



OUTER HOUSE, COURT OF SESSION

[2019] CSOH 90

A45/14

OPINION OF LORD GLENNIE

in the cause

ALLAN ROBERT JOHNSTONE

Pursuer

against

NHS GRAMPIAN

Defenders

**Pursuer: Ms Sutherland QC; DAC Beachcroft Scotland LLP
Defender: McConnell; NHS Scotland Legal Office**

13 November 2019

Introduction

[1] The pursuer was born in January 1952. He is now 67. Since 1980 or slightly earlier he has suffered from a condition known as acromegaly, which results when the pituitary gland produces excessive growth hormone. This sometimes occurs as a result of a benign tumour in the pituitary gland. As is often the case, the pursuer's acromegaly manifested itself in acute and worsening arthritis.

[2] In 1980, in an attempt to cure his acromegaly, the pursuer underwent transsphenoidal surgery to remove a large pituitary fossa – the adjective transsphenoidal (sometimes spelt “transphenoidal” or “trans-phenoidal”) meaning that the operation was carried out by entering through the sphenoid sinus, the sinus cavity at the back of the nose.

The operation was carried out by Professor Teasdale at the Institute of Neurological Sciences at the Southern General Hospital in Glasgow. It was viewed as a success. After the operation the pursuer's pituitary function was found to be satisfactory and, for a while, the acromegaly was thought to be inactive. For many years thereafter he attended Professor Bevan at the Centre for Endocrinology and Diabetes in Aberdeen Royal Infirmary ("ARI"). His level of growth hormone (IGF-1 level) was monitored on a yearly basis. Over the years his IGF-1 levels rose; and after a few years they were generally found to be in excess of the reference range.

[3] Between about 2000 and 2004 the pursuer was prescribed medications to reduce his hormone growth but they proved ineffective.

[4] In 2004 an MRI scan performed at ARI showed an enlarged pituitary fossa filled with cerebral spinal fluid ("CSF"). No images from the scan were in evidence at the proof but it is not disputed that the scan bore to show that a tiny amount of enhancing pituitary tissue was present at the end of a normal stalk. At this time and thereafter the pursuer's IGF-1 levels were constantly in excess of the reference range, sometimes over twice the maximum level within that range.

[5] In May 2010 a review of the pursuer's condition was carried out at Professor Bevan's clinic by Dr McGeoch, a specialist registrar. Dr McGeoch gave evidence about this and other matters in which she was involved, but her evidence was non-contentious and it is unnecessary to do more than refer to her involvement in this part of the narrative. At her suggestion an MRI scan of the pituitary was performed by Dr Shona Olson, a consultant radiologist. The purpose of the scan was to see whether there was a residual mass which might be secreting growth hormone. Dr Olson reported that the scan showed a small nubbin of tissue measuring about 8 mm in diameter in the right-hand side of the pituitary

fossa. It was unchanged from the time of the previous scan. The findings were suggestive of a persistent pituitary adenoma. The nubbin of tissue was tucked in on the loop of the right carotid artery.

[6] On 16 August 2010 the pursuer's case was discussed at a multidisciplinary team ("MDT") meeting of the Pituitary Radiology Group in Aberdeen. Thereafter Professor Bevan wrote to Mr Kamel, a consultant neurosurgeon who had not been at the meeting, asking him to review the images from the MRI scan and provide an opinion on whether it was possible to use an endoscopic surgical approach to deal with the problem or whether radiosurgery would be appropriate. Mr Kamel wrote back giving his view that the area identified on the MRI scan would probably be amenable to surgery, an option which should be explored prior to radiosurgery, since radiosurgery might not be suitable.

[7] In September 2010 Mr Kamel saw the pursuer, who was accompanied by his wife, and there was a discussion about the medical problems and the options open to the pursuer. There is a very significant difference between the pursuer and his wife on the one hand and Mr Kamel on the other as to what precisely was discussed and in how much detail. That is a matter to which I shall have to return in some detail. The outcome of that meeting was that the pursuer was put on the waiting list to undergo surgery.

[8] After a couple of cancelled appointments late in 2010, the pursuer underwent surgery on 31 January 2011. Before the operation he signed a form stating that he consented to undergo the operation and that the effect and nature of the operation had been explained to him. There is a dispute as to the extent of any explanation given to the pursuer on that occasion and there is also a dispute as to whether any explanation was given on that occasion by Mr Kamel.

[9] The operation was carried out by Mr Kamel. No tumour was found, though tissue was taken for analysis during the operation. The pursuer was discharged from hospital on 4 February 2011. A few days later he became unwell. He was given DDAVP because of the development of diabetes insipidus in the days following the operation. He required hydrocortisone replacement. On 10 February 2011 he developed a severe headache and by 11 February he was experiencing neck pain. He was admitted to hospital. He was diagnosed as suffering from a post-operative leak of CSF and meningitis. The CSF leak was repaired by endoscopic surgery using an abdominal fat graft. He has been left in a condition where he will require medication for the rest of his life and now suffers from a number of other problems. It is unnecessary to say any more about these problems since the parties have reached agreement on quantum in the event of a finding of liability.

[10] A further MRI scan was performed. That scan demonstrated no change from the scan performed in 2010. Since then the pursuer's condition has been managed conservatively without further surgery.

The issue in the case

[11] The pursuer's case is that although he gave his consent to the operation being performed on him, and did so both in September 2010 and on the morning of the operation in January 2011, that consent was not given on the basis of full or sufficient information about the potential risks of the operation, the alternative treatments available and the risks attached to them, and the option of simply doing nothing. It was not true consent.

[12] The pursuer advances his case in reliance upon the decision of the Supreme Court in *Montgomery v Lanarkshire Health Board* 2015 SC (UKSC) 63. For present purposes, the ratio of

that decision can be taken from paragraph 87 of the judgment given jointly by Lord Kerr of Tonaghmore and Lord Reed JJSC, with whom the other members of the court agreed:

“... 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.”

In the present case it is argued that the pursuer was not given sufficient information to decide, on an informed basis, whether to undergo transsphenoidal surgery or whether, instead, to opt for radiosurgery (which might be described as a more intense and focused dose of radiotherapy, where a precisely selected area of tissue can be excised using ionised radiation rather than excised with a blade); and, indeed, that he was not given sufficient information about the risks of not having any treatment at all, so as to enable him to decide whether, instead of undergoing surgery of any kind, he could sensibly decide not to have any further treatment. The failings, it is said, were failings by Professor Bevan and Mr Kamel for which the defenders are vicariously liable.

[13] It will be necessary to consider the case law in a little more detail after setting out the relevant evidence and my findings of fact, but it is important to make it clear at this stage that the only criticism levelled at the defenders is in respect of the alleged failures by Professor Bevan and Mr Kamel to provide relevant information to the pursuer relative to the proposed surgery and the alternatives available to him and to ensure that the pursuer was aware of the relevant options and the risks and benefits associated with each. There is no case pled against the defenders alleging negligence in diagnosis or in the carrying out of the

surgical operation or in the treatment he received after discharge from the hospital or any other aspect of treatment. It is accepted on behalf of the pursuer that any such case would have to be distinctly pled and would fall to be approached on the basis of the law as expressed in *Hunter v Hanley* 1955 SC 200.

GMC guidance

[14] In the course of the proof I was referred to Guidance issued by the General Medical Council (“the GMC Guidance” or simply “the Guidance”). I am not sure that it advanced matters, given that the law has been authoritatively laid down by the Supreme Court in *Montgomery* and the fact that GMC Guidance was expressly referred to in the judgment in that case. However, I summarise it below for what it is worth.

[15] The relevant version of the GMC Code in force at the time came into effect on 2 June 2008. The document is headed: “Consent: patients and doctors making decisions together”. The passage headed “About this guidance” explains that the guidance in a publication called “Good medical practice”, which requires doctors to be satisfied that they have consent from the patient before undertaking an examination or investigation, providing treatment or involving patients in teaching and research, continues to apply. In the next section, entitled “How the guidance applies to you”, it is made clear that the Guidance is not and cannot be exhaustive, so doctors should use their own judgement in applying the principles set out in the Guidance to situations faced in their own practice. Serious or persistent failure to follow the Guidance will put the Doctor’s registration at risk.

[16] Part 1 of the Guidance is headed “Principles”. It emphasises that for a relationship between a doctor and patient to be effective it should be a partnership based on openness, trust and good communication. Paragraph 5 identifies a “basic model” which applies to all

cases where patients have the capacity to make decisions for themselves. That model provides as follows:

- The doctor and patient make an assessment of the patient's condition, taking into account the patient's medical history, views, experience and knowledge.
- The doctor uses specialist knowledge and experience and clinical judgement, and the patient's views and understanding of their condition, to identify which investigations or treatments are likely to result in overall benefit for the patient. The doctor explains the options to the patient, setting out the potential benefits, risks, burdens and side-effects of each option, including the option to have no treatment. The doctor may recommend a particular option which they believe to be best for the patient, but they must not put pressure on the patient to accept their advice.
- The patient weighs up the potential benefits, risks and burdens of the various options as well as any non-clinical issues that are relevant to them. The patient decides whether to accept any of the options and, if so, which one. They also have the right to accept or refuse an option for a reason that may seem irrational to the doctor, or for no reason at all. ...

[17] Part 2 of the GMC Guidance is headed: "Making decisions about investigations and treatment". It is emphasised in paragraph 8 that the doctor "should not make assumptions" about the information a patient might want or need, the clinical or other factors a patient might consider significant or a patient's level of knowledge or understanding of what is proposed. Paragraph 9 states that the doctor must give patients the information they want or need about a number of matters including (a) the diagnosis and prognosis, (b) any uncertainties about the diagnosis or prognosis including options for further investigations,

(c) options for treating or managing the condition, including the option not to treat, (e) the potential benefits, risks and burdens, and the likelihood of success, for each option, and (i) the patient's right to seek a second opinion. Paragraph 10 emphasises that the doctor should explore these matters with patients, listen to their concerns, ask for and respect their views, and encourage them to ask questions. It is emphasised in paragraph 11 that the doctor should check whether patients have understood the information they have been given and whether or not they would like more information before making a decision. It must be made clear to the patient that they can change their mind about a decision at any time. In paragraph 12 it is said that the doctor must answer patients' questions honestly and, as far as practical, answer as fully as they wish. Paragraph 18 makes it clear that the patient must be given time to reflect both before and after making a decision, particularly if the information is complex or the proposed course involves significant risks. In paragraph 19 it is stated that information should be given to patients in a balanced way; and that if the doctor recommends a particular treatment or course of action he should explain the reasons for doing so but not put pressure on the patient to accept his advice. Paragraph 26 emphasises that the responsibility for seeking a patient's consent lies with the doctor providing the treatment. It is for that doctor to discuss it with the patient. If that is not practical the responsibility can be delegated but it must be to someone who is suitably trained and qualified, has sufficient knowledge of the proposed investigational treatment and understands the risks involved, and understands and agrees to act in accordance with the guidance in the GMC Guidance booklet.

[18] Under the heading "Discussing side-effects, complications and other risks", paragraph 28 provides that clear, accurate information about the risks of any proposed investigational treatment must be provided in a way patients can understand and which

enables the patient to make informed decisions. The amount of information about risk to be shared with patients will depend on the individual patient and what they want or need to know, and the discussions with the patient should focus on their individual situation and the risk to them. Paragraph 29 emphasises that, to have any effective discussion with patients about risk, the doctor must identify the adverse outcomes that may result from the proposed options, including the potential outcome of taking no action. The doctor must consider the nature of the individual patient's condition (paragraph 30) and do his best to understand the patient's views and preferences about any proposed investigational treatment and the adverse outcomes about which they are most concerned (paragraph 31). The doctor should not make assumptions about a patient's understanding of risk or the importance which they attach to different outcomes – that should be discussed with the patient. Paragraph 32 emphasises that patients must be told if an investigational treatment might result in a serious adverse outcome, even if the likelihood is very small, and also about less serious side effects or complications. Information must be given in a balanced way (paragraph 33), avoiding bias, explaining both the expected benefits and the potential burdens and risk of a proposed investigational treatment. In terms of paragraph 34, the doctor must use clear, simple and consistent language when discussing risks with patients, being aware that patients may understand information about risk differently from him, and check that the patient understands the terms that he is using, particularly when describing the seriousness, frequency and likelihood of an adverse outcome. Paragraph 36 emphasises the importance of keeping up-to-date with developments in the doctor's particular area of practice. Finally, under the heading "Making decisions", paragraph 43 emphasises that the doctor must respect the patient's decision to refuse an investigational treatment, even if the doctor thinks that that decision is wrong or irrational. The doctor should explain his

concerns clearly to the patient and outline the possible consequences of the decision; but he must not put pressure on the patient to accept his advice.

[19] Under the heading “Recording decisions”, paragraph 51 of the GMC Guide states that the doctor must use the patient’s medical records or a consent form to record the key elements of his discussion with the patient. That record should include the information discussed, any specific request by the patient, any written, visual or audio information given to the patient, and details of any decisions that were made.

The central factual issue

[20] The central issue of fact in this case relates to what the pursuer was told before consenting to undergo transsphenoidal surgery in Aberdeen. He says that he was told virtually nothing about the risks of the transsphenoidal surgery recommended by Mr Kamel; that he was told nothing about the benefits (and risks) of radiosurgery, which could have been carried out as an alternative to transsphenoidal surgery (and would, at that time, have had to be carried out in Sheffield); and that it was never made clear to him that his condition was such that he could reasonably opt not to undertake surgery of either type at that time. The defenders, by contrast, insist that the pursuer was given full or at least adequate information about all these matters and that his consent to proceed with the operation was “fully informed consent”.

[21] In order to resolve this issue it is necessary to look carefully at the evidence given by the pursuer and relevant members of his family and by Mr Kamel and other individuals concerned in the treatment of the pursuer during this period. Professor Bevan was not well enough to give evidence. There were a number of letters and other notes written by him in process, and it was agreed that they could be looked at, exercising the appropriate degree of

caution in interpreting what was recorded in them; but, quite properly in the circumstances, it was not suggested that any adverse inferences should be drawn from his failure to attend as a witness at the proof.

[22] The oral evidence falls to be considered against a background of letters, notes and other documentary records written during the period from early 2010, when the process began which ultimately led to the decision to operate, until the end of January 2011, when the operation was carried out, and beyond. It is important, also, to set this in the context of expert evidence about the different possible forms of treatment (specifically transsphenoidal surgery and radiosurgery); and against the background of the pursuer's medical history, so far as relevant to his acromegaly, from the time of his earlier operation in 1980 through to 2010, and going through the diagnoses and decisions about future treatment made prior to the operation.

The pursuer's medical history from 1980 to 2010

[23] The pursuer's detailed medical history before the events with which this action is concerned is not in dispute. In August 1980 he underwent transsphenoidal surgery under the care of Professor Teasdale at the Southern General Hospital in Glasgow. The aim of the surgery was to remove a large pituitary fossa seen on a CT scan. During the course of the surgery two clips were placed in the floor of the pituitary fossa and one on the diaphragm sellae. After the operation his pituitary function was tested and found to be satisfactory. In 1985 the acromegaly was thought to be inactive. During the period after the operation he attended Professor JS Bevan at the Centre for Endocrinology and Diabetes in Aberdeen. His growth hormone and IGF-1 levels were monitored on a yearly basis. It was agreed by the experts at the proof that IGF-1 levels provided the more accurate indication; and accordingly

I shall generally refer to these readings. I take the relevant readings from the Report of Mr LT Dunn, a consultant neurosurgeon called to give evidence by the defenders. There are some differences between these and other records, but not such as to make any relevant difference. The readings are sometimes recorded using different scales and different reference ranges, so care must be taken to compare like with like. Over the years the pursuer's IGF-1 levels were usually found to be elevated above the reference range. In 1994 it was slightly elevated, at 1.45 u/ml compared to a reference range 0.3 to 1.2. In 1996 tests recorded a slightly elevated IGF-1 level as previously noted. Results were similar in 1998. In 2001 his IGF-1 level was recorded as 43 nmol (reference range 8 to 30). He was prescribed Cabergoline 500 mcg in an attempt to suppress it. In 2002 the dosage was increased to 1 mg twice weekly for persistent acromegaly. Octreotide was tried. In 2004 his IGF-1 level remained slightly elevated. The drug treatment was judged to be ineffective. An MRI scan performed at ARI showed an enlarged pituitary fossa filled with cerebral spinal fluid ("CSF"). A tiny amount of enhancing pituitary tissue was present at the end of a normal stalk. Appearances were compatible with previous surgery. In 2005 his IGF-1 level was recorded as 71 nmol per litre (reference range 12 to 32). In May 2007 it had dropped to 37.8 nmol per litre (with the same reference range of 12 to 32). It had risen again in December 2008 to 62.9 nmol per litre (reference range 11 to 30). In 2009 IGF-1 levels were seen to have risen to double the upper limit of the reference range. Throughout this time the pursuer suffered from severe arthritis, brought about by his acromegaly. Treatment options at that time were said to be limited to radiotherapy, which would take time to take effect, and Pergvisomant, which might not be available and might in any event not be appropriate given that he had previously not tolerated Octreotide and Cabergoline.

