Neutral Citation Number: [2023] EWCA Civ 605

Case No: CA-2022-000579

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
HIS HONOUR JUDGE BLAIR KC
QB-2019-000039

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 13 June 2023

Before :

LADY JUSTICE KING
LORD JUSTICE COULSON
and
LADY JUSTICE NICOLA DAVIES

- -

Between :

(1) SIDRA BILAL (2) HASSAAN AZIZ MALIK (Administrators on behalf of the estate of MUKHTAR MALIK, deceased)	**Appellants**
- and -	
ST GEORGE'S UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	**Respondent**

- -
- -

Matthew Stockwell (instructed by **Stewarts Law LLP**) for the **Appellants**
Andrew Post KC and Matthew Barnes (instructed by **Bevan Brittan LLP**) for the **Respondent**

Hearing date: 28 March 2023

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Approved Judgment

This judgment was handed down remotely at 10.00am on 13 June 2023 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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Lady Justice Nicola Davies :

1. This is an appeal from the judgment of HHJ Blair KC sitting as a Deputy High Court Judge ("the Judge") in which he dismissed the claim of Mr Malik for personal injury following elective surgery performed by Mr Minhas, a consultant neurosurgeon at the respondent's hospital, on 13 August 2015 which resulted in spinal cord injury. Mr Malik died on 14 July 2021 from causes secondary to his spinal condition. The appeal is pursued by his children as administrators of his estate.

2. Permission to appeal was granted by Stuart-Smith LJ on 5 August 2022. In granting permission, Stuart-Smith LJ permitted the respondent to submit that the point now being taken by the appellants based upon the failure of Mr Minhas to obtain from Mr Malik the duration of the intercostal pain is not open to the appellants because it was neither pleaded nor put to Mr Minhas in cross examination.

Factual background

3. Mr Malik, aged 48 at the date of trial, had a history of spinal problems commencing in 2012 which caused pain, leg weakness and altered sensation. During the subsequent two years, his symptoms deteriorated causing falls, increased leg weakness and pain in the left leg.

4. On 14 July 2014 Mr Malik attended the respondent's accident and emergency ("A & E") department, MRI scans were obtained which disclosed that his spinal cord was severely compressed at the interface of the 10th and 11th thoracic vertebrae ("T10/T11") and there was cauda equina compression around the 3rd and 4th lumbar vertebrae ("L3/L4"). Mr Minhas performed emergency spinal surgery namely a laminectomy and discectomy to decompress the spinal cord at T10/T11. There is no criticism of the execution of this surgery, the spinal cord was successfully decompressed at T10/T11 but Mr Malik had suffered neurological damage and subsequently experienced numbness and weakness of his left leg. The medical records for 2014/2015 show that Mr Malik attended his GP practice and the respondent's A & E department.

5. On 27 April 2015 Mr Malik attended Mr Minhas' outpatients' clinic, further MRI scans were ordered to ascertain whether Mr Malik required further surgery. The MRI scan performed on 9 May 2015 reported a number of findings which included the following:

> "T9/T10: there is disc extrusion causing severe narrowing of the central spinal canal. There is moulding of the theca. There are bilateral mild narrowing of the exiting neural foramina. There is no definite compromise of exiting neural foramina.
>
> T10/T11: there are prominent left paracentral/lateral disc/osteophyte bars effacing the left lateral recess and causing severe narrowing of the exiting neural foramen. The left exiting nerve root is contacting the disc/osteophyte bars. There is moulding of the theca. There is moderate to severe narrowing of the central spinal canal.
>
> …

> L3/L4: there is broad-based disc bulge associated with bilateral severe facet degenerative changes. There is severe narrowing of the central spinal canal. There is no definite compromise of exiting nerve roots.
>
> L4/L5: there are bilateral severe facet degenerative changes. There is mild narrowing of the left exiting foramen…."

6. Mr Minhas stated that when he saw Mr Malik at his outpatient clinic on 13 July 2015 for a review appointment, Mr Malik was experiencing terrible pain from the left side of his back with left side intercostalgia in addition to the ongoing left sided sciatic pain down the length of his leg and into his foot. It was the opinion of Mr Minhas that there were elements of Mr Malik's pain emanating from the spinal cord as well as from the left T10 nerve root and L3/L4 spinal canal stenosis. This was dual pathology, neuropathic pain from the spinal cord together with possible neuropathic or radiculopathic pain from the nerve root compression. Mr Minhas stated that the intercostal pain was particularly severe and concerning. In his witness statement Mr Minhas recorded that: "Mr Malik was desperate to have the surgery as soon as possible as I recall the intercostal pain was severe and causing him particular difficulty." Mr Malik denied complaining of left sided pain in his ribs or abdomen.

7. Following the consultation, and in a letter to Mr Malik's general practitioner dated 21 July 2015, Mr Minhas recorded his review of Mr Malik's symptoms and his proposal of surgery as follows:

> "… his follow up MRI scan in May 2015 shows that although there is no longer pressure on the thoracic spinal cord at the site of his thoracic laminectomy and decompression for discs at T9, T10 and T11, there is still significant osteophyte and probably impingement on the exiting thoracic nerve roots. In addition he also has some lumbar canal stenosis at L3/L4. There has been progressive improvement in the power in his legs. He no longer has to walk using a walking stick, but he is in terrible pain from the left side with left-sided intercostalgia (01:03) and left-sided sciatic pain all the way down his leg and into the foot. Given these ongoing symptoms I think it would be worthwhile considering a further operation with a revision thoracic decompression and a lumbar decompression at L3/L4 to help to try and resolve these existing symptoms.
>
> Mr Malik is desperate to have this done as soon as possible and I will aim to admit him within the next three weeks…"

8. The surgery which Mr Minhas advised was to be undertaken at two sites namely: (i) a revision thoracic decompression of the exiting nerve root on the left side at T10/T11; (ii) a lumbar decompression at L3/L4.

