Neutral Citation Number: [2021] EWHC 1733 (QB)

Case No: QB-2016-001353

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 25/06/2021

Before :

HIS HONOUR JUDGE AUERBACH
(sitting as a Judge of the High Court)

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Between :

TALITHA DOYLE	**Claimant**
- and -	
PROFESSOR NAGY HABIB	**Defendant**

- -
- -

The claimant appeared in person
Ms N Cambell-Clause (instructed by **BLM LLP**) for the **Defendant**

Hearing dates: 17 – 20 May 2021

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APPROVED JUDGMENT

Covid-19 Protocol: This judgment was handed down remotely by circulation to the parties' representatives by email and release to Bailii. The date for hand-down is deemed to be on 25th June 2021.

HIS HONOUR JUDGE AUERBACH:

Introduction

1. The defendant is a consultant liver surgeon and a Professor of Hepatobiliary Surgery. On 6 February 2013 the claimant attended a consultation with him. Imaging had identified the presence of three lesions on her liver. On 26 February 2013 the defendant carried out a liver resection of the largest lesion and cholecystectomy (removal of the gall bladder).

2. The claimant claims that the defendant was negligent. In summary, her case is that he wrongly diagnosed her condition and advised her to undergo surgery that was neither needed nor required. Her case is that the surgery has also caused her various adverse health consequences over the years since.

3. The defendant denies negligence. He stands by his advice. He accepts that the surgery left the claimant with a scar and that the wound subsequently became infected. The defendant does not accept that the operation caused any other adverse effects.

4. The trial before me was of liability only, that is, breach of duty and causation.

5. The claimant has throughout been a litigant in person. The progression of the matter to trial was interrupted by her being declared bankrupt in 2017. But in 2018 her trustee, the Official Receiver, disclaimed any interest in this claim.

6. For a period the claimant's mother, Mrs Linda Doyle, acted as her litigation friend. However, at the direction of the court a report was commissioned from a psychiatrist, Dr Cutting. That report, of October 2020, concluded that the claimant has mixed anxiety and depressive disorder, and post-traumatic stress disorder, both of at least moderate severity. However, it also described her as being of high intelligence, and concluded that these conditions were not so severe as to have impaired her capacity; and that she did not lack mental capacity to conduct this litigation. Following that, Mrs Doyle's status as a litigation friend was terminated by an order made in December 2020.

7. At trial the claimant represented herself. She was assisted by Mrs Doyle. The defendant was represented by Ms Campbell-Clause of counsel. Bearing in mind that the claimant is a litigant-in-person, I spent some time with the parties at the outset discussing how the trial would be conducted and explaining matters of protocol. The claimant raised the question of breaks, and we agreed a regime of mid-morning and mid-afternoon breaks, but on the basis that she could also request ad hoc breaks should the need arise.

8. The claimant made a short opening statement. Ms Campbell-Clause then indicated that she considered that this had included some particular allegations of negligence that were not in the Amended Particulars of Claim, and which, if the claimant wished to pursue them, would require an application to amend. In particular, the claimant's pleaded case was that her matter had not been discussed at a Multi-Disciplinary Team (MDT) meeting at all. The defendant's case was that it had, and that the MDT had endorsed the defendant's recommendation of surgery. Ms Campbell-Clause noted that the claimant had not pleaded any alternative case as to the outcome of the MDT if (contrary to her case) there *had* been a discussion.

9. The claimant said that she was not seeking to add to the particular allegations of negligence that were set out in her amended pleading. Ms Campbell-Clause then asked me to rule that cross-examination of the defendant's witnesses on the subject of the MDT must be confined solely to the question of whether the claimant's case was discussed by it at all. I declined to do so. Their witness statements set out their evidence about the outcome of the MDT meeting that they said had discussed her case (in line with his pleading). Questions challenging that evidence were potentially relevant to the pleaded issues.

10. As to witnesses of fact, I heard evidence for the claimant from the claimant herself and from Mrs Doyle. For the defendant I heard from the defendant, Mr Madhava Pai, and Mr Charis Kyriakides.

11. As to expert evidence, in 2016 the claimant served with her Amended Particulars of Claim, a letter from Professor Nigel Heaton, Professor of Transplant Surgery, and a report from Professor Roger Williams, Professor of Hepatology, both of whom were, as we shall see, treating clinicians. She subsequently served a further report from Professor Williams.

12. A Master's order made in November 2017 permitted the claimant to rely upon a report from "a consultant hepatobiliary surgeon or physician" (unnamed) and the defendant to rely upon a report from a consultant hepatobiliary surgeon, Mr Brooks. In May 2018 the claimant served a report from Professor Williams, and the defendant a report from Mr Brooks. The two of them met and then produced a joint statement in June 2018.

13. Sadly, Professor Williams died in the summer of 2020. The claimant did not thereafter apply to call any other expert witness in his place. Accordingly, I heard expert evidence in person only from Mr Brooks. Ms Campbell-Clause did not object to Professor Williams' report being included in my bundle, or my reading it; but, as I will describe, she submitted that it was inadmissible as *expert* evidence, and/or that I should attach little or no weight to it.

