reject the recommended treatment and for that purpose to understand the doctor's advice and the possibility of harm resulting from the treatment.

I do not subscribe to the theory that the patient is entitled to know everything nor to the theory that the doctor is entitled to decide everything. The relationship between doctor and patient is contractual in origin, the doctor performing services in consideration for fees payable by the patient. The doctor, obedient to the high standards set by the medical profession impliedly contracts to act at all times in the best interests of the patient. No doctor in his senses would impliedly contract at the same time to give to the patient all the information available to the doctor as a result of the doctor's training and experience and as a result of the doctor's diagnosis of the patient. An obligation to give a patient all the information available to the doctor would often be inconsistent with the doctor's contractual obligation to have regard to the patient's best interests. Some information might confuse, other information might alarm a particular patient. Whenever the occasion arises for the doctor to tell the patient the results of the doctor's diagnosis, the possible methods of treatment and the advantages and disadvantages of the recommended treatment, the doctor must decide in the light of his training and experience and in the light of his knowledge of the patient what should be said and how it should be said. 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. The patient is free to decide whether or not to submit to treatment recommended by the doctor and therefore the doctor impliedly contracts to provide information which is adequate to enable the patient to reach a balanced judgment, subject always to the doctor's own obligation to say and do nothing which the doctor is satisfied will be harmful to the patient. When the doctor himself is considering the possibility of a major operation the doctor is able, with his medical training, with his knowledge of the patient's medical history and with his objective position to make a balanced judgment as to whether the operation should be performed or not. If the doctor making a balanced judgment advises the patient to submit to the operation, the patient is entitled to reject that advice for reasons which are rational, or irrational, or for no reason. The duty of the doctor in

these circumstances, subject to his overriding duty to have regard to the best interests of the patient, is to provide the patient with information which will enable the patient to make a balanced judgment if the patient chooses to make a balanced judgment. A patient may make an unbalanced judgment because he is deprived of adequate information. A patient may also make an unbalanced judgment if he is provided with too much information and is made aware of possibilities which he is not capable of assessing because of his lack of medical training, his prejudices or his personality. Thus the provision of too much information may prejudice the attainment of the objective of restoring the patient's health. The obligation of the doctor to have regard to the best interests of the patient but at the same time to make available to the patient sufficient information to enable the patient to reach a balanced judgment if he chooses to do so has not altered because those obligations have ceased or may have ceased to be contractual and become a matter of duty or care. In order to make a balanced judgment if he chooses to do so, the patient needs to be aware of the general dangers and of any special dangers in each case without exaggeration or concealment. At the end of the day, the doctor, bearing in mind the best interests of the patient and bearing in mind the patient's right to information which will

enable the patient to make a balanced judgment must decide what information should be given to the patient and in what terms that information should be couched. The court will award damages against the doctor if the court is satisfied that the doctor blundered and that the patient was deprived of information which was necessary for the purposes I have outlined. In the present case on the judge's findings I am satisfied that adequate information was made available to Mrs. Sidaway and that the appeal should therefore be dismissed.