9. On the day of the consultation Mr Minhas completed some paperwork in order to include Mr Malik on his waiting list for an urgent operation.

10. The proposed surgery took place on 13 August 2015. No criticism is made of the quality of the surgery performed by Mr Minhas but regrettably the outcome for Mr Malik was to render him significantly worse off. His previous symptoms were not improved, he suffered a paraparesis and would be wheelchair dependent for the remainder of his life.

The trial

11. At [16] of his judgment the Judge set out the allegations of breach of duty as particularised in the Particulars of Claim namely:

> "(1) Mr Minhas failed to recognise that the pain was of neuropathic origin rather than radicular;
>
> (2) he failed to make any adequate attempt to identify or differentiate between those causes of pain and its location or origin;
>
> (3) he failed to discuss/recommend alternative treatments including pain management and/or appropriate injections for diagnosis/treatment;
>
> (4) in recommending surgery he failed to limit (or advise about the relative risks/benefits of limiting) such surgery to the lumbar spine;
>
> (5) he failed to counsel the claimant adequately or at all as to the risks of surgery and all alternatives;
>
> (6) he failed to ensure that the claimant had provided full and complete consent to surgery before listing him for a complex procedure;
>
> (7) the defendant failed to complete the surgical consent form adequately with all of the risks of the surgery;
>
> (8) the defendant failed to explain adequately the risks as set out on the form, so the claimant was unaware that the surgery could cause a spinal cord injury up to complete motor and sensory paralysis;
>
> (9) the defendant failed to prepare the consent forms legibly so it was clear to the claimant what the risks were;
>
> (10) the defendant failed to obtain adequate consent, such that any risks that were discussed was conducted in haste, without a period of 'cooling off', so that consent could not be freely given because he was by then committed to surgery."

12. At [17] the Judge recorded that:

> "It is then pleaded that the injury sustained as a result of the August 2015 surgery would not have occurred if he had not undergone multilevel surgery and he should have recovered at least to the level of function he had a year earlier after the previous surgery."

13. At [18] the Judge noted the development of the case at trial and identified the 'principal matters' for determination as follows:

> "As the case developed at trial the principal matters for my determination essentially emerged as follows:-
>
> i) was the claimant complaining of terrible intercostal pain on 13 July 2015 when he visited Mr Minhas' clinic?
>
> ii) if he was, how long had he been suffering from it?
>
> iii) if he was, would a responsible body of competent and reasonable neurosurgeons have concluded that a significant proportion of that pain was radicular in nature and caused by compression to the left sided T10/T11 nerve root?
>
> iv) if so, would a responsible body of competent and reasonable neurosurgeons have offered revision surgery at that location in the light of its reasonably and competently assessed potential benefits and risks?
>
> v) even if they would, were there reasonable alternatives to surgery which, in the light of their respective benefits and risks, no responsible and reasonably competent neurosurgeon would have omitted to offer to the claimant?
>
> vi) was the offer of surgery (and, if established, any reasonable alternatives which should have been offered) adequately explained to the claimant in terms of its benefits and risks so as to obtain his informed consent to the surgery performed?
>
> vii) if a breach of duty has been proved on the balance of probabilities, applying the appropriate legal test, has the claimant also established that the negligence caused his injury and loss?"

14. The Judge observed that the case turned principally on the resolution of questions of fact. He stated at [8]:

> "In large part (although not exclusively) it depends upon what was said when the claimant visited Mr Minhas' outpatients' clinic on 13 July 2015. It requires me to consider what Mr Malik was saying he was suffering from, diagnosis of the causes of those complaints, the reasonable treatment alternatives which were available for the diagnosed conditions, and the explanations given to Mr Malik of the respective benefits and risks of any such reasonable treatment alternatives so that he

> could make an informed choice before consenting to the treatment which Mr Minhas advised."

15. As the Judge recognised, the evidence of Mr Malik and Mr Minhas fundamentally conflicted in many respects. Each had provided a witness statement and given oral evidence. The material differences included whether or not Mr Malik's condition was deteriorating in the first quarter of 2015, what Mr Malik was told of any risks of the proposed surgery and what information he was given as part of the consenting process to the procedure by Mr Minhas' assistant surgeon (who was not called as a witness) prior to the completion of the written consent form on 13 August 2015. The consent form records the proposed procedures as being that of a revision thoracic laminectomy (……intercostalgia) plus lumbar laminectomy (…… L3/4). The intended benefits were to "Improve intercostalgia symptoms" and to "Improve leg symptoms…". The serious or frequently occurring risks included bleeding, infection, CSF leak, spinal cord/nerve damage, leg weakness, sensory disturbance, bladder/bowel/sexual dysfunction, GA risk.

16. As to the disputed area of a complaint by Mr Malik of left sided pain in his ribs or abdomen at the outpatient appointment on 13 July 2015 Mr Minhas stated that: "… Had he not had that pain, there would be no need to particularly go into the previously operated area at T10/11." The description given was consistent with intercostalgia starting at the back of the chest and ribs and extending over to the abdominal surface. The symptoms married up with what was shown on the MRI scan of nerve root compression. Mr Minhas accepted that Mr Malik had not been complaining of this pain when he saw him on 27 April 2015.