14. Evidence was completed by mid-morning on day 3. It was agreed that I would hear Ms Campbell-Clause's closing submission that afternoon and that of the claimant the next morning. Because of some personal circumstances that had arisen, on arrival at court on day 4 the claimant requested that the start time be put back from 10.30 to 11.30, which was agreed. When court convened, the claimant indicated that she was ready and able to proceed, and made her closing submission. Following a reply from Ms Campbell-Clause, and in view of the matters covered (and without objection), I allowed the claimant to make some further submissions in response. I reserved my decision.

The Facts

15. The following findings of fact draw on my appraisal of all of the relevant evidence available to me, in the witness statements, given in court and in the documents. In this part of my decision I set out my primary findings, taking events chronologically. I address some further aspects in later sections. I have not addressed in this decision every last point of detail that was canvassed in the evidence, or every detailed point of factual dispute. I have focussed on the factual matters, and findings, that it was necessary for me to make, in order fairly to determine the issues that I have needed to decide.

16. The claimant was born in 1974.

17. In 1998 the claimant was diagnosed with hypothyroidism. In 2004 an ultrasound recorded that her liver, and other abdominal organs scanned, were "all normal". In 2006 she was diagnosed with pernicious anaemia and prescribed B12 injections. Over succeeding years the claimant periodically reported to her GP persistent tiredness. For some years she was treated for endometriosis with oestrogens, by way of the oral contraceptive pill.

18. As we shall see, during the period from 2012 onwards, both before, and in the years following, the operation performed by the defendant, the claimant saw a number of different clinicians. During this period she was accompanied to all of these appointments by Mrs Doyle.

19. In a consultation with her GP on 11 July 2012 the claimant reported "extreme fatigue". An endocrine referral was made and in August she was seen by Dr Walker of that team. He suspected possible early menopause, of which there was some family history. She was then seen by Dr Dove of the same team in October. He reported "some very mild abnormalities of her liver function with a gamma-GT of 72 (5 to 36) and an ALT of 37 (10 to 36). I would think both of these would be associated with a slight weight increase. Neither of them is of concern at the current time." He excluded early menopause. In summary, in his view none of the tests showed anything of consequence. In November Dr Dove wrote to the claimant that the remainder of her blood tests were fine, other than a slightly high vitamin B12 level.

20. The claimant and Mrs Doyle understood that Dr Dove was not planning to see her again. However, she then received a letter notifying her of a follow-up appointment with him, and on 22 January 2013 he saw her again. His report to her GP on that consultation stated that the claimant told him that she remained tired. Her mother was concerned about her thyroid function. They were both still concerned that something remained wrong and, for reassurance, Dr Dove had organised an abdominal ultrasound and further blood tests.

21. On 24 January 2013 the claimant saw her GP. She asked to be referred to Dr Sassoon Levi, a gastroenterologist, saying she had had dyspepsia for "ages". The claimant had been to see Dr Levi on some previous occasion. She had BUPA cover, and the next day her GP wrote asking him to see her.

22. Meantime, on 28 January 2013 the ultrasound scan of the claimant's liver requested by Dr Dove was carried out. The report of Dr Al Naib included:

> "[T]he liver is normal in size. Intrahepatic biliary tree is not dilated. There are 2 lesions in the right liver lobe the largest measures 4.4cm at the second lesion is a smaller measuring 1 cm. These lesions cannot be characterised by ultrasound, further investigation is highly recommended either CT scan or MRI of the liver."

23. As the ultrasound showed what Dr Dove described in a later report to the GP as "two abnormalities", he then requested a CT scan.

24. On 30 January 2013 the claimant had that CT scan. The report of Dr Anilkumar included:

> "There are two arterially enhancing lesions measuring 1.6 and 4cms in the liver which are isodense to the liver on portal venous phase scan. The larger lesion has suggestion of a central scar. Findings are most likely to represent focal nodular hyperplasia. The differential would be hepatic adenomas."

25. Overlapping with Dr Dove's ongoing involvement, the claimant saw Dr Levi. It is clear from his later letter to her GP, that he had sight of the ultrasound that had been commissioned by Dr Dove, consideration of which led *him* to commission an MRT scan and a CT scan. The MRI scan was conducted on 1 February 2013. The report by Dr Hassan stated:

> "MRI Liver with contrast: there are two hyper vascular liver lesions. The largest one seen in segment 4B which measures 4cm and showed persistent nodular enhancement on arterial phase and a smaller one showed more homogeneous enhancement. These lesions showed residual and increased enhancement on venous phase. The appearances are in keeping with adenomas. The less likely diagnosis is focal nodular hyperplasia. No other focal liver lesion. No duct dilation. The gallbladder pancreas and spleen are normal.
>
> Follow-up imaging in 6 months' time is recommended."

26. Dr Levi also commissioned a CT scan. The report by Dr Hassan included:

> "Arterial venous phase performed. The arterial phase showed a large almost 4cm x 3.2cm regularly enhancing lesion in segment 4 anteriorly. The vascular type of enhancement is nodular and showed gradual filling on venous phase with a central area of low attenuation. The appearances may well be due to adenoma or the other differential focal nodular hyperplasia."

27. On 5 February 2013 the claimant attended Dr Dove again in the endocrine clinic. Following this clinic he wrote to the claimant's GP, including:

> "Her liver function tests have changed slightly and the alkaline phosphatase is now a little elevated at 105, her albumin is 50 and the ALT has increased from 37 to 42.
>
> Her liver ultrasound showed two abnormalities on the ultrasound and therefore a CT scan was organised to further investigate.
>
> The CT scan has shown these to be vascular lesions though the report has not been formalised. They were confident about this being a benign process due to the venous washout phase.

