



Neutral Citation Number: [2021] EWHC 1913 (QB)

Case No: QB-2019-000039

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 12/07/2021

Before :

HIS HONOUR JUDGE BLAIR QC
Sitting as a Deputy Judge of the High Court

Between :

MUKHTAR MALIK	<u>Claimant</u>
- and -	
ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	<u>Defendant</u>

David Knifton QC and Matthew Stockwell (instructed by **Stewarts Law**) for the **Claimant**
Matthew Barnes (instructed by **Bevan Brittan LLP**) for the **Defendant**

Hearing dates: 15-19 March 2021

APPROVED JUDGMENT

I direct that pursuant to CPR PD 39A para 6.1 no official recording shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

Covid-19 Protocol: This judgment was handed down remotely by circulation to the parties' representatives by email and release to Bailii. The date for hand-down is deemed to be on 12th July 2021.

His Honour Judge Blair QC :

A. Introduction and Background

1. The claimant, Mr Malik is now aged 48 and has had a history of spinal problems which began to emerge symptomatically in the Spring of 2012 when he first attended his General Practitioner for pain, leg weakness and altered sensation. Over the next 2 years his difficulties with walking and pain fluctuated - at times having to use two crutches, sometimes one, and at other times none. From time to time he was prescribed analgesia to manage pain. He was significantly overweight which did not help.
2. Matters deteriorated in the early summer of 2014. His legs were so weak he couldn't carry things, he started to feel sharper pain in his left leg. He had been stumbling a little, but this developed into ever more frequent falls, which even led to him becoming fearful of getting out of bed. In July that year he was urgently referred for MRI scans. He says he had been pressing his GP for 2 or 3 months because he was in such a bad way. However, his pain and lack of mobility became so bad that he called an ambulance on 14 July 2014 and was taken to the defendant's accident and emergency department.
3. MRI scans were then obtained and they disclosed two highly concerning areas of his spine – 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').
4. He agreed to undergo emergency spinal surgery which was performed by Mr Minhas, a consultant neurosurgeon working for the defendant. This involved a laminectomy and discectomy to decompress the spinal cord at T10/T11 where it was severely compressed.
5. Whilst the surgery was executed without criticism and the spinal cord was successfully decompressed at that location, the claimant's recovery was slow and incomplete. He had suffered neurological damage and experienced ongoing numbness and weakness of his left leg.
6. Some of the precise detail of the claimant's health in the months after he was discharged from hospital on 6 August 2014 is the subject of dispute. Records show that he was seen by his GP practice in February 2015 when it was noted he was awaiting news on having lumbar surgery. On 1 March 2015 he visited the defendant's A&E department having twisted his back. He saw his GP again later in March 2015.
7. On 27 April 2015 he saw Mr Minhas, his surgeon, at an outpatients' clinic. Mr Minhas ordered further MRI scans to consider whether the claimant needed further surgery. The further scans were undertaken on 9 May 2015; the claimant visited his GP later that month; and then on 13 July 2015 he visited Mr Minhas again so as to review the MRI scans.
8. This case turns principally on the resolution of questions of fact. 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, Mr Minhas' 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.

9. Mr Minhas advised further surgery be undertaken at two sites, namely:
(i) a revision thoracic decompression of the exiting nerve root on the left hand side at T10/T11; and (ii) a lumbar decompression at L3/L4. Mr Minhas filled out some paperwork that day in order to put the claimant on his waiting list for an urgent operation to those areas.
10. The surgery took place a month later on 13 August 2015. Whilst, again, there is no criticism about the quality of Mr Minhas' surgery or the defendant's post-operative care, very regrettably the outcome for the claimant was to render him very significantly worse off than he had been before. He now suffers from what is called T7 AIS D incomplete paraparesis, confining him for the most part to life in a wheelchair.
11. The evidence of Mr Malik and Mr Minhas conflicts fundamentally in very many respects. I have read their witness statements with great care and observed their oral evidence during the course of the trial. It has been necessary to assess their credibility in connection with the material differences between their respective accounts. This assessment has in some respects been aided by reference to contemporaneously recorded notes and correspondence to reveal the accuracy of their recollections; by the internal consistency (or otherwise) of their accounts; by the internal logic of their explanations; and observing the manner and content of their responses to questions challenging their evidence.
12. The trial has been conducted on-line over 'Microsoft Teams' with counsel and all witnesses appearing remotely. Happily we were not troubled or affected by any significant technical difficulties and, whilst in some ways it has perhaps been a more intensive experience for the participants than would have been the case had the trial been conducted in a conventional court room, I have not consciously found that it has adversely affected my ability to assess the witnesses and their credibility. Regular breaks were held throughout the 5 day trial every 60 to 90 minutes and I took care to ensure that the claimant in particular felt that he had been able to express himself as he had wished, given the pain and disability from which he suffers.

B. The Law

13. There is no real difference between the parties as to the relevant law to be applied in this case. The test for assessing negligence in the clinical practice of diagnosis and treatment derives from the case of *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 583 at 587:

“...he 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.”