17. At [57] the Judge records the evidence of Mr Minhas that "… even though the intercostalgia was a recent symptom, the severity of it was such that the patient was desperate to have something done about it and couldn't manage as he was." When challenged on the issue of giving Mr Malik only one option Mr Minhas replied:

> "I think it was the only realistic option because, as we have discussed, we can't go through nerve root injections as being something that is going to help with this. Pain management pathways and trying to go down the route of chronic high dose analgesia with opiates and things, again, didn't seem a prospect. So, the two options, basically, in front of us were do we operate on his disc, and the lumbar spine obviously because he still getting the symptoms on his leg; or do I just turn him away, say we are not going to operate, give it time, see if it will settle."

Mr Minhas said that in one sense Mr Malik had had a trial of conservative therapy in the months before the operation.

18. At [74] the Judge identified the claimant's case as being that Mr Malik did not give his informed consent for revision surgery. The Judge stated that: "It is argued that his adverse outcome is the result of not being informed of alternative treatments which he could, and would, have chosen in preference to surgery if he had been told properly of the risks of this surgery and the scale of its potential benefits. Thus, it is argued, his injuries from unsuccessful surgery have been legally caused by the defendant's negligence."

Findings of fact

19. For reasons set out at [84] the Judge stated that he did not have confidence in the reliability and accuracy of Mr Malik as a witness. At [85] he found Mr Minhas to be "an impressive, cogent and convincing witness when describing the conditions Mr Malik was voicing in July 2015."

20. The Judge's findings are set out at [86] – [95]:

> "86. However, that said, when considering all of the relevant evidence and giving it the weight it was due, the claimant was not able to persuade me on a balance of probabilities that he was not complaining of very serious and debilitating intercostalgic pain when he visited Mr Minhas' outpatient clinic on 13 July 2015.
>
> 87. It is not possible to say exactly how long the claimant had been suffering that terrible pain, but it was clearly acute and demanded some speedy intervention for its relief. It could not have been going on for more than a couple of months.
>
> 88. The expert evidence in the case led me very firmly to the conclusion that a responsible body of competent and reasonable neurosurgeons would have concluded that a significant proportion of Mr Malik's intercostal pain was radicular in nature and caused by compression to the left sided T10 nerve root. His symptoms tallied entirely with the very clear MRI scan images of the nerve root being interfered with. Whilst some of the pain could have been neuropathic from spinal cord damage as Mr Minhas reasonably acknowledged, it was entirely reasonable for him to conclude that a significant proportion of the pain was likely to be radicular from compression of the T10 nerve root because of its later onset and its reported path around and into the abdominal dermatome.
>
> 89. I am quite satisfied that a responsible body of competent and reasonable neurosurgeons would have offered Mr Malik revision surgery at the T10/T11 level of his thoracic vertebrae in July 2015. In my view Mr Minhas reasonably and competently assessed the potential benefits and risks of undertaking that procedure. I accept Mr Minhas' evidence that he gave appropriate advice to Mr Malik both of the types of risk that can result from such surgery but also of the general order of magnitude of that level of risk by using adequate comprehensible language. The process of ensuring the defendant had the consent of Mr Malik to the operative procedures was in my view quite properly confirmed by the completion of an adequate consent form signed by the claimant when he attended the hospital for his operation in August 2015.

90. As to whether Mr Malik should have been advised by Mr Minhas of alternatives, I find that analgesia had been tried at increasing levels. Mr Malik had indicated previously that he was not keen on trying to mask his pain with medication (he had expressed a desire to reduce a prescription); he did not like some of the side- effects he had experienced (constipation); and he was not keen on becoming dependent on some of the stronger drugs. It was reasonable for Mr Minhas to conclude that offering stronger analgesia would simply be avoiding confronting the identified acute problem and would fail to secure the benefits which Mr Malik was desperate to seek to achieve.

91. I am not persuaded on the balance of probabilities that it was negligent for Mr Minhas not to discuss with Mr Malik his logical opinion about the pointlessness of putting the claimant on a long waiting list for a complex thoracic nerve root injection. That procedure had inherent risks of its own, would extend the period over which Mr Malik would suffer from terrible pain and, once administered, was most unlikely to provide anything but some possible short-term pain relief if anything.

92. Similarly I am not persuaded that it was negligent for Mr Minhas not to discuss a pain treatment strategy with Mr Malik as an alternative. I find that Mr Malik was desperate for Mr Minhas' intervention. He was in terrible pain and wanted a curative solution which was not going to involve pharmacology or long-term pain management.

93. Whilst the leading case of *Montgomery* identifies that there is a duty to take reasonable care to ensure a patient is aware of any reasonable alternative treatments (because an adult is entitled to decide for themselves which, if any, of the available forms of treatment to undergo and thereby give their informed consent to an interference with their bodily integrity), in the circumstances of this case I consider that a responsible, competent and respectable body of skilled spinal surgeons would have reasonably concluded that there were no reasonable alternative treatments available in the context of the parameters and discussion that the claimant had with Mr Minhas.

94. Even if I had been persuaded that the defendant had been negligent in any of the pleaded particulars, which on the evidence which I have heard I am not so persuaded, I would not have found that any negligence was causative of the injuries which the claimant has suffered. As Mr Todd the claimant's neurosurgical expert accepted, surgical intervention was a reasonable course to advise given the available evidence. Mr Malik had experience from the previous year of how uncertain the outcome of surgery can be.