> Miss Doyle continues to feel unwell and has not been reassured by the findings.
>
> Under these circumstances, I have referred her to the Gastroenterologists so they can discuss appropriate follow up for the findings."

28. It appears that, when he saw the claimant on 5 February, Dr Dove was not aware of the tests that Dr Levi had commissioned. In fact (and as indicated in his letter to her GP) Dr Dove himself that day made a referral to Dr Levi.

29. Dr Levi, for his part, reported back to the claimant's GP. He referred to her having been investigated by the endocrine team and the recent ultrasound scan, on which he had confirmed the presence of a lesion in the gallbladder bed of the liver. He observed of the CT and MRI scans that *he* had arranged, that "the conclusion … is that the lesions are likely to be adenomas, less likely FNH, and less likely anything else." He also observed that the claimant had stopped taking the contraceptive pill about nine months before, which he stated that she should not restart, as it was "linked with adenomas."

30. It appears that the claimant and Mrs Doyle had, at some point, had a further consultation with Dr Levi in which he had explained to them his view of those scan results. Although Dr Levi's letter to the GP does not mention it, and there was no copy of any referral letter in my bundle, what is certainly clear is that Dr Levi referred the claimant on for a private consultation with the defendant, whom he knew, in order to gain the benefit of his specialist view.

31. At the time the defendant saw only a very small number of private patients. He did so at the same location as his NHS patients, the Hammersmith Hospital in London, and with the same team. At that time the team included Mr Pai, who was then a Specialist Registrar in Hepatobiliary Surgery, Mr Kyriakides, who was also at that time a Specialist Registrar (although he moved elsewhere on 15 February 2013), and Dr Thalis Christophides, then a Registrar.

32. On 6 February 2013 the claimant, accompanied by Mrs Doyle, attended for the private consultation. Mr Pai and Dr Christophides reviewed the claimant's history and test results and took a full history from her. They then presented the case to the defendant. He had sight of the blood test results from 2012 and 2013 and the reports of the 28 January ultrasound, the 30 January CT scan and the 1 February MRI scan. The consultation itself then proceeded. The defendant had his colleagues with him.

33. As to the substance of the discussion at this consultation, I had witness evidence from the claimant, Mrs Doyle, the defendant and his two colleagues. The documentary evidence included the manuscript notes made by Mr Pai during the consultation and the letters that he dictated to the GP and to Dr Levi, following it. There was also an undated patient note made by Mr Kyriakides, which he told me he believed he had made at the consultation.

34. At that time, at that hospital, clinical notes were created in manuscript, by the clinician concerned writing on history sheets, which were kept together in a hard copy patient record. Each sheet had a column for the date and time on the left and another on the

right for the author's signature, name and bleep number, with the central area being for the notes.

35. Mr Pai's notes of this consultation cover two history sheets. On the first sheet are notes about the claimant's reported symptoms, tests and investigations and previous medical history. On the right hand side is a drawing of the liver, with three lesions shown as shaded discs of differing sizes. The largest is shown near to a marking on the edge of the organ labelled "GB". An arrow from the largest points to a note reading "?haemangioma / Adenoma".

36. Underneath is written: "2 Steps" with arrows pointing in two directions. The first points to the words "Observe – Scan in 2-3 months". The second points to the words: "Surgery. To resect." Underneath that are listed "Risks of complications" including: "mortality 1%", "infection" (this in turn pointing to either "chest" or "wound"), and some other risks. There are also notes about the likely lengths of the operation, and the post-operative hospital stay, and a diagram showing the shape and size of the incision to be made on the tummy.

37. On a third history sheet is an undated note made by Mr Kyriakides, as follows:

> "Patient agrees to liver resection
>
> Dated for the 26/02/2013
>
> P Verify with insurance if suitable or if NHS
>
> MDT discussion of imaging
>
> Preadmission (bloods + cross match)"

38. Mr Kyriakides said that he believed that this note was made by him at the end of the consultation on 6 February 2013, rather than reflecting a communication from, or with, the claimant on some later occasion. Had it occurred on a later date, he would have dated it and identified the nature of the communication.

39. Following the consultation Mr Pai dictated a letter to the claimant's GP. It summarised her presentation and past history. It noted that initial investigations had identified a lesion in segment 4 of the liver, and that there had then been an MRI. It set out the blood test results. It continued:

> "… after reviewing the imaging, Professor Habib thought that this most probably represented adenoma with the differential diagnosis being an haemangioma. She has three lesions, one in segment 4, one at the top of the liver in segment 8 and there is a suspicion of lesion in segment 3 of the liver. Professor Habib has explained that we will discuss this imaging in the Liver MDT, and in view of the suspicion of adenoma, the best approach would be to resect, as this is a significantly large lesion. The attempt will be for a local resection, and if there is any suspicion intra-operatively, we will ablate or locally resect the other lesions. We have explained to her the risks and benefits of

> the procedure and the complications involved and she is keen to go ahead with this at the earliest. We shall keep you update of her progress."

40. Mr Pai also wrote to Dr Levi in similar terms.

41. I make the following findings of fact about things that were said or discussed during the course of the consultation.