The test was analysed further in *Bolitho v City and Hackney Health Authority* [1997] UKHL 46; [1998] AC 232, where consideration was given to a court’s role in deciding the standard of care required of a professional when a judge is unpersuaded of the logical force of one of the bodies of expert opinion presented during a trial. The House of Lords concluded that if a body of expert opinion is incapable of withstanding logical analysis then it would not be a ‘responsible’, ‘competent’, ‘reasonable’ and ‘respectable’ body of opinion. It would likely be a rare case indeed where a court can be satisfied that one body of genuinely held clinical opinion cannot be logically supported, but if that were its conclusion then it would be obliged to reject their contrary view. A helpful summary of these principles (and some extremely useful guidance for a judge faced with differing expert opinions) is set out in the judgment of Green, J. (as he then was) in *C v North Cumbria University Hospitals Trust* [2014] Med. L.R. 189, to which both parties invited my attention. In this case I was invited by each party to the proceedings to reject aspects of the expert evidence presented by the other party. I have applied the guidance of Green, J. at paragraph 25 of the above case when making my assessment of whether or not to accept disputed expert opinions, considering whether they are logical and reasonable and whether they are representative of the views of a responsible / competent / respectable body of experts in their fields of practice.

14. In the context of a clinician recommending a particular treatment, the Supreme Court has made clear in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] AC 1430 that a doctor is under a duty to take reasonable care to ensure a patient is aware of any material risks involved, and of any reasonable alternative or variant 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. A material risk in a particular case is one where a reasonable person in the patient’s position would be likely to attach significance to the risk, or where the doctor was (or should be) aware that this particular patient would be likely to attach significance to that risk (paragraph 87). A risk cannot be reduced to simple percentages because its significance is not only one of magnitude, but is fact-sensitive and sensitive also to the characteristics of the patient. It involves of a variety of factors including the nature of the risk, the effect its occurrence would have on the life of the patient, the importance to the patient of the benefits sought to be achieved, the alternatives available, and the risks involved in those alternatives (paragraph 89). The doctor must provide comprehensible information which the patient can reasonably be expected to grasp (paragraph 90). It is the doctor’s responsibility to explain to his patient why he considers that one of the available treatment options is medically preferable to the others, having taken care to ensure that his patient is aware of the considerations for and against each of them (paragraph 95).
15. The law of causation involves a conventional ‘but for’ test: so that a claimant is entitled to be compensated for negligence where he proves on a balance of probabilities that, but for the negligence, he would not have sustained the damage of which he complains. This applies in a straightforward way to negligent diagnosis or treatment. However, for reasons of legal policy, a narrow modification to the conventional principles of

causation has been established in cases where there has been a breach of duty in advising of the disadvantages or dangers of a proposed treatment. Where the injury actually sustained fell within the scope of that duty to advise and warn of risks and as a result of a breach of that duty the patient had not been able to exercise an informed choice as to whether and, if so, when and from whom to receive treatment, then causation may be established even if the patient may later have gone on to exercise an informed choice to accept the recommended treatment – *Chester v Afshar* [2004] UKHL 41; [2005] 1 A.C. 134.

Lord Hope stated at paragraph 87:

“The injury was intimately involved with the duty to warn. The duty was owed by the doctor who performed the surgery that Miss Chester consented to. It was the product of the very risk that she should have been warned about when she gave her consent. So I would hold that it can be regarded as having been caused, in the legal sense, by the breach of that duty.”

In that case (see paragraph 39) the trial judge had found that the defendant consultant neurosurgeon had not given adequate or proper advice about the risk of nerve damage possibly resulting in paralysis and that, despite the claimant’s requests for information about such risks, she was given to understand in effect that there were none. The trial judge also found that had she known of the actual risks of the proposed surgery she would not have consented to the operation taking place when it did but would have sought a further opinion before deciding what to do.

C. *The issues*

16. The pleaded negligent breaches of duty in the Particulars of Claim are that:
- (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.

17. 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.
18. 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?

D. The relevant evidence of fact

19. I will begin with the procedures surrounding the claimant's initial surgery. In his served written statement Mr Malik had said he did not recall having been told of the risks of surgery and the consent form was simply handed to him by a nurse at the hospital. However, in his oral evidence Mr Malik accepted when cross-examined that when he underwent emergency surgery in July 2014 an assistant/associate doctor (Dr McEvoy) took him through a consent form and he was told there was a risk of paralysis from the operation. He accepted he was shown the consent form, said he did not read it all word by word, but he knew the gist of what he was signing. His explanation for the change in his account was that his memory must have become mixed-up with what happened just before the July 2015 elective surgery, when a nurse did simply hand him a consent form to sign in a waiting room and he was not warned of the risks of the planned surgery.