> 95. The claimant has not satisfied me on a balance of probabilities that he would have declined the offer of having surgery in August 2015 if an injection (or any of the other mooted options) had been explained to him by Mr Minhas, with what were Mr Minhas' perfectly respectable opinions as to their respective risks and chances of providing any desired benefit. Equally I am not satisfied on a balance of probabilities that Mr Malik would have sought another opinion or delayed making his decision. He wanted to have this surgery in order to relieve him of his terrible pain and he wanted it quickly. Mr Minhas assessed him appropriately, advised him adequately and pursued the claimant's wishes."

The law

21. There was no issue between the parties at trial nor before this court as to the relevant law. *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 583 at 587 identified the test for the assessment of negligence in the clinical practice of diagnosis and treatment as follows:

> "… [a doctor] is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in this particular art.... a man is not negligent … merely because there is a body of opinion that would take a contrary view."

22. In *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] AC 1430 the Supreme Court recognised the autonomy of the patient in respect of decision making. At para 81 Lord Kerr and Lord Reed observed that social and legal developments point away from a model of the relationship between the doctor and the patient based on medical paternalism. The developments point towards an approach to the law which treats patients, so far as possible, as adults who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices. At paras 82, 83 and 87 it was stated:

> "82 In the law of negligence, this approach entails a duty on the part of doctors to take reasonable care to ensure that a patient is aware of material risks of injury that are inherent in treatment. This can be understood, within the traditional framework of negligence, as a duty of care to avoid exposing a person to a risk of injury which she would otherwise have avoided, but it is also the counterpart of the patient's entitlement to decide whether or not to incur that risk. The existence of that entitlement, and the fact that its exercise does not depend exclusively on medical considerations, are important. They point to a fundamental distinction between, on the one hand, the doctor's role when considering possible investigatory or treatment options and, on the other, her role in discussing with the patient any recommended treatment and possible alternatives, and the risks of injury which may be involved.

> 83 The former role is an exercise of professional skill and judgment: what risks of injury are involved in an operation, for example, is a matter falling within the expertise of members of the medical profession. But it is a non sequitur to conclude that the question whether a risk of injury, or the availability of an alternative form of treatment, ought to be discussed with the patient is also a matter of purely professional judgment. The doctor's advisory role cannot be regarded as solely an exercise of medical skill without leaving out of account the patient's entitlement to decide on the risks to her health which she is willing to run (a decision which may be influenced by non-medical considerations). Responsibility for determining the nature and extent of a person's rights rests with the courts, not with the medical professions.
>
> ……
>
> 87 The correct position, in relation to the risks of injury involved in treatment, can now be seen to be substantially that adopted in *Sidaway* by Lord Scarman, and by Lord Woolf MR in *Pearce* [1999] PIQR P53, subject to the refinement made by the High Court of Australia in *Rogers v Whitaker* 175 CLR 479, which we have discussed at paras 77—73. An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it."

23. As to causation, the appellants rely upon the authority of *Chester v Afshar* [2005] 1 AC 134 which represents a narrow modification to the conventional "but for" test of causation in respect of cases where there has been a breach of duty by a clinician in advising of the risks of a proposed course of treatment. *Chester* identified the issue of causation as being addressed by reference to the scope of the doctor's duty to advise the patient of the disadvantages or dangers of the treatment proposed, as such a duty was closely connected with the need for the patient's consent and was central to the patient's right to exercise an informed choice as to whether and if so when and from whom to receive treatment. On the facts of *Chester* the injury sustained by the patient was "intimately involved" with the duty to warn. Lord Hope at para 87 held that: "the duty was owed by the doctor who performed the surgery that Miss Chester consented to. It was the product of the very risk that she should have been warned about when she gave her consent." That being so, Lord Hope held that that: "it can be regarded as having been caused, in the legal sense, by the breach of that duty."

Grounds of appeal

24. It is the appellants' contention that the Judge was wrong in law:

    1) At [89] to hold that a responsible body of competent and reasonable neurosurgeons would have offered Mr Malik revision surgery at the T10/T11 level of his thoracic vertebrae in July 2015 in the absence of any enquiry or knowledge about the duration of his associated pain.

    2) At [90] – [93] to hold that Mr Malik had been made aware of reasonable alternative treatments and had given informed consent to the above surgery.

    3) At [94] and [95] to hold that causation had not been proved.

25. Mr Stockwell on behalf of the appellants, accepted that grounds 2 and 3 were parasitic upon ground 1 and therefore if ground 1 fails so too will grounds 2 and 3.

The appellants' submissions

26. It is accepted on behalf of the appellants that the Judge's rejection of Mr Malik's evidence in favour of that of Mr Minhas is beyond challenge. It is also accepted that the Judge was entitled to find at [88] – [89] that Mr Minhas had reasonably concluded that a significant proportion of the intercostalgic pain was radicular in origin, hence potentially amenable to decompression surgery. It is undisputed that Mr Minhas did not ask how long intercostalgic pain had been present and that he did not know.

27. In essence the appellants make the following criticisms of the judgment, in that the Judge did not:

    (a) consider the failure by Mr Minhas on 13 July 2015 to ask about the duration of Mr Malik's intercostal pain;

    (b) conclude that the claimant's intercostal pain had been present for less than six weeks on 13 July 2015 and had resolved by surgery on 13 August 2015;

    (c) have regard to the failure to establish the duration of the intercostal pain when analysing the offer of surgery and the reasonable treatment options;

    (d) have regard to the duration of the intercostal pain when considering causation, and do so applying the principles in *Chester v Afshar* [2004] UKHL 41;

    (e) accurately summarise, place appropriate weight upon, or give reasons for his approach to the evidence of the pain experts.