42. The radiological findings were discussed, and the defendant outlined and explained the potential differential diagnoses – adenoma, FNH and haemangioma. The defendant gave his view that the largest lesion was most likely to be an adenoma, with the alternative possibility that it was a haemangioma. The defendant explained that there was a risk of bleeding and a risk of an adenoma becoming cancerous in the future. He also referred to the fact that the largest lesion was close to the gall bladder and the bile duct. The defendant recommended surgery. He also explained that the matter would be raised at an MDT meeting, at which a number of colleagues with a range of expertise would be present.

43. Pausing there, the foregoing aspects were all covered in the evidence of the defendant and his colleagues, were reflected in the contemporaneous evidence of the clinical notes made by Mr Pai, and the letters he dictated following the meeting, and were not materially disputed by the claimant in evidence.

44. On one point, Mrs Doyle's evidence went further. Her evidence was that the defendant said that the largest lesion *was* an adenoma. However, I conclude that she was mistaken about that. She was the only witness who recalled it that way. Further, the defendant's account is consistent with his evidence that he relied upon the MRI report. That said that the appearance of the lesions was "consistent with adenomas" with the less likely diagnosis being FNH. His account is also consistent with his evidence that it is simply not possible to diagnose the nature of such a lesion with absolute certainty pre-operatively. That this was indeed the defendant's view also chimes with the evidence of Mr Brooks, about the difficulties of diagnosis of liver lesions, even with modern techniques, which was supported by citations from the literature.

45. The gist of the evidence of both the claimant and Mrs Doyle was also that no option was canvassed other than surgery, and that the defendant indicated that it was very urgent. He had said that the tumours were the size of a golf ball, and could burst if the claimant bumped into something. The defendant's case, however, was that, while he recommended surgery, the alternative option of wait and review was also explained, and he did not indicate that an operation needed to happen exceptionally urgently. He did not use the golf ball image. Rather, he explained that the lesions were of different sizes, and he was only concerned about the largest of the three. He invited the claimant to reflect and decide whether she wished to proceed with surgery or not.

46. On that last point, I conclude that the claimant and Mrs Doyle were mistaken in their recollections. In oral evidence the claimant was uncertain as to whether the defendant had said one lesion was the size of a golf ball or all three. It is noteworthy that the particulars of claim attributed the use of the golf ball comparison to the ultrasound radiologist. Both the claimant and Mrs Doyle also recalled in evidence that the radiologist told them at the time that there was something there, which was potentially

serious, and that the claimant should see her GP the next day. This caused them considerable alarm. I conclude that the claimant and Mrs Doyle were right to recall that *someone* had used the image, but mistaken about who it was and when.

47. As to the other aspects, the consultation note is clear and reliable evidence that the defendant did canvas the option of waiting, and scanning again and reviewing in three months' time. But there was also no dispute that his clear *advice* was to have the operation. One of them asked him what he would say if it was a member of his own family. He replied that he would advise her to have the operation. There was also no dispute that he advised of the risks, if the lesion was not operated, of it bursting, bleeding, or developing into cancer.

48. It also clear that the claimant wanted to find out if BUPA would cover the operation, and the defendant told her that it could be done either on the NHS or privately. Either way the date, the location and the team would be identical. The only difference would be the private room and facilities. He also referred to the NHS indicative timescales for such referrals, of consultation within 2 weeks and any operation within 6 weeks. I accept his evidence that he was seeking to reassure the claimant that she should not be concerned if BUPA would not cover it; but it may be that the claimant and Mrs Doyle felt that what he was saying conveyed a strong sense of urgency about the operation.

49. It was also common ground that the defendant told the claimant and Mrs Doyle that they could seek a second or third opinion. Their evidence was that he also said that the advice from anyone else would be the same as his. His evidence was that he did not say that, but he did say that, if someone else's advice *was* different, that would not cause him to change his own advice. He also said in evidence, that he would have *expected* the advice of any other specialist to be the same, and I am inclined to think that the claimant and Mrs Doyle picked that up too. However, I also accept that this was a genuine offer – in evidence the defendant said that there were three other specialist units in London – and was intended to give the claimant some reassurance.

50. Standing back, I accept that, from the defendant's point of view, this matter was not *extremely* urgent. It was not a case of actual cancer, or one where there was no time even to get another opinion, if desired. The option of wait and see was there. However, he was clearly firm in his recommendation of surgery. Further, my impression is that it may have felt to the claimant and Mrs Doyle as if things had taken a swift and unexpected turn, from consultations with an endocrinologist and a gastroenterologist about health issues that the claimant had had for some time, to a series of tests, a referral to a liver surgeon, and then an advice to have liver surgery in a few weeks' time.

51. I turn to the role of the Liver Multi-Disciplinary Team (MDT). What was not disputed was that, at the consultation, the defendant explained in general terms what this team was, and he told the claimant that her case would be reviewed by it, and that it normally met every Tuesday.

52. However, the claimant's pleaded case was that her matter was not discussed at an MDT meeting prior to her surgery. The defendant's case was that the claimant's matter was on the agenda for the MDT on 12 February 2013, but, as the defendant was away that day, it was put back to the MDT meeting on 19 February 2013, which then endorsed his recommendation of surgery. The claimant put it to him, and other witnesses, in cross-examination, that the evidence suggested that the MDT had in fact formed the

view that the lesions were FNH, surgery was not indicated, and that the next step should be a further ultrasound. The defendant and his witnesses disputed that.