20. After a break in cross-examination Mr Malik asked to clarify something and sought to explain that all the discussion about paralysis with Dr McEvoy before the operation in July 2014 had involved him being told he would be paralysed if he did not have the operation and “...*it wasn't ever in my mind that this operation can cause the paralysis*”. He denied changing his evidence to try to help his case and explained that in working from his memory of events six or seven years ago there will be a few mistakes which might occur.
21. When undertaking the consent form process Dr McEvoy appears to have filled in the section headed ‘*Serious and frequently occurring risks*’ with a number of potential things that can go wrong. These are likely to be shorthand for the actual verbal discussion, but in this instance they read: “*weakness, numbness, stroke/paralysis, death, CSF leak of, failure of treatment, anaesthetic complications, unforeseen complications*”. The form was signed by Mr Malik.
22. Mr Minhas said in his witness statement that after the operation he informed Mr Malik that he was unable to remove all of the disc that had been causing his problems and he might therefore need additional surgery in future.
23. Mr Malik said in his witness statement that after the surgery in July 2014 he realised just how bad his situation was when it took him 3 weeks to be able to walk again and then only with a Zimmer frame. He was dragging one leg after the other and it took him 4-6 months to learn to walk again, first with two crutches, eventually with one crutch and then, towards November 2014 (which was in fact only about 3 months post-discharge), he was able to walk short distances to the car or local shops unaided, albeit still with a limp and an awkward gait. He was in constant pain so he could not walk far, he needed to stop after about 100 yards and found the pain would return immediately when getting up to walk again. He described the pain being more or less the same as it had been pre-surgery.
24. The hospital discharge summary dated 5 August 2014 describes him as having been made redundant from his previous job in customer services with a well-known national bookmaker; it advised that he required community rehabilitation; and noted he was on paracetamol for pain relief. Although he was due to see Mr Minhas in a clinic 12 weeks later that did not happen, probably due to miscommunication and a change of his address.
25. His GP notes next record him attending their surgery on 20 February 2015 noting a history of back pain, previous thoracic surgery and his awaiting news about having lumbar surgery. It goes on to read: “*now pains in left lower back and saciatic (sic) nerve irritation doctor in family gave him pregabalin, which he has been taking for 2 weeks with some improvement. No urinary or bowel symptoms – got quite constipated on painkillers before.*” He was prescribed the analgesics Co-codamol and Pregabalin (an epilepsy drug which is also used to treat nerve pain). Those GP notes include: “*has follow up with surgery due if painkillers not helping return for review warned re symptoms of cauda equina.*” When cross-examined Mr Malik would not accept that his pain was getting worse at that time.
26. The hospital A&E department recorded that Mr Malik attended on 1st March 2015 complaining of severe back pain. He had tripped on a pavement, held onto a wall, twisted his back and had lumbar pain “+++”. In discussing suitable analgesia he told

the hospital that Tramadol does not suit him, he declined Diazepam, but was given Co-codamol and Ibuprofen. Mr Malik seems to have put this incident down in his witness statement as having happened on 1st May 2015, but I regard that as a simple mistake of no significance.

27. Mr Malik recalled in his witness statement having gone to the clinic at the hospital to ask for an appointment; he was tired and fatigued; he had pain down his left leg which made him out of breath; and it required him to stop every few steps. Nevertheless, since his first operation he had been able to get up and walking and even managed to walk the 3 or 4 streets from his brother's house to the hospital.
28. He explains in his witness statement that the reason for going back to see Mr Minhas "*was to get better.*" He also says it was "*to ask what other options or suggestions he might have for me to improve*" but it was not specifically to ask for surgery. An appointment was fixed for 27 April 2015.
29. On 13 March 2015 at a further visit to the GP he was prescribed Amitriptyline at night – an anti-depressant which can assist with getting to sleep. In cross-examination Mr Malik said the pain wasn't getting any worse, it was quite bad anyway. He was having some very good days and some really bad days which is why he attended and the doctor then suggested this additional medicine.
30. An assessment of Mr Malik by a paramedic was undertaken by ATOS Healthcare on 31 March 2015 for the purposes of his entitlement to the state benefit of Personal Independence Payment. It records that he had last worked in February 2014. "*He is still managed by his specialist who he is seeing next month to find out if he requires further surgery to another area of spinal cord compression in the future. He says that he still complains of pain in his lower back, left arm and left hip and an altered sensation in his left leg. He has regular falls to the left still, the last one was a couple of weeks ago. He takes daily pain relief and he says that this helps for a little while. He has good and bad days, he is always in pain but 2 out of 7 days are better than others...He says that he is unable to stand for more than 4 minutes maximum...*" It states that he reported being unable to stand for long enough in front of a mirror to shave and that he always used a crutch for walking, which enabled him to move for more than 20 metres but no more than 50 metres. When it was put to him in cross-examination that this picture appears to show a worsening of pain and a deterioration in his condition in the first quarter of 2015 Mr Malik disagreed. He stated his condition was not progressively getting worse and worse, but he wanted to be in a better condition than he was.
31. Describing his clinic appointment with Mr Minhas on 27 April 2015 in his witness statement, Mr Malik said: "*I told Mr Minhas that I was now deteriorating rather than improving*". He also explained in his witness statement (paragraph 25) that he couldn't walk properly and was unable to sit for a long time as he would tire and get lower back pain. His leg and back still felt numb and he had weakness in the left leg. He was struggling to bathe, dress, go to the toilet and walk without a crutch. He had sciatic pain down his left leg from his hips down to his toes. He had periods of constipation and occasional incontinence.
32. Despite it being repeatedly put to him in cross-examination that his health was deteriorating and he had said in his own witness statement that in April he told Mr