March 2010 onwards

[24] It is necessary to look in more detail at the period beginning in March 2010 when the pursuer was seen by Dr Susan McGeoch, a specialist registrar working with Professor Bevan within the endocrine clinic in ARI, as part of the regular check-ups undertaken by the pursuer after his operation in 1980.

[25] In referring to the relevant correspondence, I have taken the date of the letter as the date on which it was dictated. Quite often the letter was not typed and sent out until a considerable time later (sometimes in excess of two weeks). That frequently explains the apparent delay in replying and the further apparent delay in responding thereafter.

[26] Dr McGeoch saw the pursuer in the endocrine clinic on 26 March 2010. Her letter that day to Dr Hoque (the pursuer's GP), wrongly dated 26 April, summarises her findings. After recording that the pursuer was on medication (which was in fact unrelated to his acromegaly and osteoarthritis), the letter (CB/10) reads as follows:

"I reviewed Mr Johnstone in the endocrine clinic today. His main complaints continue to relate to his arthritis. He has had no recurrence of the symptoms that he presented with when his acromegaly was first picked up. No sweating and no headaches. I note that when recently seen in the endocrine investigation unit a mini growth hormone profile showed average growth hormone value within the normal limits, but IGF-1 was elevated above the age-related normal range. I note that Mr Johnstone has been intolerant of Octreotide and Cabergoline in the past so the main therapeutic options would be Pegvisomant or (sic) pituitary radio therapy if his IGF-1 levels continue to climb above the normal range. Today I have simply repeated Mr Johnstone's basal pituitary function tests including his IGF-1 and growth hormone and I have checked his glucose and HbA1c. When these results become available I will discuss things with Professor Bevan to see if any further action is needed at the present time.

I will then write to you and Mr Johnstone to communicate the plan. Mr Johnstone will return to the clinic in six months time."

[27] On 7 April 2010 Dr McGeoch wrote to the pursuer in the following terms (CB/11):

"I now have your blood results from the Endocrine Clinic. These show that the IGF-1 level (a marker of growth hormone in your system) has risen a little further. I have

discussed this result with Professor Bevan, who feels that the best thing to do in the first instance would be to arrange a repeat MRI scan of your pituitary to see if there is any residual mass, which might still be secreting excessive growth hormone. I will arrange for this to be done and thereafter we will meet up with you to discuss whether any other treatment is needed."

[28] On the same day, 7 April 2010, Dr McGeoch wrote to Dr Hoque setting out her findings in rather more detail. She said this (CB/12):

"I now have Mr Johnstone's biochemistry results from his last Clinic appointment. These show that IGF-1 is more than twice the upper limit of age related normal at 74.9nmol/l (11 – 30) and his growth hormone is reasonable at 1.85 ug/l. As you know, it is now 30 years since Mr Johnstone underwent transphenoidal surgery for acromegaly and he has previously not tolerated Octreotide or Cabergoline. For the last few follow-up appointments, Mr Johnstone's IGF-1 levels have been slightly above their normal age related range but the current level has crept up a little higher. I have discussed things with Professor Bevan today, who feels that the main therapeutic options may be either a further attempt at endoscopic pituitary surgery, possibly pituitary radiotherapy if there were an obvious remnant adenoma seen on MRI scanning. Therefore in the first instance, we will arrange to repeat Mr Johnstone's pituitary MRI and take things from there."

It is perhaps worth noting that in this and other documents the perception is that the pursuer's IGF-1 levels were on the increase and that that was a problem which needed to be addressed. That may have contributed to the view that doing nothing was not a sensible or realistic option. The letter proceeds on the basis that the choice is between endoscopic surgery and radiotherapy. Whether this was a correct assessment may be open to question, but I should say that there was no challenge to this assessment and no case advanced on the basis that this was wrong, let alone negligent.

[29] On the same day, 7 April 2010, Dr McGeoch sent a request for a new MRI scan to the Radiology Department at ARI. The request form was not in process but according to Dr Shona Olson, a Consultant Radiologist within the Department of Radiology, the information which she gave on the request form read:

"Acromegaly. Trans-phenoidal surgery 1980. IGF-1 level rising. ?tumour remnant"

(see CB/42).

[30] The MRI scan was performed on 19 May 2010. The images from that MRI scan were examined by Dr Olson alongside the images from the MRI scan carried out in 2004.

Dr Olson's report was in the following terms (7/21 p.345, and see CB/42):

"The pituitary fossa is markedly enlarged, with evidence of previous transsphenoidal surgery. The pituitary stalk is deviated slightly towards the left. Within the right side of the pituitary fossa, closely related to the upper aspect of the right cavernous sinus there is a small area of soft tissue measuring 8 x 5 mm.

I have been able to obtain previous films from February 2004, and in fact this small nubbin of tissue is unchanged compared to the previous time, and is in keeping with a small area of residual tumour. No new abnormalities."

[31] After receiving the report prepared by Dr Olson, Dr McGeoch wrote to Dr Hoque on 2 July 2010, largely quoting from the report but tying it in with her previous observations about the possible treatment options for the pursuer (CB/13):

"I now have Mr Johnstone's pituitary MRI report. This shows that the pituitary fossa is markedly enlarged with evidence of previous transsphenoidal surgery. The pituitary stalk is deviated slightly towards the left. Within the right side of the pituitary fossa closely related to the upper aspect of the right cavernous sinus there is a small area of soft tissue measuring 8 x 5 mm. This small nubbin of tissue is unchanged compared to the previous time, in keeping with a small area of residual tumour. As you will recall, Mr Johnstone has poorly controlled acromegaly with the most recent IGF-1 elevated at 74.9. He has been intolerant of Octreotide and Cabergoline, so the remaining therapeutic options open to us are further surgery, radiotherapy or treatment with Pegvisomant. We will arrange to discuss Mr Johnstone's MRI films at our next Neuroradiology Meeting and we will arrange to bring him up to the Endocrine Investigation Unit to discuss the future options for treatment in around 2 months time."

It is worth, again, noting the assumption that IGF-1 levels were rising and that something had to be done: "the remaining therapeutic options open to us".

[32] According to the pursuer, he had a follow-up appointment with Professor Bevan on 27 July 2010. The pursuer says that Professor Bevan told him at that meeting that he had a tumour and that it must be growing, which was why there was a change in some blood

levels. Professor Bevan advised him that the tumour needed treatment and that, as he saw it, there were two options, viz a referral to Sheffield for laser treatment or surgery in Aberdeen. No note of this meeting was referred to in evidence but I have no reason to doubt that a meeting of that sort took place.

[33] The Neuroradiology Meeting took place on 16 August 2010. It was a MDT meeting, referred to by Professor Bevan as a Pituitary Radiology MDT Meeting. It was attended by Professor Bevan, but not by Dr McGeoch. Mr Kamel, the Consultant Neurosurgeon who ultimately performed the operation in January 2011, could not attend but was informed about the discussion relating to the pursuer by letter from Professor Bevan dated 17 August 2010. The letter was copied to Dr Hoque. There is no note of that meeting and the letter contains the only available information about what was discussed and decided. It is necessary to set out in full (CB/14):

“We missed you at the Pituitary Radiology Meeting yesterday! However, Mr Johnstone is the only patient that required your direct opinion/input.

He is currently fifty-eight years old and was operated on transsphenoidally by Professor Graham Teasdale in Glasgow for acromegaly as long ago as 1980. Since that time his growth hormone levels have been reasonably well controlled but IGF-1 has never normalised with the most recent reading elevated at 2.5 times the upper limit of normal. We have attempted to control this with somatostatin analogues and dopamine agonists, but these attempts have been unsuccessful due to poor tolerance of the medications.

We have recently performed an up-to-date pituitary MRI scan and I reviewed the images together with Shona Olson yesterday. They show that he has a small nubbin of tissue related to the upper aspect of the right cavernous sinus and measuring 8x5 mm. The rest of the pituitary fossa is enlarged but empty.

The reason for seeking better control of his acromegaly is that he has suffered from very severe osteoarthritis in recent years and is still relatively young at fifty-eight.

I would be grateful if you could review the films yourself and give an opinion as to whether a further endoscopic surgical approach is possible. Another treatment option would be to consider the use of radiosurgery but this would, of course, require referral to the Gamma Knife Unit in Sheffield.

I look forward to hearing your opinion on this case in due course and thank you for your help.”

This letter again assumes that the pursuer’s IGF-1 levels had risen rapidly recently. It proceeds on the basis that medication has been unsuccessful, but implies that that is fairly recent rather than as long ago as 2004. It appears to assume that some active surgical or radiosurgery intervention was necessary.

[34] Mr Kamel reviewed the MRI scans within a couple of days of receipt of that letter.

He replied to Professor Bevan on 22 August 2010 in the following terms (CB15):

“Thank you very much for your letter dated 17th August 2010. I have reviewed the scans on Mr Johnstone and I agree that if he is still symptomatic and his IGF-1 level is elevated at 2.5 times the upper limit of normal then he probably needs some intervention. I think this small area which is closely related to the right internal carotid artery, would probably be amenable to surgery. I think we should explore this option prior to radiosurgery which may not be suitable in his case given the close proximity to the internal carotid artery.

I will arrange a ward visit to discuss the surgical option with him if you agree (sic) with this.”

The “small area” is clearly a reference to the “small nubbin of tissue” identified by Professor Bevan in his letter of 17 August.

[35] Professor Bevan met the pursuer at his endocrinology clinic on 30 August 2010. The pursuer’s wife (Isobel) and son (Kevin) were also there. This was before the pursuer met Mr Kamel. Professor Bevan’s note of that meeting is at CB/36. It is unnecessary to quote it verbatim. The note was not spoken to by Professor Bevan, for reasons explained earlier, and it is necessary that care be taken in reading and quoting from it. The note clearly refers to the operation in 1980 and records that there had been a “poor response” to Cabergoline and that the pursuer was intolerant to Octreotide. It appears to record that IGF-1 levels had gone up and that the pursuer was suffering from spinal arthritis. By the side heading “Discussion

by Prof. Bevan", there is a reference to the MRI pituitary (i.e. the MRI scan) and the observation of a "tiny nubbin of tissue" on the right side. It notes that there has been "no change dramatically since last time", presumably meaning no dramatic change in the size of the nubbin of tissue, which was assumed to be a small tumour. After commenting that they were waiting to hear from Mr Kamel, presumably to do with fixing an appointment to see him, it notes two "options to be explored", viz the removal of the remaining tissue by Mr Kamel or radiosurgery (with references to a Gamma knife, a single dose focused on the tumour tissue and the fact that such treatment would have to be carried out in Sheffield).

[36] On 13 September 2010 Professor Bevan wrote to Mr Kamel (7/21 p.165) confirming that he would be happy for Mr Kamel to meet up with the pursuer "to discuss a possible endoscopic approach for his residual tumour." It is perhaps worth emphasising that in light of the previous letters of 17 and 22 August and the discussions at the endocrinology clinic, Professor Bevan is clearly not excluding the option of radiosurgery.

[37] There was a neurosurgical MDT meeting at around this time. All agreed that the small nubbin of tissue was a surgical target and that they should offer Mr Johnstone active treatment.

[38] Mr Kamel met the pursuer on 16 September 2010. The meeting took place on one of Mr Kamel's ward visits. Mrs Johnstone, the pursuer's wife, was present. Mr Kamel made a manuscript note of that meeting soon afterwards, not during the meeting but fairly soon afterwards and probably on the same day – I infer this from the fact that on that same day he dictated a letter to Professor Bevan referring to the meeting with the pursuer and covering many of the same points as in his note. The note is at CB/16. Although its accuracy was in dispute, it was not suggested that this note was anything other than what it bore to be, i.e. a reasonably contemporaneous note of that meeting. In other words, it was not suggested that

the note of the meeting had been fabricated after the dispute had arisen to support Mr Kamel's account of what he had discussed with the pursuer. Given the sharp contrast between the account of the meeting given by the pursuer and his wife and that given by Mr Kamel, it is necessary to set out the contents of that note in full. Allowances should of course be made for the fact that it is a note rather than a carefully drafted report. The note reads as follows:

"I met with Mr Johnstone on a ward visit today. His wife attended the meeting. I went in details over the result of the MRI scan and I have showed the MRI. I explained that the MRI has been reported as showing an area on the [right] side in the cavernous sinus area which is intimately related to the [right] internal carotid artery. This area has been reported as residual tumour. I also explained that his case has been discussed in the pituitary multidisciplinary meeting and given the persistence of his arthritis active treatment of this lesion has been recommended by the pituitary MDT.

I also explained that I discussed the same case at our Neurosurgical MDT and the consensus was also to discuss with him the option of active treatment.

The options are radiosurgery or surgery

I explained the advantages & disadvantages of each technique.

I explained radiosurgery takes 1-2 years to be effective. We will need an opinion from a radiosurgical centre (Sheffield) first.

I explained the challenges with the open surgery as the tumour is only 8x5mm & very small. It will be very challenging to locate it. I explained we will use Neuronavigation & intraoperative histopathology to try to make sure of the nature of the tumour removed. However none of these techniques have a 100% accuracy & consequently we can miss the tumour. Any pituitary surgery carries the risk of further hypopituitarism and he may need further hormone replacement in addition to the thyroxine that he is already on. The tumour is very close to the pituitary stalk so there is a risk in particular of Diabetes insipidus and need for hormone replacement. The [risk?] of hypopituitarism is \cong 40%.

I also explained the risk of carotid artery injury 1 – 2% risk of death or stroke (<5%), risk of CSF leak, meningitis & need for further surgery.

After thorough discussions with Mr Johnstone he agreed to go ahead with surgery."

[39] On the same day, 16 September 2010, Mr Kamel wrote to Professor Bevan in these terms (the letter is at 7/21 p.164):

“I had the pleasure of reviewing Mr Johnstone on a ward visit today. I have shown him the scan and I explained to him that he will require some intervention to reduce his hormone levels. I have given him the options of either radiosurgery or endoscopic exploration for excision of the residual tumour. I have explained that surgically it may be difficult to find such a small tumour and I also explained that it is in close proximity to the carotid artery. I have quoted him a risk of 1 – 2% [of] carotid artery injury. After thorough discussion he was keen to go ahead with surgery. As you know, he has been having symptoms linked to arthritis in his hands and his knees. He also has a degree of cervical pain. He has right sided trigeminal neuralgia for which he takes Gabapentin and he is on Thyroxin replacement. He does not have any symptoms related to cardiomyopathy and I understand that he has been assessed for anaesthesia in 2006. He certainly does not report any chest pain or angina symptoms. I am going to put his name on my waiting list for endoscopic excision of pituitary adenoma. I will be in touch with you in due course.”

[40] The pursuer says that he met Professor Bevan again on 8 October 2010. There is no record of any such meeting in the medical records lodged in process. It may not matter. The pursuer says that his wife was present. According to the pursuer, at this meeting Professor Bevan told him that he would be having surgery in Aberdeen. There was no further discussion about laser treatment at Sheffield. The pursuer said that he took it from this that Professor Bevan and Mr Kamel had made the decision that surgery was the only option and that was that. He said that he just accepted their views.