Ground 1

28. It is the appellants' case that the recommendation for surgery by Mr Minhas, in the absence of enquiry as to the duration of the intercostalgic symptoms, represented a clear *Bolam* breach and an enquiry that was relevant but omitted as part of a *Montgomery* compliant consenting process as Mr Minhas had not given full and informed advice as a result of which Mr Malik was not in a position to provide properly informed consent. Further, the duration of the symptoms was relevant to the issue of alternative treatments.

29. The appellants rely on the authority of *Wisniewski v Central Manchester Health Authority* [1998] PIQR, a clinical negligence case, in which the Court of Appeal stated that in certain circumstances a court may be entitled to draw adverse inferences from the absence or silence of a witness who might be expected to have material evidence to give on an issue in an action. Brooke LJ, at page 340, stated that the following principles can be derived namely:

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

30. The appellants criticise the Judge for failing to address this authority and for failing to draw an adverse inference in respect of the evidence of Mr Minhas and his failure to ask a question as to duration of pain.

31. The appellants contend that the court is compelled to hold the respondent liable absent any finding as to the duration of the intercostalgic pain or a finding that terrible intercostalgic pain was still present on 13 August 2015 because a patient who receives negligent advice and whose consent is then procured for surgery based on that negligent advice is not less deserving of protection in law than the claimants in *Chester* or *Montgomery*.

Ground 2 - Failure to advise about alternative treatments or to obtain informed consent

32. The appellants' case is that alternative treatment options were available e.g. to wait and see if the pain persisted, steroid injections, pain management services, undertaking the L3/L4 decompression which, given the evidence of the pain experts must be regarded as reasonable alternative or variant treatments within the compass envisaged in *Montgomery*. Mr Minhas should have told Mr Malik that the pain might resolve spontaneously and, if not, that other conservative options might bring improvements in themselves.

33. Alternatively the Judge at [92] – [93] erroneously imported the *Bolam* test into what should have been a strict *Montgomery* analysis. The respondent's experts had agreed

that alternatives to surgery should have been discussed with Mr Malik even if they differed in their view as to the prospects of success.

Ground 3 - Causation

34. The appellants submit that if the court finds that it cannot determine what Mr Malik would have done if properly informed of the risks of the procedure, the court should place Mr Malik in the same category as Mrs Chester in *Chester v Afshar* following which the breach will be established even though the patient was unable to say what s/he would or would not have done had the correct advice been given.

The respondent's submissions

35. A Respondent's Notice addresses the appellants' primary point that the Judge erred in not addressing the allegation that there was a negligent failure by Mr Minhas to ask Mr Malik about the duration of his intercostal pain on 13 July 2015. The respondent contends that this allegation was not set out in the Particulars of Claim or in the Reply, further it was not put to Mr Minhas in cross examination. It was not suggested to him that without knowledge of the duration of the pain, a surgeon could not reasonably have proceeded with surgery. The point put to Mr Ivanov (the appellants' neurosurgical expert), was that it would be reasonable for a neurosurgeon to ask about the duration of the symptoms, the issue was not taken further in cross examination. It was not suggested to him that without knowledge of the duration of the pain, a surgeon could not reasonably have proceeded with surgery. The only point finally put to the neurosurgical experts was that it would be reasonable for a neurosurgeon to ask about the duration of the symptoms. At trial the Judge appeared to rule that this allegation was not properly before him and thus did not deal with it in his judgment.

36. The respondent contends that for a case to be advanced on appeal which is not put to a surgeon in a claim for professional negligence is unfair because:

    (i) it was not suggested to Mr Minhas that failure to obtain a history of the duration of the pain was a breach of duty. Had it been, he may have been able to explain why it was not a breach of duty referring to literature or the severity of the pain or the fact that calcification was present which made spontaneous resolution far less likely;

    (ii) it was not suggested to Mr Minhas that failure to obtain a history vitiated his ability to offer the surgery;

    (iii) it was not put to Mr Minhas that duration of the pain is relevant to the prospects of spontaneous resolution or pain relief or the prospects of success of alternative treatments. The court does not know what he would have said had these issues been put.

37. The omission is also unfair to the Judge who is now criticised for failing to make a finding on an issue which was not before him.

38. Further, the Judge's finding that the pain could not have been going on for more than a couple of months represented the agreed evidence of the experts save that Mr Ivanov (the respondent's neurosurgical expert) was of the view that it might have started as

early as March 2015. The Judge did not expressly conclude that the intercostal pain had not resolved by 13 August 2015 but it can be inferred that it was his conclusion as it was the only conclusion open to him on the evidence. The respondent contends that the Judge's finding as to duration was one he was entitled to make upon the evidence.

39. As to duration of pain, it is the respondent's case that the Judge's finding of fact meant that Mr Malik was aware that the reason for surgery was the severe intercostal pain, he was aware that the re-operation at the thoracic level was to ameliorate the intercostal pain. The consent form referred explicitly to intercostal pain. It referred to pain at two levels such that Mr Malik must have been aware that one of the surgical sites was to ameliorate the intercostal pain. Had that pain resolved between 13 July and 13 August 2015 it is inconceivable that Mr Malik would not have reported that fact following which the surgery would not have taken place. At a GP appointment on 28 July 2015 it was noted that Mr Malik's analgesia had doubled, the implication being that the pain had worsened.

40. The issue of alternative treatment was addressed by the Judge [90] – [93]. It reflected the evidence of the neurosurgical experts. As to the criticism of the Judge that he failed to address the evidence of the pain experts, the respondent contends that this was a neurosurgical case.