Minhas he was deteriorating, Mr Malik would not accept that that was the case. He insisted that he had always been in a bad way anyway, with things being “70% bad” and he had not been improving. He disagreed that the records of his prescribed medication over time indicated a deterioration in his pain or that his accounts of his maximum walking distance appeared to be reducing. Finally, when he was asked if his brother had been wrong to say in his witness statement: “*As Mukhtar’s condition was deteriorating following his surgery we made an outpatient appointment to see Mr Minhas...*” the claimant replied, “*No, he’s not wrong.*”

33. In re-examination Mr Malik said that by the time he visited Mr Minhas in April 2015, although he kept a crutch with him because it was handy to steady himself and he didn’t have 100% confidence in his ability to walk, he was nevertheless able to walk short distances unaided. He said that he walked about a kilometre to his brother’s address on a couple of occasions in about May/June 2015 with a lot of breaks and only carrying a crutch for reassurance, and he walked from his brother’s address to the hospital for his August 2015 operation which was 3 or 4 streets away, about two to three hundred metres.
34. Mr Minhas’ account of the 27 April 2015 clinic visit in his witness statement describes Mr Malik having made gradual progress, particularly in the power in his legs, but his recovery remained incomplete with numbness, paraesthesia and pain down his left leg. In fact his and Mr Malik’s accounts of the ongoing reported physical difficulties correspond closely. Mr Minhas says he told him that the L3/L4 stenosis, visible in the 15 July 2014 MRI scans, was a possible contributing cause of his symptoms in his left leg, together with the incomplete recovery from the spinal cord compression. Therefore, he ordered further MRI scans so as to see if further surgery was required and to check the spine, particularly at thoracic level.
35. The MRI scans were taken on 9 May 2015 and a radiologist provided a report in respect of them on 11 May 2015. It says that there was no signal change shown within the spinal cord at the site of the T10 laminectomy. (That is not the view of the experts who commented in evidence to me upon these MRI scans, when they pointed out to me apparent signal change indicating some permanent neurological damage.) Among observations made about other noticeable degenerative changes at the locations of the following vertebrae: T9/T10, L1/L2, L2/L3, L4/L5 and L5/S1, the radiologist reported that at 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.*” Also, in relation to L3/L4 he said: “*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.*”
36. On 17 May 2015 Mr Malik says he had an episode of urinary incontinence when at a fast food restaurant with his children. This had happened a few times at home so he made an appointment to see his GP the next day. The medical records of that visit refer to him needing a repeat prescription of Pregabalin (he had previously been prescribed 150mg capsules to be taken twice a day) but that Mr Malik was trying to wean himself off its use. They say that since seeing his consultant in his clinic in April “*symptoms have not deteriorated but not improved, patient has long standing paraesthesia, suffers*

from occasional incontinence...” He was advised to seek urgent medical advice if his symptoms worsened

37. With this background, Mr Malik attended Mr Minhas’ clinic for a consultation to discuss his MRI scans and the way forward on 13 July 2015. They each claimed to have independent recollections of the meeting. Mr Minhas chose not to keep contemporaneous notes during his consultations, but instead made it his practice to dictate a letter to the patient’s GP straight afterwards, so as to record what had transpired and the decisions that had been made. He conceded that if he was running behind in his appointments he would carry out this task as soon as he had a moment to catch up after seeing those waiting.
38. The account from Mr Malik’s witness statement is that by this time in mid-July he was suffering some leg weakness, sciatic pain down his left leg and a stabbing/burning pain in his lower back, but that there had been a huge improvement and he was able to move around without a stick. He did not tell Mr Minhas that he was experiencing pain around his chest or abdomen or the front of his body; Mr Minhas asked no questions about that area. The only pain discussed was lower back pain and leg pain.
39. Mr Malik recalls being shown the MRI images but could not understand them; he found it very difficult to see what was being referred to since the images were moving on the screen. He was not physically examined. Whilst he accepts that he was not surprised by Mr Minhas’ suggestion of lumbar decompression surgery at L3/L4 because that had been raised as a possibility the previous summer, Mr Minhas told him he would also revisit the thoracic spine. He says that Mr Minhas told him that his spinal cord needed further space and that this meant he would require investigative/corrective surgery to resolve the problems he was experiencing with walking.
40. As to any risks of surgery, Mr Malik says that he was given no indication as to any potential adverse outcome. He was not told he could be paralysed, nor of anything else that might go wrong. Had Mr Minhas warned him of a risk of paralysis he would never have had the surgery because he was at least on his feet. He would rather have suffered any risk there was of natural neurological deterioration than suffering the risk of it from surgery.
41. Mr Malik recalled mention by Mr Minhas of the surgery being 50:50, but he thought that meant there was a 1 in 2 chance of it improving his condition. He did not think it meant that there was a chance of being made worse by surgery. Had he known that, he would not have undergone surgery.
42. As to any discussion of options for alternative treatments, there was none. He says in his witness statement that had any alternative non-invasive alternatives (such as pain management, injections or physiotherapy) been offered to him he would have taken them rather than pursue surgery.
43. Mr Minhas’ account is quite different. In his witness statement he says that when he saw Mr Malik at his outpatient clinic on 13 July 2015 the claimant was experiencing terrible pain from the left side of his back with left sided intercostalgia, as well as the ongoing left sided sciatic pain all the way down his leg and into his foot. He says Mr Malik was very keen to deal with this and states: *“It was my view 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. It was therefore my view that there was dual pathology...neuropathic pain from the spinal cord as well as possible neuropathic or radiculopathic pain from the nerve root compression. The intercostal pain was particularly severe and concerning.”