[41] The operation was carried out on 31 January 2011. Two previous appointments had been cancelled, a matter which gave rise to some dissatisfaction on the part of the pursuer and his wife.

[42] On the morning of the operation a consent procedure was undertaken by Mr Bodkin. There is, I think, no dispute that he attended on the pursuer at the hospital and went through a process leading to the completion of a Consent Form (CB/18) signed both by himself and the pursuer. There is, however, a difference in the evidence about how long

that took and how much information was given to the pursuer by Mr Bodkin before obtaining his signature. Mr Bodkin's evidence is set out later in this Opinion. Not surprisingly he has no specific recollection of this incident. In general the consent procedure would last for somewhere between 10 minutes and one hour, depending on the patient's understanding of what was being said and his wish to discuss particular matters. The pursuer has no particular recollection of the discussion while the pursuer's son, who was there to accompany his father, recollected a quick visit by a doctor (who must have been Mr Bodkin) which lasted no more than 5 minutes. What is clear is that the pursuer signed a Consent Form stating that he consented to undergo the operation "the effect and nature of which has been explained to me by Dr/Mr Bodkin". On the same form Mr Bodkin signed a statement confirming that he had explained to the pursuer the "nature and purpose" of the operation.

[43] There is, in addition, an entry in the hospital notes for that day written by Mr Kamel (CB/17) in the following terms (some punctuation added):

"Consent taken. A fully informed consent taken. Aim & risks explained, including risk of further hypopituitarism (already on thyroxine replacement) so he may need further hormone replacement (i.e. DDAVP, steroids, testosterone ...). He understands the tumour is small. I plan to use neuronavigation & intraoperative diagnosis but it may still prove difficult to find it. Other risks of CSF leak, meningitis, need for further surgery, carotid injury ... explained to him & his wife. Agreed to go ahead."

This note was the subject of some controversy. The note refers to Mr Kamel having explained matters to the pursuer "& his wife", but it is apparent from other evidence that the pursuer's wife was not there on that day; she was unable to get away from her work – her employers sent a letter (CB/25) confirming that she was present at work for the full day – and the pursuer was accompanied on this occasion by his son. Both the pursuer and his son were certain that Mr Kamel did not see the pursuer before carrying out the operation and,

therefore, were certain that Mr Kamel did not go through with them any of the matters recorded in the note. Mr Kamel did not have any recollection of this discussion in his evidence, but that is not surprising given that it happened, if it did happen, over eight years ago. But it was not suggested to Mr Kamel that this note was not written on 31 January 2011 and it is no part of the pursuer's case that the note was fabricated by Mr Kamel or inserted later by him to support his case once a dispute had arisen.

Subsequent meetings and correspondence

[44] I should refer at this stage to certain correspondence, meetings and discussions occurring some considerable time after the operation. I do this for the light it casts on what was said and done before the operation so far as relevant to this dispute.

Letter of complaint 10 July 2013

[45] On 10 July 2013 the pursuer sent a letter of complaint to NHS Grampian (CB/35). It is clear that his wife helped in drafting the letter, but there is no reason to believe that it did not represent his views and opinions. The letter contains a number of points of interest.

[46] The complaint was a complaint about "the medical treatment I received whilst in the care of Dr Kamel ...". After referring to his earlier operation in 1980 and the subsequent monitoring of his hormone levels, he said this:

"In July 2010, under the care of Professor Bevan, I had a MRI scan to ascertain if the tumour had grown again. I was never informed of the results of this scan but was presented with two treatment options.

The first option was to undergo brain surgery through the nasal cavity at ARI with a specialised camera. Second option was to go to Sheffield for laser treatment. I decided to have surgery at ARI."

The letter goes on to complain that the operation was cancelled twice but eventually went ahead on 31 January 2011, after a further scan in the morning of that day. Further details of the complaint are then set out. After the operation he asked the surgeon how much of the tumour he had removed. Dr Kamel replied: "I did not find any tumour, but removed some tissue to send to the lab for analysis." The pursuer's comment about this in the letter is that he had been told that it might not be possible to remove the whole tumour because of a risk of damaging the pituitary gland, he had never been told that the scan had not even revealed the existence of a tumour, let alone its precise location – in those circumstances he failed to understand why Dr Kamel decided to go ahead with the surgery. Moreover, the operation caused irreversible damage to his pituitary gland, by removing tissue which he had been assured would not happen. At no point prior to the operation was he warned that he might require medication for the rest of his life. Prior to the operation he did not feel unwell but he now regularly suffered from stomach problems and weight gain (a side effect of the medication he now required).

[47] Referring to his discharge from hospital on 4 February 2011, his re-admission by ambulance on 10 February due to spinal fluid leaking from his nose resulting in his developing meningitis, and a further two weeks spent in hospital on intravenous antibiotics, he complained that he was discharged too quickly after the first operation. He was told that the packing in his nose was not secure and had not been put in properly; it should have been checked before he was discharged. On his discharge the second time, he was given medication which was out of date and which prescribed the wrong dosage. That could have had serious consequences if it had gone unnoticed. His complaint letter ended on this note:

"I feel I have been used as a guinea pig and do not feel I have been presented full facts regarding test results and potential consequences of the two treatment options given to me.

As I mentioned earlier, I also fail to understand why Dr Kamel decided to proceed with the operation then failed to locate any tumour. I had been told prior to the operation that they may not be able to remove the entire tumour if there was a risk they would damage the pituitary gland, I feel it was wreckless (sic) of Dr Kamel to continue and cause irreversible damage to my pituitary gland. As well as the further medical problems this has created for me, I also suffered a prolonged recovery period due to postoperative complications and my family were subjected to considerable stress and anxiety throughout.”

NHS Grampian did not reply to that letter until 19 March 2014, by which time the pursuer and his wife had met Mr Kamel in person (see below). The reply, sent by the Chief Executive, apologised for the delay and then addressed the individual complaints. The contents of the reply from NHS Grampian are not important for present purposes.

Meeting with Mr Kamel on 30 August 2013

[48] The pursuer and his wife (Isobel) and daughter (Carrie) met Mr Kamel on 30 August 2013 to ask him certain questions and record his answers. A lady from NHS Grampian attended nearly an hour after the meeting began, ostensibly to take minutes. In the event, minutes of the meeting (CB/19) were taken and typed up by the pursuer’s daughter, Carrie. It is unnecessary to set out the minute in full. I simply pick up certain points in the sub-paragraphs below (the comments in square brackets being the pursuer’s comments after but not during the meeting). The numbering of the sub-paragraphs is mine and bears no relation to the minute itself.

- (i) Mr Kamel showed the brain scan “of what he thought was a tumour close to my pituitary gland”. They had never seen the scan before – and they had been told there was a tumour, not that “he thought” there was a tumour.
- (ii) Mr Kamel said that it was not his decision to proceed to surgery. The case was reviewed by a multi-disciplinary team and the decision was made to offer surgery.

- (iii) Laser treatment was not an option as the tumour was too near the main artery.
- (iv) As to whether the treatment options were fully explained, Mr Kamel said that the diagnosis and treatment options were both put in a letter to the pursuer's GP. He used to set out the diagnosis and treatment plan in writing to patients too, but he stopped when a patient complained that the letter was full of medical terminology which they did not understand. [There is a comment here from the pursuer saying that the full facts and side effects of surgery were never fully explained to him.]
- (v) Mr Kamel performs this type of operation about 2-3 times a month, of which only about 10-20% were on tumours of a similar size to that of the pursuer.
- (vi) There was a 40-50% risk of damage to the pituitary gland during such an operation.
- (vii) Asked if the operation should not be safer now than when it was performed in 1980, because of medical and technological advances, Mr Kamel said it was safer to operate on larger tumours. [The pursuer notes that this was not explained prior to surgery.]
- (viii) Mr Kamel said that ARI had state of the art equipment.
- (ix) Asked whether the MRI scan identified a tumour, Mr Kamel said they thought there was a tumour based on the pursuer's growth hormone levels. [The pursuer comments that he was told there was a tumour, not that he thought there was a tumour.]
- (x) Asked why he continued with the operation and destroyed the pituitary gland when the tumour was not accessible, having said prior to the operation that they would stop if there was a risk of damage to the pituitary gland, Mr Kamel said that they removed some tissue which he and the pathologist thought was a tumour, though they could not be sure of that, and then stopped the operation. [The pursuer

comments that by that time it was too late and irreversible damage had been done to his pituitary gland.]

- (xi) Mr Kamel said that the intention behind the decision to operate was to slow down the progression of the pursuer's arthritis caused by the effect that elevated hormone levels were having on his joints. He commented that arthritis is a condition that usually gets worse with age and there was no guarantee surgery would improve this. [The pursuer comments that this was not explained prior to surgery.]
- (xii) Mr Kamel said that 5-10% of patients would develop post-operative meningitis over a period of 10-14 days after such an operation. In answer to the pursuer's complaint that they were not informed about the possibility of leakage or symptoms to look out for, Mr Kamel agreed that they should be issuing instructions to patients on discharge regarding symptoms to look out for and what actions to take if they manifest themselves.

There were additional complaints, about Mr Kamel not dealing with the pursuer at a subsequent outpatient appointment and about his failure to attend a follow up consultation; and there were other questions concerning a later scan and what impact it had on previous assessments. However, none of this is relevant to the issue in this case.

Meeting with Professor Bevan on 8 October 2013 and follow up letter of 29 October 2013

[49] The pursuer (and perhaps also his wife) met Professor Bevan on 8 October 2013 and presented him with a list of questions about the decision to recommend pituitary surgery again (see CB/38). One of those questions (Q5) was: why were we offered laser treatment in Sheffield when [the] apparent tumour was too close to a major artery? Having taken time to look at the hospital case notes, Professor Bevan wrote to the pursuer on 29 October 2013

setting out his considered response (CB/20). After explaining the process by which the decision was made to proceed to endoscopic surgery, Professor Bevan said this:

“It is not routine practice for patients to be invited to attend MDMs [i.e. Multi Disciplinary Meetings] at Aberdeen Royal Infirmary. At the Pituitary MDM, we commonly discuss 12 cases in a meeting lasting just over an hour. At the meeting when your case was discussed everyone present was in agreement that some form of active treatment was required. My subsequent letter to Mr Kamel makes it clear that I was asking him to consider the feasibility of surgery, whilst keeping radiosurgery as a second option. Mr Kamel is the nominated specialist pituitary surgeon in Aberdeen and, as such, undertakes between 20 and 30 specialist pituitary operations per year. Had he decided surgery was not a practical option, we would likely have referred you to Sheffield which is one of only two centres in the United Kingdom able to offer radiosurgery (none in Scotland). The question as to whether the abnormal area was too close to an artery or other vital structure would have been considered carefully by that Specialist Team.

In the event, you accepted our joint specialist recommendation to have second surgery. Unfortunately this did not achieve its main objective (to normalise IGF1) and you suffered several of the recognised complications of this procedure, as had been described to you by Mr Kamel. Mr Kamel and I both regret the operation was not a success but we do feel that proper discussion of the risks of surgery took place. ...”

Expert Report by Patrick Statham 7 February 2019

[50] One of the expert witnesses instructed on behalf of the pursuer was Mr Patrick Statham, a consultant neurosurgeon at the Western General Hospital in Edinburgh. He produced an expert report on 7 February 2019. In preparing his Report he had a consultation with the pursuer on 23 May 2016. He recorded in paragraph 4.8 of his Report the pursuer’s account of the meeting with Mr Kamel on 16 September 2010:

“4.8 ... Mr Johnstone’s account of this meeting is at variance with that recorded by Mr Kamel. ... He says that Mr Kamel stated that they were far superior to the Southern General in Glasgow and that they were technically more advanced and that they were now teaching in ARI. Mr Johnstone recalls Mr Kamel pointing to an image on a monitor, pointing to the pituitary gland and explaining that the surgery would be done through the nose using a new navigation tool. He recalls being advised that he would need to watch for infection after the surgery. He did not receive any detailed explanation of the risks and benefits of radiosurgery compared with endoscopic surgery.”

He returned to the same topic in paragraphs 7.2 and 7.3:

“7.2 He [the pursuer] remembers the consultation of 16.09.2010 with Mr Kamel, which he describes as taking only 15 minutes. He said that Mr Kamel said the operation was now ‘more advanced’, because of the use of an endoscope rather than microscope, but still through the nose. He described that a careful watch for infection was needed. He said that the scan had shown that the tissue was ‘in a dangerous place to be’. He was reassured by Mr Kamel and there was no discussion about the risks and benefits of the endoscopic approach compared to radiosurgery in Sheffield. A further discussion was had on the morning of the operation when his son, not his wife was present.

7.3 Immediately after the operation Mr Kamel had told him that he could not find the tumour during the operation. Up to that point Mr Johnstone had been under the impression that they had been sure that there was return of the tumour and this shocked him.”

The oral evidence

[51] The main factual evidence as to relevant events was given, for the pursuer, by the pursuer himself, his wife Isobel, his daughter Carrie and his son Kevin; and, for the defenders, by Mr Kamel and Mr Bodkin. Each of them gave evidence under reference to a precognition or witness statement which was adopted by them as part of their evidence in chief. For reasons explained earlier, Professor Bevan was unable to give evidence in person.

Pursuer (Allan Johnstone)

[52] The pursuer was born in 1952. He was aged 59 at the time of the operation at the end of January 2011. His precognition is lodged at 40 of Process.

[53] The pursuer explained that he had become unwell in 1980, was referred to Aberdeen City Hospital for tests, was diagnosed as having acromegaly and, after an MRI scan, as having a large tumour near the pituitary gland. He was referred to Dr Teasdale at Glasgow Southern General and had surgery to remove the tumour. The outcome was excellent. He

only required medication for about three months after that surgery. Dr Teasdale said at the time that he was 99.5% certain that all of the tumour had been removed. Thereafter he had yearly check-ups and blood tests. After a few years Dr Bevan took over his care. In about 2002-2004 Dr Bevan tried different drugs to try and lower some blood levels but with no success. He started having problems with his stomach. However from 1980 until the events of 2010-2011 he felt he had a good quality of life and felt well within himself.

[54] Turning to the events of 2010, the pursuer gave evidence of having seen Professor Bevan early in 2010 and again on 27 July 2010 as noted in paragraph [32] above. At the meeting of 27 July 2010, according to the pursuer, Professor Bevan never told him that there was any doubt that he had a tumour or that the tumour might not be responsible for the changes in the blood results. The pursuer was left with the belief that he had a tumour and needed treatment, either by laser treatment in Sheffield or by surgery in Aberdeen. The pursuer says that he was never shown his MRI scan at this meeting. In answer to a question from the pursuer, Professor Bevan told him that the neurosurgery practice in Aberdeen was excellent and produced excellent results. He was given an appointment to see the neurosurgeon in Aberdeen.

[55] The pursuer went on to describe his appointment with Mr Kamel at his outpatient clinic on 16 September 2010. He said he had a "clear recollection" of that meeting. Under reference to the pursuer's previous surgery in Glasgow in 1980, Mr Kamel told him that they were now far superior to that in Aberdeen, were technically more advanced, and they were teaching in Aberdeen as well. His account of the meeting with Mr Kamel on that occasion covered two short paragraphs of his precognition:

"Mr Kamel then went on to show us on a small desk top monitor an image of a head showing us a brain. He pointed to the pituitary gland and explained how the surgery would be done, up through the nose with this new fantastic navigation tool.

He never showed us any tumour at any time. There was no mention of main artery or dangers. He only said sometimes small tumours are more difficult to find. We did not know if this image on the monitor was mine or not. Before we left my wife said to Mr Kamel if the tumour is in a dangerous place, you will stop and you won't go any further? He replied yes.

It seemed from that meeting that the decision was made that I would proceed to have surgery under the care of Mr Kamel in Aberdeen. Mr Kamel did not have any discussion with me about radiotherapy. I thought I was getting the best treatment and at that time trusted him. Following the meeting [there] was no further discussion about laser treatment at Sheffield. The appointment lasted less than 15 minutes."