53. My findings on this aspect are as follows.

54. Each MDT meeting would be attended by various specialists, and would discuss, in turn, the cases of a large number of patients. Among others, there always had to be at least one radiologist present. For each patient a pro forma *Word* document, the "Liver MDT Patient Report", had to be completed electronically by an administrator, the MDT co-ordinator. It had sections for completion under different headings, some including tick-box options.

55. In my bundle were two typed Liver MDT Patient Reports, referring to the claimant, one for 12 February and the second for 19 February 2013.

56. Under "History" the first form records: "Epigastric pain & fullness, weight loss, US shows left lobe liver lesions ?adenoma. To discuss CT and MRI" Under "Investigations" it refers to the MRI of 1 February and the CT scan of 31 January 2013. Under "MDT Outcome" it records: "To be discussed at Liver MDT 19th Feb 2013 with input from Prof Habib."

57. The 19 February 2013 form has the same entries under "History" and "Investigations". Under "MDT Outcome" is recorded:

> "imaging CT 31/01/13: small area of hypervascular tension MR 01/02/13 no high signals to suggest hemorrhage Contrast: small lesions centrally ?FNH
>
> Plan US with contrast"

58. In evidence the defendant said that this record was not correct. He said that there was no permanent MDT co-ordinator at the hospital in February 2013 and this led to a system failure in the record-keeping. In my bundle was another partially-completed MDT record relating to the claimant, referring to a meeting on 31 December 2013, which the defendant said was simply wrong.

59. The defendant's evidence was that surgery was endorsed at the MDT meeting on 19 February 2013. In his witness statement he wrote:

> "The memory that I have in relation to the case of Talitha Doyle is that her case was discussed at the MDT. I can recall the debate being as to whether or not if Talitha Doyle was our daughter/sister etc., i.e. a young woman in her 30s, what would we do operate or observe? Everyone at the MDT on 19 February 2013 agreed that this was a case in which surgical resection was indicated and would be the right thing to do."

60. He also stated that the Liver MDT policy (then and now) was, first, that biopsy was inadvisable, because of the risk of bleeding, dissemination of neoplastic cells and occasional failure to obtain the relevant tissue; secondly, to advise surgery whenever there was an element of doubt that the lesion is an adenoma rather than FNH; and,

thirdly, to advise surgery for any type of lesion, including FNH, if located adjacent to the bile duct. In oral evidence he said that this policy was in line with national NHS policy.

61. The defendant also referred in evidence to a note regarding the MDT that was made by Mr Pai on the operation note. He said that the usual separate MDT pro-forma sheet "has not been completed properly". He would never operate on a patient until he had discussed their case with colleagues in an MDT.

62. The note made by Mr Pai, to which the defendant referred, read:

> "Liver MDT
>
> Sg IV(a) lesion ?Adenoma ?FNH
>
> Patient keen for removal Sg VIII – haemangioma"

63. Mr Pai's evidence was that there would have been a discussion at the MDT "with the scans to ensure that everyone was of the view that surgery was the best option." At the time a locum was dealing with the MDT records and the outcome was not recorded appropriately. He would make his own notes on a list of patients discussed at the MDT, of the outcomes in relation to his patients, which needed to be implemented. It was his practice to record the outcome of the MDT on the operation notes, because these had a red corner, and could quickly be located in a voluminous patient record bundle. The notes he made on patient lists were always securely destroyed, once they had been actioned, because they referred to multiple patients and were not part of the official clinical record. Based on his operation note, he was satisfied that the conclusion of all present at the MDT was that surgery was the best course.

64. Mr Kyriakides said that his experience was that no patient went to surgery without an MDT discussion. The MDT decision was respected. If there were concerns about whether or not surgery should happen, "agreement was generally reached and treatment proceeded accordingly." There were concerns during 2013 with regard to how MDT meetings were documented. There was a problem with a co-ordinator and there were interim or temporary staff who did not appropriately record the outcome of some MDT meetings.

65. I note also that in November 2014 BUPA wrote to the defendant informing him that the claimant had complained to them about his care. His reply included the following:

> "We reviewed her imaging in the liver MDT at Hammersmith Hospital and the MRI findings were suspicious for adenoma. In view of this and due to its size along with symptoms of fulness in the epigastrium I offered her surgical resection as decided by the MDT."

66. Mr Brooks obviously had no personal knowledge of what happened at this MDT meeting. But he explained in evidence that radiological investigations start with an ultrasound, which is easy and non-invasive. If something is found, this may lead to a CT and/or an MRI. The MRI was the most sensitive and specific scan with a view to trying to differentiate different entities within the liver. It was the gold standard.

However, an MRI still could not deliver certainty. He observed that the reference to a contrast ultrasound in the MDT record of 19 February did not seem to fit with the question raised. To request an ultrasound after an MRI would be a step back and an unusual thing to do.

67. Mr Brooks also confirmed that it was not the responsibility of the chair of an MDT to make a formal record. That was done by the administration. He also confirmed that notes made by a clinician on a list of patients from an MDT, by way of an aide memoire or personal action note, would be uniformly destroyed safely and securely, whereas contemporaneous notes taken at an individual patient consultation would be kept as part of that patient's records.