44. His witness statement explains that his view was that it was worthwhile considering a further decompression at the thoracic level to alleviate the intercostal symptoms and a decompression at L3/L4 to resolve the left leg symptoms. He says: “*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.*” He says that if Mr Malik had only had the leg pain he would not have been inclined to operate urgently and been happy to wait several months to see if the leg pain would improve further; arranging surgery within a month reflected the seriousness of the symptoms and Mr Malik’s eagerness to have the surgery. Ordinarily an operation would be planned within two or three months.
45. As to non-surgical alternatives Mr Minhas says in his statement that nerve root injections were not a realistic treatment option as there can often be a wait of up to 6 months and typically the effects only last for a limited period of a few weeks or so. In this case he says the severity of the compression as demonstrated on the MRI scans and the pain and discomfort experienced by Mr Malik meant the clinical and radiological picture presented a more dire situation than one where nerve root injections might potentially have been considered as an alternative.
46. Mr Minhas explained that his invariable practice is to dictate a letter to the patient’s GP straight after the consultation. An external service provider then types-up the letter for him to check before signing and then it is sent. In this case the letter is dated 21 July and states: “*...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.*”
47. Mr Minhas says that the time stamp entered by the transcribers next to the word intercostalgia in that letter was something he remembers being asked to confirm as correct, which he did, because he recalled Mr Malik’s appointment and that specific complaint. It led to his secretary resending a perfected copy of the letter by fax to the GP.
48. Under cross-examination it was suggested to Mr Minhas that Mr Malik did not complain of any left-sided pain in his ribs or abdomen at the outpatient clinic appointment of 13 July 2015. Mr Minhas answered: “*I can be quite clear on my recollection that he did have that pain. Had he not had that pain, there would be no need to particularly go into the previously operated area at T10/11.*” Mr Minhas said he pressed Mr Malik as to where the pain was going around to and the description given was consistent with intercostalgia, starting at the back of the chest and ribs and extending over to the abdominal surface. He said he deliberately used that specific

word as one to describe the particular pain which was being described. Those symptoms married-up with what was shown on the MRI scan of nerve root compression, which therefore enabled him to be reasonably confident that this was the cause. It was less likely to be the spinal cord causing the problem, although not impossible, because of its later onset and its distribution. He agreed that Mr Malik had not been complaining of this pain when he saw him on 27 April 2015, but insisted that he was on 13 July 2015.

49. When Mr Minhas was cross-examined as to how one might distinguish between neuropathic pain and radicular pain - from damage to, or compression of, the intercostal nerve root, he explained that it is very difficult to know how much is coming from which. This led him to comment on what one does to manage a patient who has both. He said it was very difficult to progress unless you treat what can be treated surgically, namely the radicular pain. Surgery can be enough to help relieve enough pain to enable meaningful use or improvement in quality of life. He said there are very few other options available and none of those other things (e.g. a pain management pathway, physiotherapy, a spinal cord stimulator) can happen until you have actually treated the underlying surgical pathology and said: "*We have nothing else to do. This is how the patient is.*"
50. He dismissed the suggestion that he should have advised a diagnostic nerve root injection because of the severity of Mr Malik's pain, the urgency of sorting things out (given the delay that would have been involved), the continuing uncertainty of whether a failure to relieve the pain might simply have been from an ineffective administration of the injection, and because there is an additional special risk of damaging an artery supplying the lower part of the spinal cord which in 75-80% of people accompanies the T10 nerve root. He said such an injection might provide a little bit more supporting evidence in an equivocal scenario, but that in this case the symptoms and the scan were not equivocal. Whilst it might be nice to have some further reassurance, he speculated that his colleague consultant radiologist would ask "*why aren't you going to get on and operate on him, because he has an appropriate distribution of his pain and we have a lesion on the nerve?*" Mr Minhas concluded it wasn't a realistic possibility because it would give no longer lasting benefit and would take time to organise.
51. Mr Minhas did not accept that the August 2015 revision surgery to the T10 nerve root attracted a level of risk of adverse consequences of the order suggested to him by the claimant's counsel. He said that the percentages being suggested to him were ones for different kinds of operation than this. In August 2015 he was not operating proximal to the spinal cord (as he had been in August 2014) but was coming alongside the spinal cord. The fact that he had to approach through scar tissue makes it difficult and slower, but the scar tissue was not in and amongst the spinal cord and nerve roots, so that factor doesn't increase the risks. He explained that the post-operative MRI scan shows he achieved nerve root decompression by means of removing the disc alongside but not directly on the spinal cord itself.
52. Mr Minhas regarded serious neurological injury or complications from this procedure to be a rare occurrence; in his 25 year experience as neurosurgeon he thought it very rare - something that might happen every 5 or 6 years or so. (Overall he said he undertakes 250 neurosurgical operations of all kinds in a year.) The sort of complications he had in mind were injuring the nerve, or there being a sufficiently bad post-operative blood clot which compressed the spinal cord that was not relieved in

time. He said in his view the risks were certainly less than 1% but he would not use percentages or frequency figures with patients; instead his standard expression to his patients is to say: “*it is rare, it is unlikely to happen, but if it does it can be a very significant thing*”.