[56] The pursuer said that he had an appointment with Professor Bevan on 8 October 2010 at which Professor Bevan told him and his wife that he would be having surgery in Aberdeen. According to him, there was no further mention about laser treatment at Sheffield. He thought that Mr Kamel and Professor Bevan must have decided that surgery was the only option and that was final. They accepted the views of doctors and didn't feel it was their place to raise anything.

[57] After his meeting with Professor Bevan on 8 October 2010, he was notified of an appointment for the surgery to take place on about 17 October 2010, only a week or two later. He did not want to have the operation at such short notice. When he told the hospital this, he was told that he should never have received this letter. Someone had not followed the correct procedure. A further surgery date was arranged and then cancelled before the operation went ahead on 31 January 2011.

[58] The pursuer was admitted to hospital on 30 January 2011 but then sent home for the night and told to come back first thing in the morning for an MRI scan. He returned on the morning of 31 January 2011 with his son, Kevin, who stayed with him except when the pursuer was taken away for a scan. The pursuer's evidence is that he never saw Mr Kamel on the morning of the operation. He joked with Kevin that Mr Kamel must be practising

with his navigation tool which must be something like satnav. Someone did come to get the consent form signed but it was not Mr Kamel.

[59] The pursuer says that he went down to the operating theatre at about lunchtime and was back in intensive care late that evening. The next morning Mr Kamel came to see him and he asked him how much of the tumour had been removed. Mr Kamel replied that he could not find any tumour but he took tissue samples to send to the lab. The pursuer was rendered "completely speechless" by this answer:

"... it was like something out of a horror movie. I thought what the hell has he done. ... I felt this was a total mess. I have never been able to come to terms with that meeting."

The pursuer remained in hospital until he was discharged on Friday 4 February 2011.

[60] The pursuer had an appointment with his GP on Monday 7 February and everything seemed fine that stage. On Tuesday 8 February he had an appointment with the nurse for bloods. He told the nurse that fluid had started coming from his nose during the night but she reassured him that it was quite normal after the type of surgery that he had had. A doctor was contacted. There was a discussion about painkillers and the doctor agreed to change them. The doctor said he would contact the ward about the fluid coming from his nose. There was no further contact. On Thursday 10 February at about 4 am the pursuer woke with a really bad headache and sore neck. His wife telephoned the hospital ward and subsequently NHS 24. The next thing the pursuer remembered was being in intensive care. He remembered hearing some conversation about the packing in his head not having been put in properly, but not much else. He was taken back to theatre for repair surgery and spent a further two weeks in hospital before being discharged on Thursday 24 February. There was a problem with the DDAVP tablets he was sent home with.

[61] The remainder of the pursuer's precognition deals with questions of his subsequent checkups, his physical and mental condition resulting from the operation and later events. This is not directly relevant to the issues in the case because, as I have said, quantum (in the event of a finding of liability) has now been agreed.

The pursuer's son, Kevin Johnstone

[62] Kevin Johnstone is a construction engineer. Throughout 2010 and 2011 he was often working away from home. He was 28 at the time of the operation on his father. His precognition is lodged as 43 of process. He spoke to it briefly in his oral evidence. Because he was so often away from home, most of his evidence was an account of what he was told by his parents coupled with his assessment of how his father would have acted or reacted had he been given relevant information and presented with a number of options for treatment. According to Professor Bevan's clinical note, Kevin Johnstone attended the pursuer's consultation with Professor Bevan on 30 August 2010, but he gave no evidence about that.

[63] His only first-hand evidence of any direct relevance to the issues in this case related to the events of 31 January 2011, when he accompanied his father to the hospital for the purpose of assessment before the operation. He confirmed that his mother was not there. After arriving at the ward and being booked in by the nurses, his father was taken through to a room to get changed. After waiting for about 10 minutes he was shown through to the room where his father was. A doctor came through with paperwork to sign. It was not someone that he had seen before. He asked his father whether it was Mr Kamel. His father said it was not Mr Kamel and they joked about how Mr Kamel "was probably practising on the satnav". He did not recall everything that was said by the doctor but he did recall him

saying something along the lines of “the risks are as previously discussed”. The doctor was in and out within two to three minutes. It was not a case of the doctor sitting down and discussing the risks with his father. His father was then taken for a scan. After about half an hour his father arrived back in the room and they were together for the entire duration until his father was taken down for surgery just after lunchtime. He never saw Mr Kamel during this time and was led to believe that Mr Kamel was performing another operation at the time.

The pursuer's daughter, Carrie Johnstone

[64] Carrie Johnstone is a cost controller. Her precognition is lodged at 41 of process. She was 30 at the time of her father's operation in January 2011. She recalled hearing that her father required brain surgery. It came as a shock to her since her father was not at that time suffering from headaches or other symptoms.

[65] Carrie Johnstone attended the meeting with Mr Kamel on 30 August 2013. She took notes of the meeting and produced the Minutes (CB/19). The relevant parts have been set out earlier. She noted in particular that Mr Kamel had opened the meeting by showing the MRI scan “of what he thought was a tumour close to my pituitary gland”, as she recorded in her Minutes. The point is dealt with in two places, the complaint being that before the operation her father had been told there was a tumour, not that they “thought” there was a tumour. Mr Kamel is recorded as stating that there was a 5-10% chance of a patient developing post-operative meningitis over a period of 10-14 days after the operation, and the complaint is made that the pursuer was never told of any such risk either before agreeing to undergo the operation or, more particularly, when he was discharged. Had they

been told that there was this risk they would have acted immediately when the pursuer's nose began to drip.

[66] Carrie Johnstone said that she too was at the meeting with Professor Bevan on 8 October 2013, though the clinical note does not record this. Nothing turns on this apparent discrepancy.

The pursuer's wife, Isobel Johnstone

[67] Isobel Johnstone trained as a nurse and subsequently made her career in pupil support, helping children with Asperger's syndrome. This is relevant because it shows that she was capable of taking in and understanding medical terms and advice given in a medical context.

[68] Mrs Johnstone explained that in 2010 the pursuer had had blood tests to check his blood levels. After some discussion with a doctor at the Woolmanhill Clinic, the pursuer was sent for a scan. The pursuer then had an appointment with Professor Bevan at which she was present. Professor Bevan told them that the change in blood levels meant that the tumour must have grown again. He said that there were two options: laser treatment in Sheffield or surgery in Aberdeen. The pursuer asked how good they were in Aberdeen and Professor Bevan said that they were excellent. The pursuer asked if they could investigate the Aberdeen option first, but without discounting the possibility of pursuing the Sheffield option. An appointment was arranged for the pursuer to be seen in Aberdeen.

[69] They attended the appointment with Mr Kamel in Aberdeen in September 2010. He said: "I believe you have had surgery before to remove a tumour". The pursuer replied: "yes, in 1980 in the Southern General Hospital, Glasgow". Mr Kamel responded by saying: "We are much more advanced and superior to them now. Our technology is far more

advanced. This is the best place for the best treatment. We are also teaching here now.”

Mr Kamel then showed them on a desktop screen an image of a brain. According to Mrs Johnstone, he never told them it was the pursuer’s scan, but he pointed out where the pituitary gland was. He never showed them any tumour but he did point to a grey area on the scan (which would in fact have been the tumour). Mr Kamel then proceeded to tell them that the surgery would be performed by going up through the nose. He described how new technology had produced this fantastic navigation tool to locate the area where the tumour was. He did not talk to them about the risks of surgery. He never told them that the suspicious grey area was near to a main artery. Mrs Johnstone did not remember Mr Kamel saying anything at all about the carotid artery. Nor did he tell them about any other problems that could occur during or after surgery. He did not tell them about any of the risks inherent in the surgery, and specifically did not mention either the risk of meningitis or the risk of death. Mrs Johnstone said that if Mr Kamel had mentioned the risk of death if he hit the carotid artery the pursuer would not have gone ahead with surgery. The pursuer had no symptoms and was feeling fine – why would he undertake that risk? Mr Kamel did say that small tumours were sometimes more difficult to find. Mrs Johnstone said that the last thing she said to Mr Kamel before leaving was: “if the tumour is in a dangerous place, you will stop and not go any further?”, to which Mr Kamel replied: “Yes, I won’t go any further”. Mr Kamel did not take any notes in their presence.

[70] Mrs Johnstone said that there was no discussion with Mr Kamel of the risks and benefits of radiosurgery. The pursuer was not offered the chance to go to Sheffield. He would willingly have travelled to Sheffield to discuss the details of the laser treatment. It was not true that Mr Kamel had told them that radiosurgery carried none of the risks of conventional surgery. Radiosurgery was simply not mentioned at all. If Mr Kamel had

explained that radiosurgery was risk free, or even just less risky than transsphenoidal surgery, they would have gone with radiosurgery. And if they had been told that radiosurgery could be carried out with day care and under local anaesthetic – instead of with a full hospital admission and general anaesthetic such as would be required for transsphenoidal surgery – then again they would have opted for radiosurgery. There was no reason for them not to go to Sheffield.

[71] Sheffield was never mentioned again. Mrs Johnstone said that Professor Bevan and Mr Kamel must have decided between them not to refer the case to Sheffield. “We just assumed they had decided surgery was the best option.”

[72] A short time after seeing Mr Kamel, they had an appointment with Professor Bevan. I have already mentioned that the pursuer gave evidence about a meeting with Professor Bevan on 8 October 2010, but there is no record of any such meeting. Presumably Mrs Johnstone is referring to the same meeting. Be that as it may, Mrs Johnstone said that at that meeting Professor Bevan told them that the pursuer was having surgery in Aberdeen. He was on the waiting list. There was no mention of Sheffield. Nothing else was discussed. The meeting was short and to the point.

[73] The following week they were given an appointment for the operation. They cancelled it because it was too short notice. There was another cancellation before the surgery went ahead on 31 January 2011.

[74] The admission date for the operation was Sunday 30 January 2011 at 12 noon. She accompanied the pursuer. They waited all afternoon and then were told to go home and come back in the morning. The next day the pursuer was taken back to hospital by their son, Kevin. Mrs Johnstone could not go with him that day because one of the children she was working with had an important exam and she had to be there to prompt. She went to

visit the pursuer in hospital at about 8pm but he was still very drugged up from the anaesthetic. The next day the pursuer was told by Mr Kamel that they could not find the tumour – they had taken tissue samples but until they came back from the lab they did not know what they were. Mrs Johnstone was concerned that he might have removed the tissue from the pursuer's leg which had been used by Professor Teasdale to pack the hole left by the first operation in 1980.

[75] The pursuer was discharged on Friday 4 February 2011 with no instructions about post-operative care. They were not told that there had been any problem during surgery nor that there had been a leak of spinal fluid. The pursuer saw his GP on the Monday of his discharge and then on the Tuesday saw a nurse for blood tests. By this time there was fluid coming from his nose – the nurse said that it was probably due to the surgery and that there might be some inflammation. A GP was contacted but nothing more happened and they assumed everything was alright. Early on Thursday morning (9 February) the pursuer woke, looking for painkillers. Eventually a Doctor arrived. He suspected meningitis. After a long delay waiting for an ambulance, the pursuer was "blue-lighted" to hospital. An operation was carried out to repair the leak. He was confused and not making much sense for a few days. He was kept in hospital for a couple of weeks after that.

[76] Mrs Johnstone's evidence canvassed a number of complaints about the conduct of Mr Kamel and Professor Bevan in the period after the pursuer's discharge from hospital in February. I need not set them out – they are not relevant to the issues in this case.

[77] A letter of complaint sent in July 2013 went unanswered (until 2014). In the meantime, a meeting with Mr Kamel was arranged for 30 August 2013. The minute of that meeting made by the pursuer's daughter, Carrie, has already been referred to.

Mrs Johnstone confirmed the details of that minute. She added a number of points.

Mr Kamel told them that he had not been at the MDT meeting to discuss the pursuer's case. He himself had only seen the MRI scan from 2010; he had never seen any earlier scans to compare it with. He said that in his opinion laser surgery was not an option because it was too close to the carotid artery. The pursuer expressed concerns about the lack of information before surgery about the possible risks and outcomes – Mrs Johnstone said that Mr Kamel told them that the only difficulty was that it was often more difficult to find a small tumour, but that shouldn't be a problem because of the state of the art navigation tool. Mrs Johnstone said that they were preparing to leave when Mr Kamel "appeared to panic". "He then proceeded to say that the decision to operate was made by the MDT [at a meeting at which he was not present], not him".

Mr Mahmoud Kamel

[78] Mr Kamel is a consultant neurosurgeon at Aberdeen Royal Infirmary. He has been performing pituitary surgery since 1998 and has held the position as consultant neurosurgeon at ARI since July 2008. Like the other medical professionals involved in the case, he has an impressive CV. A copy was lodged in process (at 7/18/1). It is unnecessary to refer to it in any detail.

[79] Mr Kamel explained that acromegaly was a condition involving the secretion of excessive growth hormone. In most cases that was due to a benign tumour of the pituitary gland. Diagnosis is carried out by an MRI scan and an IGF-1 test, IGF-1 being a marker which reflects growth hormone. Levels of growth hormone can vary at different times, and therefore the test may not be wholly accurate. At the initial stages at least, the tests are all carried out by endocrinologists, not by neurosurgeons. If the endocrinologists felt that surgery was an option for a patient, they would bring that patient up at a MDT meeting,

where a collective decision would be taken as to whether surgery was appropriate for the particular patient. As a neurosurgeon, Mr Kamel would not know any of the patients until they were referred to him by his endocrinologist colleagues. When a patient was referred to him, he would consider whether to offer that patient radiosurgery in Sheffield. Not every patient was suitable for radiosurgery. For most patients, surgery was the best option.

However, in Mr Johnstone's case, which was a complex case, radiosurgery was an option.

In advising patients about the potential risks and benefits of radiosurgery, Mr Kamel would start by giving them a very broad picture of what radiosurgery involved and would then tell them that if they were interested he would be happy to refer them to Sheffield and then it would be up to Sheffield to assess whether they were suitable for radiosurgery or not.

Mr Johnstone was not interested in radiosurgery – he chose surgery.

[80] In perhaps 70-80% of cases where Mr Kamel performs surgery to remove a tumour, he succeeds in removing the whole tumour. But much depends on the size of the tumour and where it is in relation to inoperable areas. He tends to get a good idea during surgery as to whether or not the entire tumour has been removed, but he does not know for certain until after an MRI scan after the surgery. Tumours can be divided into micro-tumours (of less than 1 cm) and macro-tumours (which are larger than that). With a micro-tumour the challenge is to find it. That was the challenge in Mr Johnstone's case as the tumour was so small. In Aberdeen they use a process called intra-operative neuro navigation, which is a bit like a GPS – you point the device on different parts of the brain and use that on the scan. They had expected some difficulties in Mr Johnstone's case and wanted to make sure that they had identified the right area. The process of confirming that they have located a tumour normally involves taking a piece of the suspected tumour and sending it to a pathologist who is on-site and on-line. This is done during the operation. The pathologist

will examine the specimen and give an answer within about 30 minutes. This was done in Mr Johnstone's case. The pathologist did not think that the specimen sent to him was from a tumour so Mr Kamel stopped the operation. If a tumour is not completely removed, that means that the condition is not cured. Sometimes it is necessary to go and operate again, but sometimes the patient would instead be referred for radiation. If the whole tumour was removed the acromegaly could be cured.

[81] Mr Kamel noted that Mr Johnstone had had similar surgery before, back in 1980. When he explained the procedure to Mr Johnstone, Mr Johnstone was clearly familiar with it and he was familiar with the risks involved. Because he had had the surgery before, the explanation of what it involved was not difficult. Mr Johnstone clearly understood what was involved.

[82] Mr Kamel was referred to the letter from Professor Bevan dated 17 August 2010 (CB/14). This referred to the Pituitary Radiology MDT meeting the previous day. Such meetings were held in the x-ray department about once a month on average. They were usually attended by Dr Olson (the neuro-radiologist), Professor Bevan (the endocrinologist), perhaps some trainees, ophthalmologists (as there are often eye problems), oncologists, a neurosurgeon and sometimes specialist nurses like pituitary specialist nurses. The meetings tended to last for about one hour and in the course of a single meeting some 5-10 cases would be discussed. Notes of the meetings were taken by someone within the endocrinology team, usually a trainee. After that, a letter would be dictated such as the letter from Professor Bevan dictated to Mr Kamel discussing Mr Johnstone's case.