68. I have no difficulty understanding why, in view of the contents of the 19 February 2013 MDT form, the claimant questioned whether it had supported the recommendation of surgery. In closing submissions she also suggested that Mr Pai's own note could be erroneous, given that it was made on the operation record a week after that MDT meeting. She also expressed incredulity that notes made at an MDT meeting would then be destroyed.

69. I was referred to an observation of the Court of Appeal in *Synclair v East Lancashire Hospitals NHS Trust* [2015] EWCA Civ 1283, that contemporary medical records are ordinarily "by their nature likely to be reliable". More generally, there is much discussion in the modern authorities as to the reliability, or not, of contemporary documents and of the human memory. But there is no iron rule about these things. I note that the court in *Synclair* also reiterated that a court must always consider whether a particular contemporary document is reliable, and what weight it can be given. Further, as has recently been discussed in *Kogan v Martin* [2019] EWCA Civ 1645, in each case the court must appraise *all* the relevant evidence, witness and documentary alike.

70. In this case, having considered the whole picture, my conclusion is that the MDT on 19 February 2013 concurred in the defendant's recommendation of surgery. It would be expected that the other differential diagnoses, and their possible implications, were discussed. That is reflected in Mr Pai's note adding "?FNH" to "?adenoma". But as the "?"s indicate, I do not find that they considered that the lesions *were* FNH, or that they advised *against* surgery. This is most likely what happened for a number of reasons.

71. First, it is consistent with the evidence I had, that the MDT had the MRI report available to them, which indicated that this lesion was most likely adenoma, and the evidence, not just of the defendant and his colleagues, but of Mr Brooks, that an MRI is the most informative type of imaging when seeking to assess liver lesions. Secondly, it is consistent with the evidence (including of Mr Brooks) that even an MRI, however, cannot deliver certainty. Thirdly, it is consistent with the evidence about the MRI policy at this time, including that, even in cases of FNH, surgery is recommended if there is a risk of obstruction.

72. While the evidence of the defendant, and even of his colleagues, might be said to require some cautious handling, it therefore does not stand alone. They all gave evidence to the effect that surgery would not be carried out without the blessing of the MDT; and they all referred to the administrative difficulties with the compiling of MDT records at

that time. Bearing in mind that it was his job to implement arrangements for surgery, that the MDT happened only a week before, and that he was a clinician thereby creating a patient record, I consider that Mr Pai's operation note is also a more reliable source than the administrator's MDT record in this case. I also accept that the notes he took at the MDT meeting itself were destroyed for good reason. The explanation that this was because they referred to other patients, and were not themselves patient notes, entirely made sense, and was supported by Mr Brooks.

73. I move on to other events between the 6 February consultation and the operation. The claimant and Mrs Doyle gave evidence that, after the consultation, they "went back" twice and spoke to members of the team, as the claimant remained anxious about the prospect of surgery. The claimant recalled asking (someone) about having a biopsy and being told this was not possible. In evidence and argument the claimant and Mrs Doyle expressed concern and amazement that there were no patient notes of such discussions.

74. What precisely happened? No witness on either side had a good detailed recollection of this aspect of events. The claimant and Mrs Doyle were not entirely firm or consistent as to whether they had spoken just to Mr Pai or also to the defendant. Mr Pai could not be sure. He thought it entirely possible that a patient record of such a conversation had not been made. That did sometimes happen if, for example, the physical notes were in the records section when a follow-up telephone discussion happened. Nowadays it was all done on computer. The defendant's evidence was that, on 6 February, he invited the claimant to reflect, and advise whether she wished to go ahead with surgery. She also needed to check the position with BUPA. That tends to suggest that there would have been at least one further discussion involving some member of the team.

75. My conclusion is that there was at least one conversation following the consultation meeting, possibly two, with someone on the team, in which the claimant confirmed that she had BUPA cover, sought further reassurance about proceeding with the surgery, including asking whether a biopsy was an option, and being told not; and also did confirm her wish to go ahead.

76. Mr Pai also said in evidence that he thought she would have been told the outcome of the MDT, as this was the usual practice. As to that, my conclusion, on balance, is that she probably was told, but neither she nor Mrs Doyle remembered it. From the point of view of the defendant and his colleagues, it was routine to explain to the patient the role of the MDT, and in due course to confirm the outcome of its meeting, when known. The green light from the MDT was required, but they did not regard that as seriously in doubt in this case, so while it is reasonable to infer that the outcome would have been shared, it is unlikely to have been the focus of much discussion.

77. As I have found, the claimant and Mrs Doyle were right to recall that there were some further communications, but, as I have said, their recollection of the detail was shaky. My firm impression is that the claimant embarked on this litigation because of her conviction (shared by Mrs Doyle) that the defendant had simply given her the wrong advice, based on the wrong diagnosis, at the consultation, with (on her case) terrible consequences; not because of anything to do with the MDT. That is why it does not feature in her witness statement or that of Mrs Doyle; and it is entirely plausible that they might both have simply forgotten being told the outcome.

78. It appears to me that the role of the MDT found its way into the pleaded claim because of (as I will describe) Professor Williams' mistaken understanding, when he first became involved, that the MDT had not discussed the claimant's case at all. It was, as we shall see, his first letter (and that of Professor Heaton) which directly formed the basis for the original particulars of claim. As I have described, it was at trial that the question of the *outcome* of the MDT meeting on 19 February assumed greater prominence.