53. Mr Minhas agreed that he did not discuss non-surgical treatments with Mr Malik. He said the pain being described to him was of a nature (“*terrible*”) that Mr Malik was desperate to have something done about it. Just waiting to see if it will get better was not an available option.
54. He did not consider injected nerve root blocks were going to help Mr Malik for the reasons he had already given. Whilst accepting they were statistically less risky than surgery, he said that the benefit of ever being able to get the patient better also has to be weighed against the risks. Repeated nerve injections into a left T10 nerve root were not likely to be the thing that was going to sort out Mr Malik’s problems. Mr Minhas would have reservations about wanting to inject that particular nerve root and, in his view, applying an electrical stimulation to that area would be contra-indicated.
55. He considered that pain specialists were not going to suggest undertaking a complex pain management programme whilst there was a surgical alternative available to Mr Malik which may provide him with some long-term benefit; the entry point for pain specialists is when nothing can be done surgically.
56. His response to the suggestion of trying a differently constituted regime of analgesic medications was to comment that Mr Malik had already tried some significant doses of painkillers and escalating this approach has more significant side-effects. He observed that the tide has very much turned against this sort of approach because patients have an increased mortality from being on these sorts of medications long-term. Also they actually provide very little benefit long-term. Again he considered that embarking on that approach to try to make the symptoms more tolerable would only be appropriate after exhausting other avenues – in this case taking the surgical option first.
57. He reiterated 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 about only giving Mr Malik one option he 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.*” In one sense he said that Mr Malik had had a trial of conservative therapy in the month before the operation.
58. In further cross-examination about the risks, Mr Minhas said he told Mr Malik that he felt surgery was likely to help, but Mr Malik had to be aware that there was still a possibility it may not. He specifically recalled showing Mr Malik the MRI scans and Mr Malik asking about the risks of the surgery. Mr Minhas said he told Mr Malik that he didn’t think this was going to be as risky as the first operation, but there is no operation on the spine without risk, there is always the possibility. It was not as high a risk as from the first operation but of course there was still a risk, as there is with any

operation on the spine. Mr Minhas did not believe he told Mr Malik that there was a 50:50 chance of the surgery providing an improvement, other than probably just to say that he thought it was most likely that it would be helpful. In his view a sensible evaluation of the probability of the planned surgery providing an improvement would have been two-thirds likely.

59. When asked if he voiced explicitly a risk of paralysis, Mr Minhas said the risk was less than in the 1st operation and whether you call it weakness, or numbness or paralysis, he believed Mr Malik understood that very well because of his experience over the preceding months. He admitted that he normally states the risks in his clinic letter and on this occasion erroneously did not.
60. When Mr Malik attended on 13 August 2015 for the operation Mr Minhas said that his assistant surgeon completed the formal consent form. That person did not give evidence at trial. The form is filled in in handwriting to say that the health professional conducting the consent process explained the intended benefits of the procedures as: *“Improve intercostalgia symptoms Improve leg symptoms”*. Also the following handwritten ‘serious or frequently occurring risks’ are noted: *“bleeding, infection, CSF leak, spinal [?] / nerve damage (leg weakness, sensory disturbance, bladder/bowel/sexual dysfunction) GA risk”*.
61. In re-examination about advising patients at clinics about the risks of surgery Mr Minhas confirmed his witness statement that he invariably explains there is always a risk of neurological deficit – muscle weakness, numbness, effects on the bladder or bowels, or even complete paralysis. He added that he tends to use the term that it is potentially something that could cause paralysis or complete paralysis from the waist down.
62. Another inconsistency emerged in the evidence of Mr Malik in relation to his explanations about signing consent forms at the defendant’s hospital before the surgeries in 2014 and 2015. His written statement asserted that in 2014 he did not recall anyone telling him about the risks of surgery but was simply given a filled out consent form by a nurse ready for him to sign. This featured in the section of his statement dealing with that emergency surgery in 2014. Under cross-examination he initially said he was simply handed the consent form to sign without discussion. Ultimately he conceded that Dr McEvoy undertook the consent procedure with him in 2014 and said he must have confused himself between what happened in 2014 and 2015 because it was such a long time ago. Going through the different risks listed in the consent form for 2014 Mr Malik claimed to be able to remember which of the risks were mentioned to him and which were not. In the context of these inconsistencies I am simply unable to accept Mr Malik’s evidence as reliable in relation to the alleged failures in the consenting process at the hospital in either of 2014 or 2015. His brother gave some evidence about being with the claimant when he went for surgery in 2015 but that evidence did not displace my conclusion that on the balance of probabilities the process of obtaining his signed consent to surgery at the hospital in 2015 was competently and properly done and done so in an informed manner.
63. Before turning to the expert evidence, the defence drew attention to the fact that in his letter before claim on 2 May 2019 the claimant said he was unable to return to work after the July 2014 surgery. However, in his Particulars of Claim almost a year later (30 April 2019) on which he signed the ‘statement of truth’, it was pleaded that he

“returned to employment in customer services at Ladbrokes”. He also signed a ‘statement of truth’ on his preliminary Schedule of Loss, which states: “*The claimant was able to return to work following his 2014 surgery but to date has been unable to return to work following the 2015 surgery due to his injury.*” When questioned about this change Mr Malik explained that this was simply a mistake.