[83] Mr Kamel was performing surgery that Monday and therefore could not attend the MDT meeting at which Mr Johnstone's case was discussed. The letter from Professor Bevan (CG/14) was to tell him what had been discussed and to seek his opinion as to whether a

further endoscopic surgical approach was possible. It is made clear in the letter that the IGF-1 readings for Mr Johnstone had never normalised. That meant that the acromegaly was not under control and the risk of death was about three times higher than normal. Acromegaly can shorten a person's life. Mr Johnstone was still relatively young – he was then aged 58 – but he was suffering from very severe osteoarthritis. That was a symptom of the acromegaly. Medical treatment to deal with the acromegaly had failed and there was therefore a need to escalate treatment either to radiosurgery or surgery. The preference was for surgery. From the terms of that letter Mr Kamel thought that the tumour was recurring and that was the cause of the acromegaly. While it was always an option to let the patient continue suffering from acromegaly untreated, that was not a very wise decision.

[84] Mr Kamel replied to that letter on 22 August 2010 (CB/15). As noted in that letter, he had reviewed the MRI scans and agreed that if Mr Johnstone was still symptomatic and his IGF-1 level was elevated at 2.5 times the upper limit of normal then he “probably” needed intervention. The word “probably” was important because it was up to Mr Johnstone to decide. There was no doubt in Mr Kamel's mind, however, that Mr Johnstone required some treatment. He thought that the tumour would probably be amenable to surgery. That depended on whether they could find the tumour and where it was located. Mr Kamel thought that that would be the best treatment for functional adenomas. Surgery has a higher success rate and works quicker than radiosurgery. Surgery was the better option provided that Mr Johnstone accepted the risks involved. But Mr Kamel had not made up his mind – that was why he had used the word “probably”. So far as concerned the statement that radiosurgery “may not be suitable in this case given the close proximity of the tumour to the internal carotid artery”, Mr Kamel said that the risk of damaging the carotid artery was very small, whether the tumour was dealt with by surgery or by radiosurgery. He was

not saying that the risk of damaging the carotid artery was greater with radiosurgery. As to the statement that radiosurgery “may not be suitable”, Mr Kamel emphasised that he was not an expert in radiosurgery. He was not shutting that down as an option and he could arrange a visit to discuss radiosurgery if that was what was wanted.

[85] Mr Kamel met the pursuer and his wife on 16 September 2010. He confirmed that the manuscript note in the hospital records (CB/16) was his note of that meeting. The note was not made during the meeting but he would typically write a note (and any necessary letter) immediately afterwards. The note was kept in the patient’s records (in a binder) within the NHS. He met the pursuer in the office of Mr Bhatt. They shared offices.

Mr Kamel knew that the pursuer had previously had surgery under Professor Teasdale, a famous neurosurgeon in Glasgow. He said that he would have explained to the pursuer that the risks of undertaking a further operation were greater than those associated with the first surgical operation. In particular there was a risk of spinal fluid leakage. Mr Kamel said that he would not assume that the patient knew it all. He remembered meeting Mrs Johnstone, and remembered that she had mentioned that she was a nurse. This was important because it helps the patient understand what he was saying. But he still “consented” the patient in the usual way. He showed Mr and Mrs Johnstone the most recent MRI scan – “a picture is worth 1,000 words”, it helps with an understanding of the surgery and the risks involved. Mr Kamel was certain that he had told Mr and Mrs Johnstone that the MRI scan images were images of his brain.

[86] So far as concerned the rest of the conversation with Mr and Mrs Johnstone on 16 September 2010, Mr Kamel said that he obviously could not remember all the details of what had been discussed. It had occurred many years ago. He could only go by the note which he had written afterwards (CB/16), aided by what he described as his “usual

practice". He would have shown Mr and Mrs Johnstone the artery on the MRI scan. He would not have used technical language such as was used in his note – instead he might have described something as "the big vein behind the eye" or "a major artery". Shona Olson had reported the tumour as a "residual tumour". Mr Kamel would have seen her report before meeting Mr Johnstone. Normally, he said, he would seek advice from an endocrinologist as to whether there were any other possible causes of the acromegaly, but in this case Professor Bevan had already discussed such matters at the MDT meeting.

Mr Kamel said that one could never be sure from an MRI scan, but it seemed likely that the tumour was the cause of the acromegaly. He commented that the CAT scan carried out nowadays was more specific, however that technology was not available in 2010. Mr Kamel emphasised that he had not been at the MDT meeting but according to Professor Bevan's letter the medical approach to the acromegaly was not working and there was now a necessity for active treatment, i.e. surgery or radiosurgery. Surgery was the first line of treatment in this type of case. Mr Kamel's note mentions that Mr Johnstone's case had also been discussed at the neurosurgical MDT meeting and that the consensus was to discuss with Mr Johnstone the option of "active treatment", meaning surgery or radiation. The neurosurgical MDT meetings were held on a weekly basis, also in the x-ray department. In attendance would be neurosurgeons, oncologists and radiologists. He would normally attend those neurosurgical MDT meetings. They generally lasted about one hour and on average some 5-10 cases would be discussed at each meeting, though it could be more. His usual practice was to dictate a letter or make a record in the patient's notes detailing what had been discussed. Mr Kamel said that he could not recall the exact date of the meeting at which Mr Johnstone's case was discussed. It would certainly have been before 16 September 2010. It would have been attended by himself, Mr Al-Haddad (who had since moved away),

Mr Bhatt (who is still at ARI) and probably a fourth consultant who would have been a locum. At such meetings they would put up the relevant MRI scans and present the patient's history. There would then be a discussion. In the case of Mr Johnstone they would have agreed that there was an abnormal area shown on the scan. If the hormone level appeared to be elevated and Professor Bevan felt that medical treatment had failed, then the option would be there to explore surgery. The options were surgery or radiosurgery.

[87] Mr Kamel confirmed that, as stated in the note, he explained to Mr Johnstone the advantages and disadvantages of each technique. He would always discuss all the options with a patient. He would have referred back to what Professor Bevan had recommended. If Mr Johnstone had said that he was not keen on either form of treatment, he would have gone back to Professor Bevan and asked whether there was anything else which could be offered instead. Referring to the option of doing nothing, of ceasing treatment altogether, Mr Kamel said that this was not an attractive option at all. He could not now remember precisely what he said to Mr Johnstone, but his practice was to say that the options were to do nothing, to have surgery, or to undergo radiosurgery. So far as concerned radiosurgery, he told Mr Johnstone that that would take place in Sheffield and that if he was interested in pursuing that option he could make an appointment for him. As set out in the note, he would have explained the advantages and disadvantages of each technique. He would have told Mr Johnson that radiosurgery avoided the risks of surgery. That was not recorded in the note but he was confident that he would have said that. He would usually say: although it is called radiosurgery, there is actually no surgery in it and it therefore avoids the risks of surgery. Mr Kamel said that he carries out this type of surgical operation about 25-30 times a year. On each occasion he has personally consented the patient and he has a familiar talk or patter which he goes through with each patient. He was confident that he had offered

Mr Johnstone the opportunity to get an opinion from Sheffield but Mr Johnstone had made it clear that he wanted surgery. That was confirmed by the hospital notes and, subsequently, by Mr Johnstone's letter of complaint (CB/35). Mr Kamel said that he explained to Mr Johnstone that they were not 100% sure that it was a tumour. If the sample showed that the tissue was normal then they would stop the operation. Mr Kamel was clear that he told Mr Johnstone that there was also a risk of missing the tumour. Referring to his hospital note, he was not sure that he would have used the words "Diabetes insipidus" but he would have talked about things such as thirst and peeing. So far as concerned the reference to the risk of a CSF leak, he explained that the risk of a leak during the operation was higher (about 10-20%) than that of a leak after the operation (about 2%). The risk of meningitis is linked to the risk of a CSF leak. It was pointed out to Mr Kamel that his note did not mention the advantages of surgery, as opposed to the risks, but he was clear that he would have set out the advantages as well as the risks. The meeting would have taken between 15 and 45 minutes. At the end of the meeting Mr Johnstone agreed to surgery. That was Mr Kamel's recommendation and Mr Johnstone accepted it.

[88] Mr Kamel was referred to the letter he wrote to Professor Bevan after meeting Mr Johnstone on 16 September 2010 (7/21 p.164). That did not set out as much detail as in the note, but it confirmed that Mr Kamel had given Mr Johnstone the options of either radiosurgery or surgery and that Mr Johnstone was keen to go ahead with surgery. That was accurate.

[89] The operation was performed on 31 January 2011. The procedure for obtaining consent on the day fixed for the operation was standard. Typically the registrar would obtain the patient's consent and this was done in the present case by Mr Bodkin. Mr Kamel said that he would usually try to see the patient before the operation, but sometimes this

was not possible, for example if he was caught up in surgery. He could not recall meeting Mr Johnstone on 31 January prior to the surgery – he may have met him or he may not, he simply could not remember. So far as concerned the entry in the hospital notes for that day written by Mr Kamel (CB/17 and 7/21 p.238) Mr Kamel could not say whether that was a note of what he had told Mr Johnstone on that occasion or whether it was simply a summary by him of the relevant parts of what he had noted at his earlier meeting with Mr Johnstone on 16 September 2010. He rejected any suggestion that he had made up an entry of something that did not happen.

[90] Mr Kamel was referred to the minutes of his meeting with Mr and Mrs Johnstone on 30 August 2013 (CB/19). He said he had a vague memory of that meeting. He had no recollection of saying, as noted in those minutes, that laser treatment was not an option as the tumour was too near the main artery. He would never have said that. It was not within his expertise.

[91] At the end of his cross-examination Mr Kamel repeated that although he was not trying to hold himself out as an expert in radiosurgery, he was able to give Mr Johnstone enough information about it to enable him to make an informed educated decision.

[92] Mr Kamel noted that Mr Johnstone had first complained because his operation was cancelled a few times. The reason it was cancelled was because there was no neuropathologist available on those dates. As already explained, the neuropathologist is an important part of the team carrying out the operation.

Mr Peter Bodkin

[93] Mr Bodkin is a consultant neurosurgeon. In January 2011 he was a neurosurgical registrar at ARI. He was the only registrar there at the time. He had a variety of roles –

assisting in operations, taking care of pre- and post-operative management of patients, dealing with emergency referrals, and the like. He said that Consent Forms were mainly completed by him – that would be expected of any registrar of his stage in training and was a daily duty. He would do it for all kinds of procedures performed in the unit, including pituitary surgery. Pituitary surgery was a sub-specialist area and at that stage he would be expected to understand the operation but would not be expected to perform it without a good deal of hands on supervision. As at January 2011 Mr Bodkin was in the process of taking his FRCS (Neurosurgery) exams so his knowledge base for the generality of neurosurgery was good. By January 2011 he had assisted 22 pituitary operations and had performed three such operations under supervision. The majority of those cases have been consented by him personally. He would not be party to any decision-making about who should or should not have surgery – that was a multidisciplinary decision to which he would not be party.

[94] It was Mr Bodkin who completed the Consent Form with the pursuer on 31 January 2011. At that time the form did not have any space for detailing the particulars of what was discussed with the patient. Not surprisingly, Mr Bodkin had no recollection of either the pursuer or the particular Consent Form. He could therefore speak only to his general approach to consenting patients. Consent was carried out by him according to the PARQ routine, the acronym standing for: Procedure, i.e. an explanation of the details of the operation; Alternatives, i.e. alternatives to surgery; Risks, i.e. potential risks of surgery; and Questions, i.e. allowing the patient to ask questions regarding the procedure. He explained that the consent process had to be flexible, since operations vary in complexity and patients vary in the extent of explanation that is required. He admitted that his adoption of the PARQ principle had developed over some years and he could not recall precisely when he

adopted that particular process; but at the time in question he had been consenting patients for more than 10 years, including surgical consents, and the general principles of ensuring adequate informed consent was very familiar to him. If it was not the precise PARQ process it would have been something very similar.

[95] Absent any recollection of the particular patient or the particular Consent Form, all he could do was outline the kind of conversation that he considered that he would have had, adopting the PARQ process or something similar.

[96] So far as concerned Procedure, he would have told the patient that there would be a general anaesthetic which the anaesthetist would talk him through. He would be positioned on the operating table with due care, especially to pressure areas. A machine would be used, a bit like sat-nav, that uses the scan to help direct them in the operation (a form of neuro navigation). The first part of the operation is done by the ENT surgeons. They go up the nose with cameras and open a small hole in the back of the nose to allow access to the pituitary. Usually both nostrils are used. Mr Kamel would then proceed with the operation, again using a small camera (endoscope). The bony pocket where the pituitary gland sits is opened very carefully. The area is explored, looking for a tumour. Sometimes, if the lesion is small, this can be quite difficult; and in such cases the satnav machine can help. The tumour is gently removed using little scoops. This is then sent off to the laboratory where it is examined. Once the surgeon is happy that the lesion is removed the defect is closed. Often a small amount of fat is required to plug the gap to stop any leak of brain fluid. This fat graft is taken through a small incision in the tummy. The ENT surgeons can also carry out procedures to cover the defect, swinging some tissue from the back of the nose to fill any gaps. You will wake up in recovery where staff will be looking after you. You will have

packs in your nose. Sometimes it is necessary to place a tube into your lower back to drain off brain fluid.

[97] So far as concerns Alternatives, he would tell the patient that the decision about treating his tumour is quite complicated, requiring discussions between surgeons, hormone doctors and x-ray doctors. He would say that he understood that the consensus is that surgery has been recommended. There are, however, always alternatives. One could just leave it alone, sometimes hormones can be given, and sometimes radiotherapy can be offered. He would recommend discussion with Mr Kamel and the pituitary team if the patient wanted to explore this further. He would discuss alternatives with the patient even on the day of surgery. It is better for a patient to decline surgery, even on the day of it, than for the operation to proceed without fully informed consent. Mr Bodkin said that he did not have regard to what the consultant might think if the decision was taken not to go ahead.

[98] So far as concerns Risks, he would tell the patient that the procedure is done quite frequently in this hospital but there were some potential risks that he should be aware of. The majority of patients do not run into these problems, but they certainly can happen. The operation itself requires opening the back of the nose, which can result in loss of the sense of smell and taste, nasal discomfort, bleeding and crusting. There were some very important structures close to where they were operating. In particular, the main artery to the brain runs either side of the pituitary. Great care is taken and a sensor is often used to tell them when they were close to the artery. Damage to the artery could, however, result in death, coma, stroke, or permanent or temporary brain damage and further procedures. Thankfully the chances of this were small. Otherwise, there are small nerves in the vicinity which could be damaged, resulting in problems with moving the eyes. The optic nerve is also close by and blindness would result if it were to be damaged. There was also a chance that brain

fluid will leak through the operative site. Many precautions are taken to avoid this, such as packing the defect with fat and glue, etc. If there has been a leak of fluid in theatre they would often place a tube in the back to drain off excess fluid. This would take off some pressure and allow the hole to heal. Infection can occur either in the tissues in the back of the throat or in the brain – meningitis. The pituitary itself can be damaged. It releases a lot of different hormones and it may be that hormone replacement might be required either temporarily or lifelong. There is always the risk of incomplete removal of tumour. Sometimes this necessitates a further operation or radiotherapy to treat any remaining tumour.

[99] So far as concerns Questions, Mr Bodkin said that he would ask the patient if he had any questions and allow sufficient time to clarify any issues.

[100] Mr Bodkin said that the time for taking a patient's consent can vary enormously. It would obviously be more than a couple of minutes. A couple of minutes would not be sufficient. It would normally be at least 10 minutes but it could last for up to an hour. He could not think of any situation where he would sign a consent form without having established that the patient did in fact consent. He would not sign it if he had not done what it said he had done.