79. I move on to the operation and its aftermath. On 26 February 2013 the operation was performed by the defendant. Mr Pai was present. Prior to the operation the claimant signed a consent form which referred to the risks, including post-operative leak, collection and wound infection. The defendant re-sectioned the largest liver lesion. He also removed the claimant's gallbladder. In evidence he explained that this was done in order to provide him with access to the lesion in segment 4. I so find.

80. On 2 March 2013 the claimant was discharged from hospital. She felt unable to walk very far and made use of a wheelchair.

81. On 4 March 2013 the histopathology report was received. It indicated that the lesion was not an adenoma but FNH. The claimant was informed of this.

82. There were post-operative clinics with Mr Pai. On 13 March the claimant was recorded as having recovered well from surgery and the incision was healing well. On 22 March she was "doing remarkably well" and feeling much better in herself overall, though still in recovery. The wound "has healed well". On 28 March, however, she was complaining of pain and feeling tired and weak. But there were no obvious signs of wound infection, nor any cause emerging from an ultrasound. That evening she saw Dr Levi complaining of chest pain. A CT scan was normal and she was prescribed analgesia.

83. The claimant saw Dr Levi again on 3 April reporting that the pain had not changed. He noted that she had developed a minor infection in the wound in the last few days and had visited a walk-in centre. He anticipated that this would settle very quickly without further intervention, but noted that the claimant had been exceedingly distressed by it. She saw the defendant on 10 April and then Mr Pai on 17 April, who noted "some pain around incision" but no discharge. She returned to Dr Levi on 15 May as she was still experiencing some pain. He reported to her GP that the wound infection had settled and the wound had healed "really well". He had advised her to pace herself.

84. At clinic with Mr Pai in July 2013 the claimant reported pain in the wound and there was some discharge. She returned to Dr Levi in September 2013 who reported: "She had gone downhill again, feeling tired, run down with right upper quadrant epigastric pains that are affecting her mobility e.g. getting into and out of bed." At review in October with Mr Christophides, and at a further appointment with Dr Levi, she was still reporting pain in the wound area and tiredness. Dr Levi advised that an MRI showed nothing of concern at all. He referred her to a rheumatologist.

85. The rheumatologist, Dr Mackworth-Young, saw the claimant in November 2013 and various tests were carried out. The findings were positive. There was no evidence of underlying malignancy or persisting inflammatory disorder. He opined that her fatigue could be explained by the liver pathology, surgery and subsequent infection, slightly

inadequate thyroid replacement or sleep disturbance. At clinic with Mr Pai and Mr Christophides in December, the claimant continued to report pain. A further MRI was ordered but there was no evidence of acute pathology.

86. In June 2014 the claimant saw Dr Levi again. He noted that she had seen various physicians whose overall advice was to allow herself more time to get over the operation. It had been two steps forward, one back, but she was moving in the right direction and now reported feeling a million times better than in the few weeks following the surgery. At the request of the claimant and Mrs Doyle he had ordered more tests but was hopeful that they would prove reassuring. An ultrasound in September detected nothing abnormal or that might explain the reported pain and fatigue.

87. In October 2014 the claimant saw Professor Williams for the first time. He suspected a small pocket of infection and started her on Ciprofloxacin. However, in November, following a PET/CT scan, he reported that there was "no focus of infection which can explain her continuing symptomology."

88. At review with Professor Williams in January 2015, and again in March, the claimant continued to report pain under the right costal margin. But an ultrasound and MRI in March reported only mild macro steatosis of the liver. Professor Williams referred the claimant to Professor Heaton. He saw her in April and noted a recurrent suture sinus in the upper midline of the scar, but could not find a clear cut aetiology for the abdominal pain.

89. The severe upper right quadrant pain persisted, however, and in July 2015 Professor Williams referred the claimant back to Professor Heaton. An MRCP scan noted mild fatty deposition within the liver and a small focus nodularity at the resection margin. There were "no features to suggest a focus of infection and no evidence of post-operative adhesion." In August Professor Williams wrote to the GP that the most likely diagnosis was a "small pocket of infection" related to the surgical resection of the liver. He and Professor Heaton recommended a one-month course of potent intravenous antibiotics.

90. That course was indeed followed, and on 8 September 2015 Professor Heaton reported that the intravenous antibiotics had been "highly successful, with complete relief of her symptoms" although the Claimant had had trouble with the port, and a switch to a canula was mooted. The port was then removed.

91. In the summer of 2016 Professor Williams referred the claimant back to Professor Heaton, as she continued to be symptomatic with right-sided abdominal pain mainly located in the mid-transverse aspect of her abdominal scar. In June Professor Heaton noted that the claimant had developed urticaria and other issues. Further tests and investigations were planned.

92. In November 2016 Professor Williams saw the claimant again after a six-month gap. The main problem had been urticaria, for which she had been seeing a dermatologist. She had been on antidepressants for 5 months "and is feeling very much better, so much so that she has not required antibiotics for 6 months now and the pain in the right upper quadrant, which has been such a feature of her post-surgical illness, is much less." She

was still tender in the same part of the scar "but very definitely less tender than previously."