41. In any event, the appellants' claim must fail on causation as there is no good evidential basis for the assertion that, having regard to the unchallenged conclusions of the Judge on causation, with different advice based on the duration of the intercostal pain, the claimant would not have undergone surgery on 13 August 2015.

Discussion

42. The appellants' primary focus in this appeal has been the failure by the Judge to address the issue of the failure by Mr Minhas to ask Mr Malik on 13 July 2015 how long he had been suffering with intercostalgic pain.

43. The difficulty for the appellants is that the failure of Mr Minhas to ask this question was not a pleaded Particular of Negligence. It was not an issue raised with the neurosurgical experts prior to trial, as a result neither addressed the absence of the question, nor any consequence of the omission, in their reports nor in their joint statement. It was an allegation that was not put to Mr Minhas in cross examination, as a result he was given no opportunity to address the issue which the appellants now elevate to the core of this appeal.

44. The importance of pleading the specifics of a case was identified by Rimer LJ in *Lombard North Central PLC v Automobile World (UK) Ltd* [2010] EWCA Civ 20 at para 75 as follows:

> "It remains a basic principle of our system of civil procedure that the factual case the parties wish to assert at trial must ordinarily be set out in their statements of case ('pleadings'). That is not a principle based on mere formalism. It is essential to the conduct of a fair trial that each side should know in advance what case the other is making, and thus what case it has to meet and prepare

> for. It is the function of the pleadings to provide that information."

45. The importance of pleadings carries particular weight in clinical negligence claims which can be complex and are dependent on expert evidence. The pleaded allegations of negligence will form the basis of the instructions to the relevant expert, who will then prepare a report. This will be followed by a meeting(s) of experts, the agenda for which will reflect the pleaded particulars.

46. The appellants' advisers would have seen from an early stage of proceedings the letter which Mr Minhas wrote following the consultation on 13 July 2015 (para 7 above). Within the letter, Mr Minhas provided no information as to the duration nor as to the onset of the intercostalgia. Further, in his witness statement, Mr Minhas does not state that he had knowledge of the duration or onset of the pain. Upon the basis of these documents, it would appear that Mr Minhas did not have such knowledge. It follows that if Mr Malik, and his legal advisers, intended to rely upon an allegation that there was a negligent failure by Mr Minhas to ask Mr Malik about the duration of the intercostal pain, it was necessary to plead that allegation in the Particulars of Claim and this was not done.

47. At trial, it was during the cross examination of Mr Minhas that the following exchange took place:

> "Q. … Let me come on next, if I may, please, to the duration of this intercostalgia; did you ask the claimant when it had commenced?
>
> A. So, no, again, if you recall, I had seen him in April. At that time there was not any concern about this. It had obviously come on since then. I had not made any comment about how long it is, but more that it is something that has come on since that time."

48. Given the acceptance by Mr Minhas that he had not asked the question as to the duration, if there was to be a challenge that the question should have been asked on 13 July 2015, this was the time to attempt take it. Further, if there was to be alleged a negligent failure to ask about the duration of the intercostal pain, and to do so in the terms now relied upon for the purposes of this appeal, fairness required that an attempt to put this allegation to Mr Minhas should have been made so as to give him the opportunity (absent any objection that the allegation was not pleaded) to respond and explain why he had not asked the question. This was not done.

49. The first time the duration of the intercostal pain was raised with an expert was during the lengthy re-examination of Mr Todd, the claimant's neurosurgical expert. He stated:

> "…...the intercostalgia was much more recent. We are not entirely sure when it started, but it may have been present for a couple of months. … it was something of some weeks, a couple of months maybe, of intercostalgic pain. The natural history of radicular pain in general is that it improves. So a watch and wait policy for intercostalgia was an option because there was a

> chance of it getting better. But, as Mr Minhas has said, and others, and I don't disagree with this, the pressure is on the surgeon to do something if the pain is severe.
>
> Severe disabling pain is a pressure not to watch and wait, but to do something. So, there would be those two tensions: severe pain, yes, but short lasting pain also.
>
> … the probability of pain improving – intercostalgia due to compression improving in this patient was less than radiculopathy generally…
>
> I think, on the balance of probabilities, it would not have resolved.
>
> I think the probability of it resolving was of a lowish order. I think it is very difficult to say. I would probably have said about 30 per cent chance of it resolving, 70 per cent not. But others will have their own view, and I would not necessarily disagree with slightly different figures."

50. As to the offer of surgery in respect of the pain, during the same re-examination Mr Todd was asked:

> "… was it reasonable to offer surgery if intercostalgia was a new complaint, where the surgeon had no information or had not asked about how long that complaint had been present for?
>
> A. Clearly, if his Lordship finds that pain had been present for a very short time, you said a day or a week, then that would not be an indication for surgery, particularly not this revisional surgery.
>
> Radicular pain typically improves, from whatever cause. Because there is nerve root swelling … That swelling can settle down or the pathology can get better, but not -- as we said, probably not this pathology. So, with a short lasting period of radicular pain, the radicular pain could have improved spontaneously.
>
> We have said already that the chance of that happening, because it was a calcified disc osteophyte is less, but the chance of it happening is greater the shorter the period of radicular pain. So, if it is a day or two, or three or four, there was a very good chance of it settling. If it was three months, much less so.
>
> Q. Second question going on from that is: if a surgeon was going to offer surgery for radicular pain of recent onset, would it be appropriate for a surgeon to offer that surgery at that appointment without there being a further review?"