Expert evidence

[101] Both parties called expert evidence. Some of that evidence went into matters which are not directly relevant to the issue in this case. For example, some of the experts reviewed the pursuer's medical history and offered opinions as to the appropriateness of the assessment made by Professor Bevan and Mr Kamel of the pursuer's condition and the decisions they took as to the need for surgical intervention. However, it was accepted by

Ms Sutherland QC for the pursuer that such matters could only be the subject of criticism on a *Hunter v Hanley* basis and that no such criticism was made in the present case. Other aspects of this evidence were of more relevance and I summarise them briefly below.

Mr Matthias Radatz

[102] Mr Radatz is a consultant neurosurgeon. He is the director and former lead clinician of the National Centre for Gamma Knife Radiosurgery in Sheffield. He was appointed to his current position as consultant neurosurgeon in May 1999 and has led the Gamma Ray centre in Sheffield since then. At the time with which this case is concerned, there was no facility for Gamma Ray surgery in Scotland but it was not uncommon for people from elsewhere in the UK, including Scotland, to be referred to Sheffield for radiosurgery or at least for advice in connection with the possibility of having radiosurgery. Mr Radatz produced three expert reports (CB/6, 8 and 9) and gave evidence under reference to those reports.

[103] Mr Radatz confirmed that the pursuer had a benign tumour (adenoma) in the pituitary gland. In his report he identified three options for treatment. Option 1 was "Watch and Wait/Observation"; Option 2 was "Trans-sphenoidal surgery (endoscopic assisted or not)"; and Option 3 was "Radiotherapy/Radiosurgery".

[104] So far as Option 1 was concerned, this did not amount to a policy of doing nothing but involved continuing treatment with drugs. Both in his evidence in chief and in cross-examination he was pressed as to whether that was a real option in this case. His answers varied. At one time he agreed that it was advisable to undergo further treatment (i.e. transsphenoidal surgery or radiosurgery) but he would not say that such further treatment was mandatory within a particular period of six, 12 or 24 months. The problem had been around for a long time. Under reference to the fact that medicines had proved ineffective

earlier, he was asked whether in late 2010 having no further active treatment was a reasonable option. He replied that it was an option and it was up to the patient to decide, provided that he was told the potential disadvantages of making that decision. But he accepted that the option of no treatment would not have been recommended by clinicians. At one point he accepted that, in terms of what options were reasonable, Option 1 (Watch and Wait) could be disregarded. A line could be put through Option 1. In re-examination, however, while accepting that advice from the medical fraternity would have been to have further treatment, "do nothing" should still have been offered as an option. As to whether it was a reasonable option, he remarked that it was not a life or death decision. If the patient decided to do nothing he could always change his mind later if his problems became unbearable.

[105] So far as concerned Option 2, Mr Radatz stated that transsphenoidal surgery was indicated as first-line therapy for patients with symptomatic pituitary apoplexy, for clinically non-functional pituitary micro-adenomas that abut the optic chiasm, and those with Mass effect such as visual field defect, and for tumours that demonstrate progressive increase in size. He said that surgery might be indicated when the diagnosis was in doubt, in order to confirm the diagnosis. The majority, more than 90%, of pituitary adenomas are removed by transsphenoidal surgery, which is carried out with the use of minimally invasive techniques and computer guided neuro navigational devices. The pituitary is approached via either a trans-nasal submucosal or sub-labial. Intraoperative MRI scanning had been introduced and might improve surgical outcomes. Data suggested that the endoscopic approach was safe and effective. Such an approach potentially provided improved visualisation of the surgical field compared with a traditional microscope based transsphenoidal approach. He himself had last carried out such an operation about 10 years

ago. He accepted that he would not call himself an expert on transsphenoidal surgery – he was not giving expert evidence on that.

[106] Mr Radatz set out some statistics concerning the effectiveness of transsphenoidal surgery and the risks involved in it. He commented that transsphenoidal surgery was a very effective way to treat clinically non-functional pituitary adenomas. Hormone deficits were resolved in 15-50% of patients, and hyperprolactinaemia resolved in more than two thirds of patients. Surgery may induce a new hormone deficit in 2-5% of patients. Transient diabetes insipidus may occur in up to one third of cases, but the risk of permanent diabetes insipidus is only 0.5-5%. Post-operative tumour recurrence varies from 12% to 46%.

Following transsphenoidal surgery, visual field defects are improved or normalised in 51-96% of cases. Improvement of visual function may continue until one year after surgical treatment in some patients. Data from studies concerning post-operative pituitary function were conflicting: 62% showed an improvement while 30% showed no significant improvement or some deterioration in pituitary function after surgery. The growth hormone axis was the least likely to recover following transsphenoidal surgery. He emphasised that assessment of the effectiveness of transsphenoidal surgery is recommended at about four months following surgery by which time post-operative changes have typically resolved themselves. Close follow-up with repeated MRI scans is recommended.

[107] So far as Option 3 was concerned, Mr Radatz said that radiotherapy was typically used to treat a post-operative leak, when there was significant residual tumour mass, particularly tumour invading the cavernous sinus or to treat a recurrence. It might also be used for tumour growth control in those who were poor surgical candidates. What was in issue here was not conventional radiotherapy but “stereotactic radiosurgery”. With stereotactic radiosurgery the goal is to deliver a high radiation dose to a more defined target,

thus minimising damage to surrounding tissues. The surgery aspect relates to the use of invasive fixating frames to immobilise the patient. MRI and CT scans are used to define tumour anatomy and map out the radiation field. From a single dose up to five doses of radiation are delivered either via a linear accelerator or via multiple cobalt beams (Gamma Knife). In Sheffield they used the Gamma Knife technique. Gamma Knife radiosurgery usually involves multiple isocentres of different beam diameters to achieve a dose plan that conforms to the irregular three-dimensional volumes of most mass lesions. Mr Radatz explained that in patients with pituitary adenomas, radiosurgery was meant to inactivate the tumour cells, thereby preventing or normalising tumour growth and, for functioning adenomas, also normalising hormone overproduction. Ideally those goals are met without damaging the residual normal pituitary gland and surrounding vascular and neuronal structures. Radiosurgery should also be performed in a way to avoid delayed radiation associated secondary tumour formation.

[108] Mr Radatz said that the success rate in normalising the hormone production by stereotactic radiosurgery depended on the radiation dose delivered. Success rates vary greatly in different research published over the decades, but it could be as high as 96%. Realistically, however, he would state to patients with acromegaly that there was a statistical chance of 50-60% of succeeding in normalising hormone levels over an interval period of two to four years. That was not exact, and there was no guarantee of success (though that applied to surgery as well). The main benefit of radiosurgery was its lack of invasiveness. It did not carry the same risks as surgery. There was no risk of CSF leak. There was no risk of causing meningitis. Nor was there any risk of injury to the carotid artery. There was a small risk of causing double vision (3-5%) and a risk (perhaps 10%) of there being an impact on pituitary function with a need for hormone replacement.

[109] Every case referred to his department in Sheffield was evaluated independently.

Each evaluation was focused on the particular patient, their anatomy, and the location of the tumour in relation to the nervous system and the arteries, etc. Not every patient had to go to Sheffield for the initial consultation – they offered telephone advice. Typically a discussion might last 25 minutes though it could last longer, and it took place against a background of the patient having been provided with a written information booklet. In such a discussion they would talk about the risks and benefits of radiosurgery and would always include the option of doing nothing. Sometimes patients are seen after they have had other discussions about the possibility of transphenoidal surgery. The advice could also be given to the medical team treating the patient, so that they could make the patient aware of the advantages and disadvantages of radiosurgery. Mr Radatz said that he had evaluated images of the pursuer. Based on those images, because of the position of the pituitary stalk and the location of the tumour, he would have been able to use a high dose without exposing the pursuer to the risk of hypopituitarism. The pursuer was a good candidate for radiosurgery.

[110] Mr Radatz was shown the relevant paragraphs of the GMC Guidance. He was also shown the hospital notes (CB/16) in which Mr Kamel had recorded the discussion with the pursuer and his wife on 16 September 2010. His evidence was that Mr Kamel's note suggested that he had not fully explained to the pursuer the risks and benefits of radiosurgery. It would generally take two to four years for radiosurgery to work, though in some cases the patient may respond earlier. In those circumstances one to two years as recorded by Mr Kamel in that note was a reasonable estimate to give.

Mr Patrick Statham

[111] Mr Statham is a Consultant Neurosurgeon in the Department of Clinical Neurosciences at the Western General Hospital in Edinburgh, a post which he has held since 1993. His particular areas of interest are pituitary and skull base surgery and spinal surgery. He gave his evidence under reference to two reports lodged in process as CB/5 and CB/7. His CV is at CB/4.

[112] I have already summarised that part of Mr Statham's main report which records what he was told by the pursuer, in particular about what, according to the pursuer, was discussed at the meeting with Mr Kamel on 16 September 2010. Much of the main report is taken up with an account of the pursuer's medical records and his presentation in 2010. Mr Statham gave his opinion in section 9 of his main report. He confirmed that possible causes for a rise in IGF-1 levels could be a recurrence following previous surgery or could be explained by physiological factors such as stress or disease. He was prepared to defer to an endocrinologist to determine whether there might be other possible explanations beside the known residual tumour. I did not understand Mr Statham in this part to suggest that the rise in IGF-1 levels in this case were due to anything other than a recurrence after the previous surgery. Mr Statham said that the options for treatment at the relevant time were (i) drug treatment (Pegvisomant), (ii) stereotactic radiosurgery/radiotherapy and (iii) surgery. He described these all as reasonable options for treatment but added that if surgical risks were low and the tumour accessible, then surgery was more likely to result in it being cured quickly, which was obviously an advantage to the patient. Risks of sleep apnoea, heart failure, diabetes, colonic polyps and hypertension diminish faster. It was not suggested during the proof that the pursuer should have been put on a course of

Pegvisomant; accordingly, since other medications had proved ineffective some years previously, the drug treatment option was not pressed.

[113] The main focus of Mr Statham's evidence was in relation to what risks he considered that Mr Kamel should have explained to the pursuer in relation to the proposed transsphenoidal surgery. He listed the main points. First, there was the risk of not curing the acromegaly, for example by not fully removing the tumour, or not finding it, or from it recurring despite apparent removal (as had happened previously). Secondly, the risk of CSF leaking was considerable, given the adjacent pool of CSF relative to the "small nubbin" which was being explored. The risk would be greater than 50%. Inherent in that was the risk of subsequent meningitis if the leak was not adequately dealt with, which could be life-threatening. Thirdly, there was the risk to life from damaging the carotid artery. The risk of damaging it was very small (less than 1%) but if it was damaged it would be difficult to control and the consequences would be very severe. Fourthly, hypopituitarism (a worsening pituitary function) is more likely after a second operation, and lifelong hormone replacement might be necessary (though the risk of that was less than 20%). In his later report, Mr Statham commented specifically on what, according to the note of 16 September 2010, Mr Kamel had told the pursuer. He recognised that Mr Kamel had mentioned the common and serious side effects of surgical treatment on a small lesion which would be difficult to locate. Those were hypopituitarism and diabetes insipidus requiring hormone replacement. Mr Kamel had then given a rough estimate of a 40% risk of other problems, such as carotid artery injury (1-2%), death or stroke (less than 5%), risk of CSF leak, risk of meningitis and a possible need for further surgery. He accepted that the risk of damage to the carotid artery was probably less than 1%. A risk of death or stroke was less than 5%. He thought the risk of CSF leak was high in this case (probably greater than 50%) given the

position of the remnant of tumour – that should have been emphasised more strongly by Mr Kamel. With a CSF leak comes the risk of meningitis, which was separate from the need for further surgery. The risk of meningitis would be greater than 5%. Having observed that Mr Kamel's note suggests that the comparison with radiosurgery was summarised in the course of his explanation of the advantages and disadvantages of each technique, he pointed out that radiosurgery was explained to take one or two years to be effective and that an opinion from a radio surgical centre in Sheffield would be needed. He did not discuss the risks of hypopituitarism, of carotid artery injury and subsequent stroke years after the event. He points out that no formal opinion was obtained from the radio surgical centre in Sheffield.

[114] In his evidence in chief Mr Statham said that he would expect a consultation between patient and doctor to take about half an hour, but that would be before the formal consent visit, which would take 20 minutes to half an hour. It was important to be thorough. Mr Statham said that he would always offer the option not to have surgery. In the present case the only real problem arising from the acromegaly was the pursuer's arthritis. The pursuer's IGF-1 level was rising but was at relatively modest levels. There was no urgent need of surgery now.

Mr Nick Phillips

[115] Mr Phillips is a consultant neurosurgeon at Leeds Teaching Hospitals, a position he has held since 1997. He also has a sub-specialisation in radiosurgery using the Gamma Knife technique. He was called to give evidence on behalf of the defenders. His report is at CB/47.

[116] He had reviewed the pursuer's hospital and GP records. His assessment was that a neurosurgeon in the position of Mr Kamel could be reasonably certain that the pursuer's acromegaly was caused by a residual tumour (the nubbin) which was secreting growth hormone. The only way of checking definitively was to operate and test some tissue from the suspicious area. Secretion of growth hormone had long-term health effects, and it was important to reduce the level of hormone secretion by whatever means possible. For that reason Mr Phillips would have counselled very strongly against taking the option of having no treatment. By the time the pursuer's case had been referred to the surgeon, the endocrinologists had formed the view that doing nothing was not an option. In his view, leaving it even for a year was not a reasonable option. If Mr Kamel was concerned that radiosurgery might damage the carotid artery, that concern was not justified. Nonetheless, the most effective treatment was surgery. It acted quickly and could result in a total cure for the problem. Radiotherapy could take some time to be effective. He said that transsphenoidal surgery "is still the first-line treatment of choice in acromegaly", as it is more successful than radiotherapy and acts more quickly. In his view, Mr Kamel was right to focus on surgery. Mr Phillips had read Mr Kamel's note of his discussion with the pursuer on 16 September – based on that note, he considered that Mr Kamel had explained the risks of complications appropriately. There was a very full explanation of the risks of neurosurgery. Mr Phillips disagreed with Mr Statham's assessment that the risk of CSF leak during or after surgery was 50%. Mr Kamel's assessment that radiosurgery might involve a delay of one to two years to be effective was, if anything, optimistic. Radiosurgery had a success rate of about 50-60%, or slightly less.

Mr Lawrence Dunn

[117] Mr Dunn was also called on behalf of the defenders. He is a consultant neurosurgeon who has been in full time clinical practice since 1996. He is based in Glasgow. His report is at CB/46.

[118] Mr Dunn reviewed the history of the management of the pursuer's acromegaly. He summarised the pursuer's IGF-1 readings from about 1994 through to 2010. Based on a review of the MRI scan, he agreed with the assessment that the small nodule of tissue adjacent to the right carotid artery and cavernous sinus could represent a residual or recurrent tumour. From the MRI scans he could not say that there was definitely a tumour, but a tumour was by far the most likely explanation. In his report, he discussed the options available for treating the pursuer's condition. It is unnecessary to go into this in detail.

[119] In his oral evidence, Mr Dunn confirmed that if Mr Kamel's note of his discussion with the pursuer on 16 September accurately summarised what was said, then Mr Kamel had not omitted to mention any material risks of surgery. The note contained a comprehensive list. As to whether "no treatment" was a reasonable option, he considered that, in the context of elevated and rising IGF-1 levels, no treatment was not a good idea. He confirmed that it was difficult to remove tissue during the operation without going into the CSF compartment and, if this was done, there was a likelihood ("more likely than not") of a CSF leak – though that could be repaired.

Submissions

[120] In addition to comprehensive oral submissions after completion of the evidence, I had the benefit of detailed written submissions both before the commencement of the Proof and at the end of it, in advance of oral submissions. I was also given supplementary notes of

argument on specific points, no doubt addressing concerns that I had not fully grasped some of the complexities of the case. I am grateful to both counsel for their assistance in this regard.

[121] I do not propose to attempt a comprehensive summary of the submissions made to me. Despite the detail in the submissions and the wide scope of the evidence led at proof, it seems to me that, in essence, the pursuer's case is relatively straightforward. It is based on the Supreme Court decision in *Montgomery v Lanarkshire Health Board* 2015 SC (UKSC) 63 and, in particular, the summary of the relevant principle set out in paragraph 87. I have quoted from that paragraph near the beginning of this Opinion (see para [12]). I was referred to a number of cases, both English and Scottish, decided before *Montgomery*, but it did not seem to me that they added significantly to what was said in that paragraph. I was also referred to authorities from Australia and elsewhere but, again, I do not consider that those authorities advance the argument in this case.