64. His first witness statement, signed on 26 January 2020, continued to misstate the position where it reads: “...*I returned to work at Ladbrokes in around September or October 2014, following the operation in July 2014, where I continued to work until around June 2015.*” This was corrected in a supplementary witness statement dated 8 July 2020. In his supplementary statement he refers to the defendant’s request to see records from the Department of Work and Pensions. He explains how he then reviewed these, as well as his bank statements, which showed he was not working between his two surgical operations. He describes it as an inadvertent mistake; he had become confused about the timing of events; when he signed his first statement he had been through a difficult time with the death of his father and had just returned from Pakistan where he had been providing support to his mother following her bereavement. In cross-examination he insisted that there was certainly no intention to deceive.

E. The relevant expert evidence

65. I pay tribute to the very evident care and industry invested in presenting this case by the expert witnesses who were relied upon by the parties. Their reports and their answers to questions were clearly and helpfully expressed. Although I summarise their evidence succinctly in this judgment I have paid detailed attention to the entirety of their work.
66. Mr N V Todd, a Consultant Neurosurgeon and Spinal Surgeon was called for the claimant. Although no longer involved in clinical practice, he has vast experience and is active as an expert in this field and in publishing papers. He did not criticise the execution of the surgery undertaken by Mr Minhas on either occasion, but focussed his attention on the issues which I have distilled in paragraph 18 above.
67. Needless to say, it is common ground that if the claimant did not complain to Mr Minhas of terrible intercostal pain in July 2015 there would have been no basis for him to undertake revision surgery the following month.
68. Although Mr Todd had made something of a point in his written evidence about Mr Minhas over-hastily reaching a conclusion that the intercostal pain (which Mr Minhas says was being described to him) was likely to be from radicular compression, nevertheless, in his oral evidence, Mr Todd appropriately modified his view and acknowledged that one cannot always confidently distinguish between radicular and/or neuropathic pain. In fact he accepted that it was reasonable for Mr Minhas to have concluded from the claimant’s history and MRI scans that the pain (allegedly) reported to him was more radicular than neuropathic. He also accepted that a contribution of radicular pain can be an indication for surgery.
69. In Mr Todd’s opinion it was necessary, in the situation presented by the claimant, for a surgeon to discuss in general terms the quantification of the chances of the proposed

surgery providing a benefit. He insisted that the surgeon must give his patient some kind of quantification of the chance of his pain improving, if only to give him a very broad range within which it might be.

70. There is a factual dispute about what kinds of potential risks from surgery were explained to the claimant in the 'consenting' process, but there was also a difference of expert opinion as to the quantification of the potential risk of an adverse outcome from the revision surgery. Mr Todd gave very different evidence from that of the Defence as to the magnitude of adverse risks from this kind of revision surgery. In this context I was unimpressed by Mr Todd's evidence. I do not accept that he chose an accurate comparator as a statistical basis for his opinion as to the correct level of risk in this operation. More surprisingly still he set about constructing an argument of risk levels based on making unjustifiable assumptions derived from the evidence given by Mr Minhas as to the overall number of operations he had conducted and the occasions when there had been an adverse outcome.
71. Mr Todd's expert evidence also significantly parted company with that called by the defendant in relation to his view that it was necessary for the surgeon essentially to enter into an express discussion about his knowledge and opinions as to all theoretically available alternative treatments and their respective efficacy and benefit.
72. Mr Todd maintained that there were 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. These, in his opinion, potentially included injections of steroids/local anaesthetic to the nerve root, both as a diagnostic tool to check if any intercostalgia was radicular in nature from compression of the nerve root, but also to relieve pain. He considered that there was the potential for the greater use of analgesia whilst waiting to see if things improved. In addition he considered that a pain management strategy should have been discussed and offered as an alternative.
73. Each of these suggested alternatives was examined in detail. A consideration of pain management was assisted by the evidence (for the claimant) of Dr Jonathan Valentine, a Consultant in Pain Medicine. He opined on the diagnostic use of injections and on a number of pain management methodologies including nerve root injections, pulsed radio frequency therapy, TENS machines, and prescribed medications. Whilst he had a view as to the efficacy of each, he readily acknowledged that it is unlikely that medication, or other palliative rather than curative approaches, as a primary treatment, would have resulted in a satisfactory long-term outcome, as long as Mr Malik believed thoracic spinal surgery to be the only long-term approach to successfully addressing/managing his ongoing pain problems.
74. In the light of Mr Todd's expert opinions and upon the findings of fact which I am asked to make, the claimant's case is that Mr Malik did not give his informed consent to the revision surgery. 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.