51. When this second question was asked an objection was raised on behalf of the respondent namely that both questions raised allegations that were not pleaded, and in

any event, if they were going to be raised with the witness, they should have been raised by way of examination in chief rather than by way of re-examination. In response the Judge ruled as follows:

> "I have just reviewed the notes I have made of the route you have been following in this part of your re-examination. I am of the view, I am afraid, that this is a new departure from your pleaded case. I think we need to move on to the next topic."

52. The duration of the intercostal pain was subsequently raised during the cross examination of Mr Ivanov, the respondent's neurosurgical expert. He was asked: "...when Mr Minhas gave evidence yesterday, he agreed that he had never asked the claimant about when the symptom of intercostalgia had come on...Do you consider that to be acceptable?" An objection was raised on behalf of the respondent that that was an allegation that was not pleaded. The Judge responded: "I think...it has to be relevant to the option of taking no action, and not going on to Mr Barnes's concern that there should have been some further review appointment. But one of the options that we are having to consider is that whether the doctor says: well, live with it. See how we go. So I will allow you to ask the question."

53. Later in his evidence Mr Ivanov stated that in his opinion Mr Malik had symptoms of intercostalgia prior to the consultation on 13 July 2015. He believed that Mr Malik's attendance at A & E in March 2015 was consistent with the pain as a result of compression of the intercostal nerve. Mr Ivanov agreed that, intercostalgia being first reported as a new symptom on 13 July 2015, a reasonable neurosurgeon, before deciding whether to offer surgery for that symptom would want to know for how long it had been present. He stated that it would be right to ask about the duration of these symptoms, it being important to understand the source of the pain. Mr Ivanov continued:

> "In our scenario, we had a different situation. We had a pain which was – in my opinion it was there for a longer time, but it was documented in July. If the pain – I presume this pain was not there just on the first day when it was documented; I am presume [sic] this pain was before the claimant was seen by the surgeon. It was just documented on that day, but it would be unusual for this pain to develop on the day of being seen by a medical professional….
>
> In our scenario, we had a patient with calcified severe compression on the nerve root and this patient already had treatment with strong analgesia for the previous year.
>
> Various options have been explored, in my opinion, and I don't think there were many other alternatives available. So, considering that these imaging findings, which are concordant with the pain in that area, were there for some time, it was reasonable to offer surgery as an option that will give a very good chance of improvement of the symptoms of pain in that area….

> The duration of pain is important… We should distinguish between the pain which has a very good chance of improvement and the pain which has not such a good chance of improvement with 'wait and see' or conservative management.
>
> So, if we accept that the pain -- if the court were to accept that the pain started on the day when the claimant was assessed by the surgeon, then I think it will be a rush to offer the surgery before giving some more time to have another alternative. But, in my opinion, this pain did not start on the day when the claimant was assessed by the surgeon. In my opinion, it was there before and, in my opinion, it was reasonable to offer the surgery at that time because the other treatment options probably had been exceeded [sic]."

54. Mr Ivanov was asked, if the pain had developed since 27 April 2015, whether he would agree with the evidence of Mr Todd that "it may have been present for a couple of months …. some weeks." He confirmed that he would. As to the resolution of the pain Mr Ivanov stated: "...symptoms may get better or spontaneously. But, in my opinion, with the calcified disc and severe compression, this chance would be much smaller than another situation when you have a soft disc...I would not give a specific number to this...".

55. The Judge made two rulings in respect of questions as to the duration of the intercostalgic pain. As to the first: was it reasonable to offer surgery in the absence of a question as to the duration of the pain? The Judge knew that the Particulars of Claim did not allege a negligent failure by Mr Minhas to ask the claimant about the duration of his intercostal pain. At [16] of the judgment he sets out the Particulars of Negligence. It follows, and I find, that the Judge was correct to rule that the allegation that there was a negligent failure to ask Mr Malik about the duration of his intercostal pain was a departure from the pleaded case and thus was not properly before the court. Not only was the allegation not pleaded in the Particulars of Claim, it had not been put to Mr Minhas in cross examination which basic fairness required. In the circumstances, I do not accept that the Judge can fairly be criticised for not addressing this allegation in his judgment in the context of the reasonableness of the advice as to surgery. The Judge did allow the question as being relevant to the issue of alternative treatment.

56. The Judge addressed the issue of whether it was reasonable for Mr Minhas to offer surgery which required the Judge to make findings as to the duration of the pain. The Judge's finding at [87] that the intercostalgic pain lasted no longer than a couple of months is not challenged by the appellants. The appellants submit that a "long stop" of two months does not mean that the pain was present for longer than one day, a week or a month. As to that, it was the evidence of the neurosurgical experts that a complaint of intercostal pain on 13 July was unlikely to represent pain which had begun on that day. The clear sense of their evidence was that the pain preceded the consultation on 13 July. Mr Todd stated that the pain may have been present for a couple of months, Mr Ivanov agreed. This was the evidence of the neurosurgical experts which was accepted by the Judge.

57. As to the appellants' contention, that the Judge did not make a finding that the pain had not resolved on 13 August 2015, that is correct but, in my view, it was the only

reasonable inference to be drawn from the evidence. Mr Malik had been told that the purpose of one part of the surgery in August 2015 was to alleviate his intercostal pain. He was "desperate" to have the surgery because of the severity of the intercostal pain. If that severe pain had resolved, it would be reasonable to expect and thereafter infer that Mr Malik would have mentioned this to the consenting surgeon on 13 August 2015. Moreover, the absence of resolution of the pain is consistent with the evidence of the neurosurgical experts, namely that the presence of the calcified compression on the nerve root militated against spontaneous resolution. I am satisfied that the finding as to the duration of pain by the Judge reflected the evidence of fact contained in the unchallenged evidence of Mr Minhas and the opinion of the neurosurgical experts.