[122] As I have said, the pursuer's case is essentially straightforward. Before operating on him to remove the suspected tumour, the defenders required to obtain the pursuer's consent. Such consent could not be obtained without the pursuer having been made aware of any material risks involved in the proposed treatment and of any reasonable alternative or variant treatments, including the option of having no treatment at all. The defenders, through Professor Bevan and Mr Kamel, were required to take reasonable care to ensure that the pursuer was aware of all such risks before he decided to undergo transsphenoidal surgery. They failed in this duty. Although the defenders are said to be vicariously liable for the failings in this regard of both Professor Bevan and Mr Kamel, the focus of their criticism is on Mr Kamel. The pursuer says, in substance, that although the possibility of radiotherapy was mentioned by Professor Bevan to his GP, Dr Hoque, on a number of

occasions, and in fact was mentioned to him personally by Professor Bevan, by the time he came to see Mr Kamel on 16 September 2010 the idea of radiosurgery, as opposed to transsphenoidal surgery, was no longer a live consideration. According to the pursuer and his wife, Mr Kamel never mentioned the possibility of radiotherapy. They were never given the option of going to Sheffield to find out more about it. The idea of radiotherapy was no longer on the agenda. They had not ruled it out – they just assumed that Professor Bevan and Mr Kamel had decided between them that surgery was the best option. Nor was any relevant information on radiosurgery given when the pursuer was “consented” just before the operation on 31 January 2011. The pursuer says that if he had been told of the possible benefits of radiosurgery – that it was risk free and carried out under local anaesthetic without the need for full hospital admission – he would have opted for radiosurgery. Further, the pursuer says that he was never told that one reasonable option was to do nothing for the moment but to keep his acromegaly under review with the possibility of doing something later if his condition deteriorated. Again, had he been told of this option, he would not have agreed to undergo transsphenoidal surgery which was, on any view, risky and potentially life threatening.

[123] The defenders’ argument was equally straightforward. They accepted that there was a duty placed on the doctor to take reasonable care to inform the patient of the material risks involved in the recommended treatment and of any reasonable alternative or variant treatments. However they contended that the question of whether or not the doctor (and therefore the Health Board) was liable for breach of that duty was to be judged by reference to the test in *Hunter v Hanley* 1955 SC 200 and *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, in terms of which the extent of the duty to advise and the question of whether that duty had been breached fell to be decided by reference to accepted medical

practice. The pursuer had not contended (or led evidence to show) that either Professor Bevan or Mr Kamel had fallen short by reference to that standard. However, in any event, and even if the obligation on Professor Bevan and Mr Kamel was simply to take reasonable care to inform the patient of all material risks (without reference to the *Hunter v Hanley* standard), the evidence clearly established that Mr Kamel had discussed the various options in detail with the pursuer at the meeting of 16 September 2010 and in particular had taken all reasonable care to ensure that the pursuer was aware of the risks involved in undergoing transsphenoidal surgery as well as the comparable benefits or dis-benefits of radiosurgery. So far as concerned the question of “doing nothing”, this was not a reasonable option and did not require to be discussed with the pursuer; but it was in fact discussed with him. On the basis of his discussion with Mr Kamel on 16 September 2010 the pursuer made an informed decision to undergo transsphenoidal surgery. But this was not the last opportunity given to the pursuer to make an informed decision. Before the operation on 31 January 2011 the pursuer was “consented” by Mr Bodkin. As part of his PARQ processing of the pursuer he would have discussed what alternatives were available, which would have included reference to radiotherapy or the possibility of doing nothing. In any event, if there was a failure in any respect to inform the pursuer of any material risks, it was not shown that the pursuer would have made a different decision had he been told more. The likelihood was that he would have done exactly the same.

Discussion and Decision

Credibility and reliability

[124] As is so often the case, assessment of credibility and reliability is hampered in this case by the passage of time and the time taken to focus the complaint. Thus, Mr Bodkin,

who consented the pursuer on 31 January 2011, could not specifically recall anything of the events of that day. His account of what probably happened on that occasion was based almost entirely on the practice which he normally followed over a number of years in consenting patients before any operation. I did not find that at all surprising. The pursuer's account of what he was told on that occasion, and the account given by his son, Kevin, were both based on what they claimed to recall some considerable time later. The issue of what, if anything, was explained to the pursuer at the time that formal consent was taken on 31 January 2011 was not raised by the pursuer or his wife as one of their complaints until a long time after the relevant events had occurred: see, for example, the pursuer's letter of complaint of 10 July 2013 (CB/35), some two and a half years later, where this aspect of the process is not mentioned at all. Neither side's account of this meeting had the sort of detail necessary to inform a forensic analysis of precisely what took place.

[125] Perhaps more importantly, the account given by the pursuer and his wife of what they were and were not told by Mr Kamel on 16 September 2010 about the risks involved in surgery and the various options such as radiosurgery or simply doing nothing is not based on any notes or other aids to recollection and was not formulated coherently until some two years or more after the event. As against their evidence, Mr Kamel is able to refer to his note of 16 September 2010 – made, at the latest, within a few hours of the meeting – to support his account of what he said to them, but his evidence, given nine years after the event in respect of a complaint not made at the time, is necessarily devoid of the sort of telling detail which might, in other circumstances, help to pin down a point as being true or untrue.

[126] Sometimes it is possible to test issues of credibility and/or reliability by showing that the witness has given a particular piece of evidence which can clearly be shown to be wrong. But this case illustrates the care required to be taken with this approach. Despite the note in

Mr Kamel's handwriting in the hospital records (CB/17), it is the pursuer's case that he did not see Mr Kamel on 31 January 2011 before the operation. Mr Kamel's note refers to Mrs Johnstone as having been there at the time when it is tolerably clear that she was not. In his evidence Mr Kamel was uncertain on this point. Yet both parties in their pleadings make averments or admissions to the effect that Mr Kamel did see the pursuer on the morning of the operation. And witnesses were cross-examined on the inconsistency between the pleadings and their evidence on this point. In many cases such apparent inconsistencies can be indicative of a change of position and may adversely affect an assessment of the witness's credibility or reliability. But I am satisfied that in this case no such adverse assessment should be made on that basis. Mr Kamel's note, placed as it was in the hospital's patient files, gave the clear impression that Mr Kamel had seen the pursuer on the morning of the operation. The case was pled both for the pursuer and the defender on the basis of that note and what it seemed to establish. That there was a mismatch on the pursuer's side between that specific admission in the pleadings and the pursuer's own case simply reflected what appeared to be shown by the documents. I am satisfied that that admission by the pursuer was wrong. Mr Kamel did not meet the pursuer on the morning of the operation. Had he done so he could not have recorded that Mrs Johnstone was present – she was not present, she was at work. So the inconsistency in the pleading does not adversely reflect on the pursuer's credibility or reliability. But nor does it reflect adversely on that of Mr Kamel. Not surprisingly given the passage of time, he could not remember whether he did or did not see the pursuer on the morning of the operation. Nor could he say why the note was written, if he had not in fact attended the pursuer that morning. However, it was not suggested that the note was fabricated by Mr Kamel with a view to creating the impression that he had met the pursuer then – and I should make it clear that Ms Sutherland QC, on

behalf of the pursuer, expressly disclaimed any such suggestion. So, in my opinion, neither the existence of the note nor its content impacts in any way upon Mr Kamel's credibility or reliability.

[127] Having seen and heard all the relevant witnesses except, of course, Professor Bevan, I have come to the view that this case cannot be decided on the basis that one side is inherently more credible than the other. I am satisfied that all the witnesses who appeared before me were doing their best to tell the truth. Nor can I decide the case on the basis of some generalised view that some of the witnesses were inherently more reliable than others. Questions of reliability have to be decided in this case on an issue by issue basis, assessing how the evidence of the particular witness fits in with the other evidence and the contemporaneous documents. For reasons explained by Leggat J (as he then was) in *Gestmin SGPS SA v Credit Suisse (UK) Limited* [2013] EWHC 3560 (Comm) at paras 15-22, I take the view that, with that one particular exception, the documentary evidence is likely to provide the best guide to where the truth lies in this case.

What the case is not about

[128] It is convenient to start by stripping out the points which this case is not about. It is not a case about the diagnosis made by Professor Bevan and/or Mr Kamel that the pursuer had a tumour which was causing his recurrent acromegaly. In the letter of complaint sent by the pursuer, and in the oral evidence given on his behalf, there is an expression of concern that the pursuer had been told there was a tumour, not that they thought there was a tumour. Such a concern may be understandable, since the lay person will often look for and perceive certainty where there is none. But that complaint is not an issue in the case. It

is a matter of diagnosis which, if negligent, would be actionable, if at all, on a *Hunter v Hanley* basis. No such case is advanced.

[129] Similarly, there was a complaint running through the evidence given on behalf of the pursuer that he should have been told that he did not need any treatment yet, but that case cannot succeed since the diagnosis made by Professor Bevan and all those at the MDT meeting was that he did need active treatment then. That diagnosis is not challenged (nor could it have been except on *Hunter v Hanley* grounds). It would therefore make no sense to require Professor Bevan, still less Mr Kamel, to tell the pursuer that he did not yet need any active treatment since this would be contrary to the diagnosis made by the endocrinologists and others considering his case.

[130] Another matter which featured in the evidence but is not an issue in the case is the pursuer's dissatisfaction with the manner in which the operation was carried out and, more particularly, what may compendiously be described as post-operative care or lack of it, covering all problems described in paras [9], [60] and [75]. Clearly, and understandably, the pursuer was upset by what happened, and the pursuer's concerns about that featured prominently in his letter of complaint sent on 10 July 2013 (see para [47]). But in this action there is no complaint that the operation was carried out negligently or that there was negligence in the post-operative care, and it is important, as with the other non-issues, to put them to one side and focus on the live issue in the case which I have already identified.

[131] For the pursuer, much emphasis was placed by Ms Sutherland QC on the provisions of the GMC Guidance. Mr Kamel was cross-examined at some length by reference to the Guidance, including on questions such as making a record of key elements in the discussion between doctor and patient. While I accept that these provisions may set out good practice in this field, and will therefore inform the content of the *Montgomery* duty of care, they are

not prescriptive of the precise steps which, so far as concerns the question of negligence in a case such as this, a doctor must take in his dealings with the patient. But it is not for this court to police the GMC Guidance. If there is an alleged breach of the Guidance, this can be taken up with the GMC at the appropriate time and in accordance with its rules.

Case based on vicarious liability

[132] I should make one further preliminary point. The claim is brought against the defenders on the basis that they are vicariously liable for the failings (breaches of duty) of two individuals, Professor Bevan and Mr Kamel. There is no case made against the defenders alleging that they were directly responsible for ensuring, or taking reasonable care to ensure, that, before undergoing his operation, the pursuer was made aware of all material risks associated with it and of all reasonable alternative treatments. Their only liability is for such failings as are found to be proved against Professor Bevan and/or Mr Kamel personally. This is potentially of some importance, though it is probably not decisive in the present case. So, to take an extreme and hypothetical example to illustrate the point, if the court were to find that Professor Bevan reasonably understood that the pursuer would be told of all the risks of surgery by Mr Kamel at a later stage before the final decision was made to undergo surgery, and if the court were also to find that Mr Kamel reasonably believed that the pursuer had already been given all the relevant information by Professor Bevan, then the defenders would not be liable, because there is no case made against them that they themselves owed a duty directly to the pursuer to ensure, or to take reasonable steps to ensure, that the pursuer was given all the relevant information at or before the time at which he agreed to undergo surgery. In the course of final submissions, I raised this point with Ms Sutherland; but she confirmed that the pursuer's case was limited to a case based

on vicarious liability for the breaches of duty by Professor Bevan and/or Mr Kamel in failing to take reasonable care to ensure that before agreeing to undergo the operation the pursuer was made aware of all material risks associated with it and of all reasonable alternative treatments.

Vicarious liability for failings of Professor Bevan?

[133] It is convenient to consider first the case made against Professor Bevan. Ultimately it did not appear to me that this case was advanced with any conviction. And rightly so in my opinion. So far as concerns Professor Bevan, one can pick up the narrative with his meeting with the pursuer on 27 July 2010, which the pursuer spoke to in his evidence but in respect of which there is no contemporaneous note. The evidence about that meeting is summarised at para [32] above. The pursuer was told: the tumour needed treatment and there were two options, laser treatment in Sheffield or surgery in Aberdeen. On the basis of that diagnosis, to which there is no challenge in this action, Professor Bevan presented those two options. The neuroradiology MDT meeting took place on 16 August (para [33]). As noted by Professor Bevan in his letter to Mr Kamel, that meeting confirmed the diagnosis and said that two options were potentially available, endoscopic surgery or radio surgery. He asked Mr Kamel to give an opinion on whether surgery was possible. He was clearly not excluding consideration of radiosurgery, but wanted an opinion on the possibility of surgery first. On 22 August (para [34]) Mr Kamel wrote to Professor Bevan saying that he would arrange to meet the pursuer on a ward visit “to discuss the surgical option with him”. Clearly radiosurgery was not being ruled out. Professor Bevan met the pursuer again on 30 August 2010 (para [35]) – the note records discussion of two “options to be explored”. The pursuer met Mr Kamel on 16 September 2010 (para [38]), after which Mr Kamel wrote to

Professor Bevan confirming that he had given the pursuer the options of either radiosurgery or endoscopic surgery and had explained some of the risks of surgery; and that “after thorough discussion [the pursuer] was keen to go ahead with surgery”.

[134] The pursuer says that he met Professor Bevan again on 8 October (see para [40]). His account of that meeting includes the observation that there was no further discussion about laser treatment at Sheffield. If that is so, it was no doubt because Professor Bevan had been told that the pursuer had decided to go ahead with endoscopic surgery. The pursuer’s statement that he took it from that (i.e. from the absence of any further discussion about laser treatment) that Professor Bevan and Mr Kamel had between them decided that surgery was the only option cannot be accepted. It is at odds with his statement in the letter of complaint sent by him on 10 July 2013 that he was presented by Professor Bevan with two treatment options and “decided to have surgery at ARI”. It is possible that that relates to the meeting on 27 July 2010, but even so it is wholly inconsistent with the idea that the pursuer thought that Professor Bevan and Mr Kamel between them had made the decision without consulting him.

[135] Professor Bevan had no further involvement in the pursuer’s case before the operation was carried out by Mr Kamel at the end of January 2011. It seems clear that Professor Bevan himself did not go into any detail with the pursuer about the risks involved in an operation of this sort. It must be borne in mind that the pursuer had undergone a similar operation in 1980 and would have been reasonably familiar with what an operation of that sort entailed. No doubt it was on the basis of his past experience that he decided, if his letter of complaint is to be taken at face value, at an early stage to opt for surgery again. But, in any event, whether this is so or not, so far as Professor Bevan was concerned, the pursuer was being seen by Mr Kamel to discuss the surgical option, had in fact met

Mr Kamel on 16 September and, according to what he was told by Mr Kamel, the pursuer had had a full explanation of the risks and, after a thorough discussion, was “keen” to go ahead with surgery.

[136] On that narrative of events, I can see no basis for saying that Professor Bevan was at fault in not explaining all the risks of surgery himself, when it would obviously be done by Mr Kamel, and when Mr Kamel had told him that after full discussion the pursuer wanted to go ahead with surgery. Any case of vicarious liability based on an alleged breach of duty by Professor Bevan must fail.

Vicarious liability for failings of Mr Kamel?

[137] I turn then to consider the case against Mr Kamel. His first involvement of any sort with the pursuer was when Professor Bevan wrote to him on 17 August 2011 mentioning the pursuer’s case and asking him to give an opinion on whether further endoscopic surgery was possible (see para [33]). The letter mentioned the possible use of radiosurgery instead. Until then Mr Kamel had never even heard of the pursuer. His letter in reply to Professor Bevan suggested that they should explore the surgery option prior to radiosurgery. Mr Kamel arranged to meet the pursuer. He met him on 16 September 2010 at the hospital.