75. Mr Marcel Ivanov, a Consultant Neurosurgeon and Spinal Surgeon who works at the Royal Hallamshire Hospital in Sheffield, was called on behalf of the Defence. It is his view that if Mr Malik was complaining of severe intercostal pain (and he observed there would be no reason for Mr Minhas to have referred to a non-existing symptom), in his opinion it was likely to be caused by the radicular compression of the intercostal nerve root at the T10/T11 level in the light of the history and scans.
76. The description of Mr Malik suffering from severe pain (“*terrible pain*”) would, in his opinion, have been quite disabling and incapacitating. His interpretation of the medical notes is that it was deteriorating over time and Mr Malik was not responding to the documented strong (and increased dosage of) analgesia. In his view, alternative conservative treatments had been ineffective and therefore it was reasonable to offer surgical decompression of the nerve root, which the MRI scan shows was compressed.
77. Moreover, the disc herniation was calcified, so that any injection with steroids into that area would usually provide only transitory benefits, if any, lasting for between a few days to a few months. His evidence is that although some spinal surgeons would try an injection first, another perfectly reasonable group would consider it as causing an unnecessary delay in a curative procedure because a calcified disc compression will persist. Given that Mr Minhas’ experience at his hospital was that there may be up to a 6 month wait for this more challenging type of thoracic injection to be administered, which would not be curative, and with ongoing terrible pain in the meantime, Mr Ivanov concluded that it was reasonable to offer surgical decompression. His view is that surgery could be curative in 70-80% of cases.
78. As to the question of whether to mention spinal injections to the patient, Mr Ivanov considered it questionable as to whether that was logical in the above circumstances, even though he accepted some surgeons would consider it good practice. His experience was that most reasonable patients would not opt for an injection in these circumstances and would not feel aggrieved if not informed, especially where surgery would ultimately occur in any event and spinal injections have their own risks.
79. He said the choice of a treatment has to be balanced against the intensity of the patient’s symptoms, potential expected benefits and the possible risks of each treatment. He observed that it is quite common for pain to be poorly controlled or not controlled at all, even with strong analgesia. Further, the patient may suffer side effects or intolerance to analgesia, or may not want to have long-term treatment with medicines. This was not a case in which the symptoms appeared to be being well controlled by conservative treatments and in his view a reasonable body of surgeons would have offered the surgical decompression which Mr Minhas did.
80. In terms of the risks of revisional surgery he agreed that they were higher because of fibrous adhesion from scar tissue. He agreed that the patient should be informed about the expected benefits and risks of surgery, as well as those benefits and risks for any alternative treatment options and, indeed, for no treatment at all. It was his opinion, on a review of the documentary evidence, that the claimant was sufficiently informed about the purpose, benefits and types of risks of the revision surgery.
81. Dr Sanders, a Consultant in Anaesthesia and Pain Medicine, gave evidence for the defendant. He concluded that pharmacological strategies for Mr Malik were limited

and in his opinion there were no unexplored ones at the relevant time that were likely to result in either an improvement in pain or in function.

82. Dr Sanders said that injections for such pain is controversial because there is very little evidence of improvement in either pain or function beyond some short-term benefit, whereas they give rise themselves to known risks of temporarily worsening symptoms, causing permanent nerve injury and even paralysis. He said that amongst Consultants in Pain Medicine it is unlikely they would be considered with enthusiasm.
83. He explained that techniques involving physiotherapy, occupational therapy and pain psychology, are generally employed at the conclusion of interventional management (particularly surgery) and it would be reasonable not to offer them until that stage in order to maximise their potential benefit. Patients tend not to engage with these approaches until they accept they face long-term pain, which they do not do if they are aware that there is a potential surgical cure. It was his opinion that in July 2015 there were no pain treatment options available which would have been likely to have resulted in any significant long-term reduction in levels of pain or improvements of function.

F. Assessment of witnesses and findings of fact

84. Even giving Mr Malik considerable latitude for the difficulties of recall after so many years, the stress of giving evidence in a trial, his ongoing poor state of health and a natural desire to present his case in the best light, there were elements of his answers which I have summarised above which did not give me confidence in his reliability and accuracy as a witness. His oral evidence differed markedly in places from his served witness statements; his oral insistence that his pain and mobility were not worsening in 2015 over the months before his second operation was contrary to the served witness statements of him and his brother. That stated position at trial was also inconsistent with reasonable inferences to be drawn (and which I do draw) from the contemporaneous records indicating increasing attention being focussed on the prescribing of pain-relieving medication and increases in dosage. Whilst the radically different positions he presented during the preparation of his case about his employment status has been explained as an error which was not intended deliberately to deceive – for which I give him the benefit of doubt, it nevertheless displays an inattention to a matter of important detail which casts further doubt upon his reliability as an accurate witness.
85. Mr Minhas explained the reasons for retaining something of an independent recollection of important aspects of his outpatient meetings with Mr Malik. I found him to be an impressive, cogent and convincing witness when describing the conditions Mr Malik was voicing in July 2015 when he was reviewing the MRI scans which had been newly obtained. I was taken aback by his practice of simply dictating a letter to his patient's GP after an outpatient clinic appointment to relate the details of his patient's current symptoms, recording his clinical assessment, giving his opinion as to appropriate treatment(s), but omitting to state what advice he has given about the risks and benefits of the avenue(s) open to the patient. That is a practice which it seems to me is fraught with risks of being unable confidently to answer important questions many years later without having the benefit of a contemporaneous set of detailed notes.

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 intercostal 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.
96. Accordingly, I find in favour of the defendant and the claim is dismissed.