58. The appellants do not challenge the Judge's acceptance of the evidence of Mr Minhas. At [87] the Judge found that Mr Malik had been suffering from "terrible pain" that was "clearly acute and demanded some speedy intervention for its relief". The acute nature of the intercostalgic pain and its effect upon Mr Malik was evidence given by Mr Minhas.

59. In his letter to the GP following the 13 July 2015 consultation (para 7 above) Mr Minhas stated in respect of surgery: "Mr Malik is desperate to have this done as soon as possible and I will aim to admit him within the next three weeks…". In his witness statement (para 6 above) Mr Minhas stated that: "Mr Malik was desperate to have the surgery as soon as possible as I recall the intercostal pain was severe and causing him particular difficulty". This evidence provided the basis for the Judge's finding that the pain was "clearly acute" and demanded some speedy intervention for its relief.

60. It is of note that both neurosurgical experts took account of the severe nature of the pain in arriving at a view as to the reasonableness of the surgery. Mr Todd observed that if the pain is severe "the pressure is on surgeon to do something". He stated that "severe disabling pain is a pressure not to watch and wait, but to do something." Mr Todd thought that the probability of the pain improving was of lowish order, difficult to say but about thirty per cent. It was the evidence of the neurosurgeons which provided the basis for the Judge's finding at [89] that a responsible body of competent and reasonable neurosurgeons would have offered Mr Malik revision surgery at the T10/T11 level of his thoracic vertebrae in July 2015.

61. In making the findings of fact as to the duration of pain the Judge did not refer to the authority of *Wisniewski* upon which Mr Malik's counsel relied at trial in support of his contention that an adverse inference should be drawn as to the duration of the pain. Applying the principles set out by Brooke LJ (para 29 above), relevant to the third principle is the fact that there must be some evidence on the relevant issue before the court is entitled to draw such an inference. The evidence before the Judge was indicative of the fact that the pain had not risen acutely on 13 July 2015 and the fact that Mr Malik consented to the surgery on 13 August 2015 was evidence that the pain had not resolved by that time. In the circumstances the Judge cannot be criticised for any failure to draw a *Wisniewski* inference and find that the pain was of less than six weeks duration.

62. For the reasons given, and subject to the views of Lady Justice King and Lord Justice Coulson, I would dismiss this ground of appeal. Notwithstanding the appellants' acceptance that grounds 2 and 3 are parasitic upon ground 1, I will address them.

Ground 2

63. The Judge dealt with the issue of alternative treatment at [90] – [93]. Having made a finding as to the duration of the pain, I am satisfied that the Judge's findings reflected the evidence of the neurosurgical experts in respect of alternative treatment (paras 50 - 55 above). Asked about the alternatives to surgery, Mr Ivanov expressed the view that in his opinion as a spinal surgeon, the options had been exhausted. The dose of the analgesia had reached its maximum, other analgesics had been offered and declined by Mr Malik. Despite the pain killers Mr Malik was still experiencing pain. The point being made by Mr Ivanov was that analgesia can mask these symptoms as a result of which a patient will feel slightly better but it will not represent a return to a pain free scenario which would be expected in 70% of cases with surgery. The purpose of the decompression surgery is to relieve/remove the pain.

64. Further, it was the evidence of the neurosurgeons, rather than that of the pain experts, which was central to the issue of whether it was reasonable for Mr Minhas to offer Mr Malik surgical treatment as opposed to alternative treatments. It was for the neurosurgeons to assess the nature and degree of the intercostal pain and what surgery conducted by a neurosurgeon could offer in terms of resolution. The Judge did refer to the evidence of the pain experts but in my view correctly focused on the evidence of the neurosurgeons in respect of this aspect of the case as theirs was the appropriate knowledge and experience.

65. I do not accept the appellants' contention that the Judge's approach to the issue of alternative treatment represented a 'gloss' upon the authority of *Montgomery*.

66. I accept the contention of the respondent that *Montgomery* draws a distinction between two aspects of a clinician's role, namely an assessment of treatment options (*Bolam*) and an assessment of what risks and treatment should be explained to the patient because they are material (*Montgomery*). The distinction between the two roles of the clinician is contained within the judgment of *Montgomery* at para 87 where it is stated that: "the doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments." I accept that "reasonable" in respect of the assessment of alternative or variant treatments encapsulates the *Bolam* approach. As to material risks, that is the element of materiality which is to be judged from the perspective of the patient i.e. *Montgomery*. In my judgment it is for the doctor to assess what the reasonable alternatives are; it is for the court to judge the materiality of the risk inherent in any proposed treatment, applying the test of whether a reasonable person in the patient's position would be likely to attach significance to the risk. Thus the Judge at [93] was correct to apply *Bolam* and to conclude that his assessment reflected the guidance set out in para 87 of *Montgomery*.

Ground 3

67. There is no challenge to the finding of fact that the Judge made, namely that Mr Malik "wanted to have this surgery in order to relieve him of his terrible pain and he wanted it quickly". Further, Mr Malik did not give evidence that he would have had elected to defer or reject surgery if told something different about the prospects of success due to the duration of the pain. The Judge expressly rejected the claimant's case that if other options were explained to Mr Malik he would have declined the offer of surgery or

sought a second option or would have deferred surgery. There is no evidential basis supportive of the appellants' arguments upon the issue of causation.

68. For the reasons given and subject to the views of Lady Justice King and Lord Justice Coulson, I would dismiss this appeal.

Lord Justice Coulson:

69. I agree.

Lady Justice King:

70. I also agree.