The meeting of 16 September 2010

[138] The first, and critical, question is: what was said and discussed at the meeting of 16 September? The primary source material consists of (a) Mr Kamel’s note of the discussion, set out above at para [38], and (b) Mr Kamel’s letter to Professor Bevan dictated on that day, referred to at para [39]. Mr Kamel did not suggest that the note was written by him during the consultation with the pursuer. He would have written it soon afterwards. I

think it probable that the note was written on 16 September 2010, immediately after his meeting with the pursuer, at a time when the consultation was still fresh in his mind. It makes sense for it to have been written just before or just after he dictated the letter to Professor Bevan telling him of the outcome of the meeting. As stated earlier (para [38]), there was no suggestion either in cross-examination of Mr Kamel or in closing submissions that the note was written by him at a later date to support his position after a dispute had arisen. It must, in my opinion, be treated as a note written by Mr Kamel, to be placed in the hospital records for the pursuer, setting out as fully as necessary and as accurately as possible what had happened at his meeting with the pursuer on 16 September 2010, both what he had told the pursuer and what had been decided.

[139] Mr Kamel's note is quoted in full in para [38] of this Opinion. I need not set it out again. I shall simply highlight some points from the note. According to Mr Kamel:

- (1) he showed the pursuer the MRI scan;
- (2) he explained the options of surgery or radiosurgery;
- (3) he explained the advantages and disadvantages of each technique;
- (4) he said that radiosurgery takes one to two years to be effective;
- (5) he said that if the pursuer wanted radiosurgery, they would need to get an opinion from Sheffield first;
- (6) he explained the difficulties of locating a very small tumour;
- (7) he explained the risks involved in surgery, including the risk of damaging the carotid artery and, importantly, the post-operative risks of CSF leak, meningitis and the need for further surgery; and
- (8) after thorough discussions, the pursuer agreed to go ahead with surgery.

While Mr Kamel's letter to Professor Bevan that same day does not go into so much detail – which is to be expected, given that the main purpose of that letter was simply to inform Professor Bevan what had been decided and what was to happen next – what he told Professor Bevan in that letter is entirely consistent with his note.

[140] There is a sharp conflict between this account by Mr Kamel and the evidence given by the pursuer and his wife. I have set out the pursuer's evidence about the meeting at para [55] and that of his wife at paras [69]-[71]. In summary, the pursuer says that

- (1) they were shown an image of a head on a desktop monitor, but did not know whether or not that image was of his head;
- (2) Mr Kamel explained how the surgery would be done, using a new navigation tool;
- (3) there was no mention of the main artery or any dangers;
- (4) there was no discussion about radiotherapy or about laser treatment at Sheffield;
- (5) it seemed that the decision was made (presumably by Mr Kamel and Professor Bevan) that he would have surgery in Aberdeen.

Mrs Johnstone, the pursuer's wife, confirmed all of the above. She emphasised that Mr Kamel did not tell them about problems that could occur during or after surgery. She asked rhetorically: Why would the pursuer opt for surgery if he had been told there was a risk of death? And why would the pursuer not have travelled to Sheffield to discuss the possibility of laser treatment if he had been told of the risks involved in undergoing surgery?

[141] I have some difficulties with the evidence of the pursuer and his wife on this issue. First, as already noted, the idea that the option of radiosurgery was simply taken off the

table by Mr Kamel and Professor Bevan without any input from the pursuer is at odds with the statement made by the pursuer in his letter of complaint sent in July 2013, more than two years later, that he “decided to have surgery at ARI” (see para [46]). That statement is slightly ambiguous as regards when it is said that the pursuer made that decision – was it linked to the meeting with Professor Bevan in July or was the decision made later, even in September when they met Mr Kamel? – but in other respects it is wholly unambiguous; the pursuer made a decision to have surgery. That statement is impossible to reconcile with the suggestion that Mr Kamel and Professor Bevan made that decision between themselves without reference to the pursuer. Second, the pursuer and his wife both say that there was no discussion about any potential problems after the operation, contrary to Mr Kamel’s note which mentions the risk of CSF leak, meningitis and the need for further surgery. But in his discussions with Mr Statham, the pursuer is recorded as having told Mr Statham that he recalled Mr Kamel advising him of the need to watch out for infection after the surgery. This, of itself, is perhaps a small point, but it is difficult to imagine how the conversation with Mr Kamel would have turned to the question of post-operative risks without having also discussed the risks inherent in the operation itself.

[142] Of perhaps greater weight is the fact that in the letter of complaint sent in July 2013, by which time the pursuer would have had time enough to reflect on what was important and what was less important, the main concern expressed by him is as to the failure by Mr Kamel to locate any tumour. This is a theme which runs through the meeting with Mr Kamel on 30 August 2013 (see para [48] at sub-paras (i), (ix) and (x)). It is true that in the letter of complaint the pursuer says that he does not feel that he has been presented with the full facts regarding test results and the potential consequences of the two treatment options given to him, but this complaint is subsidiary to many of the other complaints in the letter

(particularly the complaint about there not having been a tumour after all). The clear impression given by the documentation and indeed by the oral evidence from the pursuer and his wife is that there was general dissatisfaction with the medical treatment which the pursuer received, starting with the cancelled operations in late 2010, running through the realisation that Mr Kamel had not discovered any tumour during the operation and continuing through the post-operative medical problems experienced by the pursuer after his first discharge from the hospital through to his re-admission about a week later. I do not suggest for one moment that that dissatisfaction was unjustified – though it has to be said that those matters were not fully investigated before me and I am therefore not in a position to make any judgment as to where fault (if any) lies. What matters for present purposes, however, is that the focus of the complaint even some two years or more after the event was on matters other than that which is now advanced in this action.

[143] By contrast, the defenders' position is supported by the note made by Mr Kamel immediately after the meeting on 16 September 2010. Nothing in the evidence given by Mr and Mrs Johnstone persuades me that that note should not be taken as a fair summary of what was discussed. Their position must be that almost the whole of that note is inaccurate, that the discussion noted by Mr Kamel simply did not happen. That is difficult to reconcile with the acceptance by Ms Sutherland QC, on behalf of the pursuer, that the note was reasonably contemporaneous and was not made up for the purpose of justifying the defenders' case after the dispute had arisen. While it might be the case that in compiling the note after the meeting with the pursuer Mr Kamel could have mis-remembered a particular matter, or filled in gaps in his recollection of the meeting from what was his usual practice in such cases, that would not explain why the note as a summary of the meeting is entirely contrary in almost every respect to the pursuer's evidence.

[144] I have not overlooked the argument made on behalf of the pursuer that it would be impossible to conceive of anyone opting for surgery instead of radiosurgery if they knew that the operation carried with it not only the risk of death but also post-operative risks, including the risk of meningitis. But I do not find this argument persuasive. Taken to its extreme, by that token no one would ever opt for surgery of this sort, but Mr Kamel's evidence, which I accept, was that he carried out more than 20 such operations each year. Other witnesses confirmed that endoscopic surgery was widely accepted first-line treatment for conditions such as that suffered by the pursuer. The pursuer had undergone a similar operation 30 years previously and it had all gone well. I do not accept that there is anything improbable in him deciding to have surgery again. He may have underestimated the risks, and may not have taken what Mr Kamel said quite as seriously as he should have – particularly if, as suggested in his letter of complaint in July 2013, he made a decision at an early stage to opt for surgery – but that cannot be attributed to any failure on the part of Mr Kamel to explain the risks to him. It may be that Mr Kamel recommended surgery over radiosurgery, but there was nothing in the evidence to suggest that Mr Kamel put undue pressure on him to make this choice – this was not part of the pursuer's case, and it would in any event be inconsistent with the evidence given by the pursuer and his wife that the risks were not discussed at all and that any choice had been removed from the pursuer by agreement between Professor Bevan and Mr Kamel.

[145] For these reasons, as well as from my assessment of Mr Kamel as a careful and reliable witness, I conclude that Mr Kamel's note of the meeting of 16 September 2010 is a fair and accurate summary of what was discussed with the pursuer and his wife. And on this point, where Mr Kamel's evidence about the meeting, including his oral evidence, differs from that given by Mr and Mrs Johnstone, I prefer the evidence given by Mr Kamel.

Pre-operation consent on 31 January 2011

[146] I shall return in a moment to consider whether the explanations given by Mr Kamel to the pursuer at that meeting as recorded in his note of the meeting are sufficient to meet the obligations placed on the defenders in terms of the *Montgomery* case. I should first, however, mention the events of 31 January 2011, on the morning before the operation. I can deal with this issue relatively briefly.

[147] Whatever may be the explanation for the entry in the hospital notes for the pursuer suggesting that Mr Kamel consented him on the morning of the operation (see para [43] above) – and the true provenance and purpose of this note remains shrouded in mystery – I am satisfied that Mrs Johnstone was not present at the hospital that day; and that Mr Kamel's note, which refers to him having explained the risks of and after the operation to the pursuer "& his wife", cannot refer to the events of that morning. Mr Kamel did not consent the pursuer that morning.

[148] But I am also satisfied that the pursuer was consented at some time that morning by Mr Bodkin. His evidence is summarised at paras [94]-[100] above. He was an impressive witness. He had a method which he followed while consenting a patient and I accept his evidence that he followed that method, maybe not to the letter, since he candidly accepted that his adoption of the PARQ principle had developed over the years, but if it was not precisely the same it would have been something very similar (see para [94]). The evidence given by Kevin Johnstone, the pursuer's son, does not cause me to doubt this conclusion. He spoke about a doctor coming through with paperwork to sign (para [63]). That would be Mr Bodkin. He thought that he was in and out within two or three minutes. But I did not get the impression from his evidence that he was paying any particular interest in what was

being discussed – he was there to provide support for his father rather than involve himself in the details of what passed between his father and the medical staff. The meeting between the pursuer and Mr Bodkin may only have lasted 10-15 minutes, but I am satisfied that he went through the PARQ process, or something similar, in that time and went through with the pursuer details of the scheduled operation and the risks involved in the operation and after it.

Adequacy of explanation given by Messrs Kamel and Bodkin

[149] Assuming, as I find to be the case, that Mr Kamel and Mr Bodkin did in fact explain the risks of the operation and the availability of other options in the manner set out in their evidence, the question arises whether that was sufficient to comply with the *Montgomery* duty of care. I have no doubt that it was sufficient. The criticism of what Mr Kamel did in relation to his dealings with the pursuer proceeded upon two distinct lines.

- (1) The first was to point to what the particular witness perceived to be the advantages of radiosurgery over transsphenoidal surgery. This was the thrust, for example, of the criticism by Mr Radatz, who was a consultant neurosurgeon at the National Centre for Gamma Knife Radiosurgery in Sheffield. Quite understandably, he had a disposition to prefer radiosurgery where there was a real option, but I accepted his evidence as professional and unbiased. The relevant parts of his evidence are summarised at paras [103]-[109]. What it came down to, so it seemed to me, was that, while urging that this was a case where radiosurgery might have been appropriate, and while emphasising the minimal risks to the patient in undergoing radiosurgery, he recognised that in certain respects the outcome from successful

transsphenoidal surgery might be better – for example, the likelihood of an immediate and complete cure, and the fact that radiosurgery might take two to four years to normalise hormone levels. He accepted that the vast majority of pituitary adenomas are removed by transsphenoidal surgery. He would have recommended radiosurgery; but that does not mean that Mr Kamel was negligent if he recommended transsphenoidal surgery. In any event, no such case of negligence was made against Mr Kamel.

- (2) The second line of criticism was to look in detail at the risks mentioned by Mr Kamel in his note of 16 September 2010 and suggest points on which he might have understated the risk to some degree or failed to emphasise a particular risk. The main evidence in support of this line was given by Mr Statham, summarised at para [113]. Mr Kamel did not accept those criticisms. It seems to me that whatever differences Mr Statham had with the explanation given by Mr Kamel as summarised in his note, those differences are differences of detail. They do not seriously undermine the correctness of the explanation and advice given by Mr Kamel to the pursuer.

[150] Finally, it was argued that Mr Kamel failed to tell the pursuer that one option was to do nothing. I do not accept this criticism for two reasons. First, I am satisfied that both Mr Kamel and Mr Bodkin did mention the possibility of doing nothing. They may not have encouraged the pursuer to take this course, and there can be no criticism of that, but I accept the evidence given by both of them that that option was mentioned. Secondly, however, I do not accept that Mr Kamel was required to treat doing nothing as a reasonable option. Both Professor Bevan and those present at the MDT meeting in August 2010 took the view that active treatment was now necessary. That was their diagnosis. Mr Kamel went along

with that. That diagnosis was not challenged (indeed it could only be challenged on a *Hunter v Hanley* basis, and no such case was advanced). I found Mr Radatz's evidence on this point (para [104]) somewhat difficult to follow. He seemed to accept that the option of no treatment would not have been recommended by clinicians. But he considered that it should still have been offered as an option. That does not make much sense, unless no treatment was offered as an option so heavily impressed with advice not to take that option that it would not have been taken up.

[151] In those circumstances the argument that Mr Kamel failed properly to explain to the pursuer the risks of the proposed operation and the reasonable alternatives in breach of his *Montgomery* duty of care must fail.

Other matters

[152] I should deal finally with two matters. The first is this. I canvassed in argument the possible finding that on 16 September Mr Kamel told the pursuer in detail about the potential risks of surgery but, so far as concerned radiosurgery, gave rather less detail and said something to the effect that if the pursuer was interested in exploring it he (Mr Kamel) could make the necessary arrangements for him. Would this be sufficient to comply with the *Montgomery* duty to explain the risks and state what alternative treatments there were? I have not in fact made such a finding, so the question is hypothetical. Were the question to arise for decision, it seems to me that much would depend on the amount of information given to the patient when suggesting this as a course. But since none of the evidence led by either party lent any support to this account of the meeting, and since neither side urged it on me, I need not say anything more on this point.

[153] Finally I should mention the question of causation. Since I have found the defenders not to have been in breach of duty, and the pursuer to have made an informed choice to undergo transsphenoidal surgery, the question of causation does not arise. Nor is it possible to say how the pursuer's choice might have been affected if Mr Kamel had given a full explanation of the risks and other relevant matters, since I have found that the pursuer was given a full explanation and decided the way he did. Suffice it to say that I considered that the pursuer was predisposed in favour of surgery to a large extent because of the success of the operation 30 years earlier. I also come back again to the complaint letter of July 2013, in which, on one view, he seems to suggest that he chose surgery in July 2010, even before meeting Mr Kamel. On that basis I do not consider that he would readily have been steered away from such a decision. So, on the assumption, which I do not accept, that there were failings by Mr Kamel in his explanations of the risks of the proposed treatment or in his description of the advantages and disadvantages of other options:

- (1) in the hypothetical situation canvassed in the preceding paragraph, I do not think it likely that the pursuer would have chosen to find out more about radiosurgery;
- (2) any inaccuracies in the various percentages of risk in Mr Kamel's explanations, or in the emphasis placed on certain risks or uncertainties, is unlikely to have affected the pursuer's decision;
- (3) any failure by Mr Kamel to mention particular advantages of surgery, or particular disadvantages of radiosurgery, would not have affected his decision: a fuller explanation of the disadvantages of radiosurgery could only have pushed the pursuer further towards his choice of transsphenoidal surgery; it is only if, contrary to my findings, the pursuer was in fact given an

explanation which significantly understated the risks of surgery and/or the benefits of radiosurgery that there would be any basis for saying that, had the explanation given been more accurate, he might have reached a different decision;

- (4) had the pursuer initially been attracted by the option of doing nothing, he would nonetheless have accepted advice from Mr Kamel to have active treatment as opposed to doing nothing.

In short, since I have found that the pursuer was told of all the material risks of surgery, and was told of the other options, yet took the decision to go ahead with surgery, I find it difficult to conceive of any probable situation in which his decision would have been different.

Disposal

[154] For these reasons I shall grant decree of absolvitor. I shall reserve all questions of expenses.