93. Upon review in March 2017 Professor Williams reported that the claimant had told him that she had "been reasonably well in terms of the recurrent right upper quadrant abdominal pain" and had "got used to it." In April liver blood tests were within the normal range. CRP was raised but not sufficiently high to merit further investigation. Professor Williams emphasised the importance of losing weight, as the liver "almost certainly has an increased fat content." An ultrasound scan in April indicated that at the site of the resection "no collection is present". The findings were stable, though the liver "remains a little fatty." When Professor Williams saw the claimant in November 2017 she was "not so tender under the right costal margins". Blood tests showed elevated CRP, which was "a constant feature of her condition throughout."

94. In her witness statement, written in March 2018, the claimant said she had been in "constant pain" since the surgery. She referred to the pain in the right side of her ribs and the back of her left shoulder, and having suffered from a severe infection in the wound. She referred to having been referred for pain management in 2013, and to things having got so bad in May 2013 that she had to start using a wheelchair, which she still did when she might have to walk long distances. She said she had been unable to work. In oral evidence she said she had at one point tried doing some work in a friend's shop, but had been unable to sustain it. She continued to find daily activities a struggle.

95. As I have described, in 2020 Dr Cutting diagnosed the Claimant with depression and post-traumatic stress disorder.

The Duty of Care – the Law

96. The classic statement of the duty of care owed by a clinician to a patient was expounded by McNair J in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 583 at 587. A skilled professional clinician:

> "… is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art … Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view."

97. Importantly, *Bolam* expressly addresses the position where there is a difference of practice within the relevant profession. So long as the individual has acted in accordance with a practice accepted as proper by a responsible body of professionals, they will not be in breach of duty merely because there is also another body of opinion that is of a contrary view.

98. The notion of a "responsible", or "respectable", body of professional opinion, was further explored in *Bolitho v City & Hackney Health Authority* [1998] AC 232. Lord Browne-Wilkinson (the other members of the House of Lords concurring) said this (at 241F – 243D):

> "My Lords, I agree with these submissions to the extent that, in my view, the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. In the *Bolam* case itself, McNair J. stated [1957] 1 W.L.R. 583, 587, that the defendant had to have acted in accordance with the practice accepted as proper by a "*responsible* body of medical men." Later, at p. 588, he referred to "a standard of practice recognised as proper by a competent *reasonable* body of opinion." Again, in the passage which I have cited from *Maynard's* case, Lord Scarman refers to a "respectable" body of professional opinion. The use of these adjectives -responsible, reasonable and respectable--all show that the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter."

99. "Maynard's case" mentioned in that passage was *Maynard v West Midlands Regional Health Authority* [1984] 1 WLR 634. As in the present case the allegation there was of misdiagnosis and recommendation of surgery. Lord Scarman said (at 638E-F):

> "A case which is based on an allegation that a fully considered decision of two consultants in the field of their special skill was negligent clearly presents certain difficulties of proof. It is not enough to show that there is a body of competent professional opinion which considers that their was a wrong decision, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances. It is not enough to show that subsequent events show that the operation need never have been performed, if at the time the decision to operate was taken it was reasonable in the sense that a responsible body of medical opinion would have accepted it as proper."

The Expert Evidence

100. I will return to the issues about the status of Professor Williams' evidence. At this stage I summarise that evidence. From his report (which built on his earlier letters referred to by the claimant) I draw, in summary, the following particular points, said to be pertinent to the issue of breach of duty.

101. The likelihood of the lesion in segment IV being an adenoma was small. There was no question of adenomatous malignant transformation. The size was less than the accepted 5cm for possible removal. There was no evidence that the lesion had bled. There was

no evidence of pressure effects on the biliary tract or otherwise. The blood results were normal apart from a minor increase in serum gamma GT level attributed to fatty change in the liver.

102. Professor Williams continued that the likelihood of the lesion being FNH was high on account of the characteristic central scar and the presence of smaller lesions which were likely haemangioma. Removal of an FNH is not indicated unless it is causing symptoms. This was not so in the claimant's case. The ill health and symptoms that *were* reported by the claimant could not be attributed to the lesions and were not likely to be relieved by this surgery.

103. In this report Professor Williams also asserted that, before operating, a liver biopsy and histology should have been carried out. He also said that if there was a concern that the lesions might be adenomas the appropriate course would be reimaging after a six-month interval so see whether they had grown. If not, then the appropriate course would be to follow up after 2 – 3 years.

104. I note that the claimant's pleading also referred to Professor Heaton's letter of 13 October 2015. Later on in this decision I will set out the more detailed particulars of alleged negligence, and I note that that letter was the source and basis for points (j) to (n). However, he was not an expert witness at this trial.

105. In Mr Brooks' report of 18 May 2018 he made, in summary, the following observations about the different types of benign liver lesion.

106. FNH is frequently found around a central fibrovascular scar. They are more common in women and weakly associated with being of reproductive age and use of oral contraceptives. Adenomas carry a risk of bleeding of 20-40%. Malignant transformation of adenomas has been reported to occur in 6 – 10% of cases. Haemangiomas are usually asymptomatic and managed conservatively unless over 10cm.

107. As to diagnosis of liver lesions, Mr Brooks said:

> "Despite advances in liver imaging, the diagnosis of being liver lesions such as focal nodular hyperplasia, haemangiomas and hepatic adenomas and differentiating these from malignant conditions such as fibrolamellar hepatocellular carcinoma remains challenging. Accurate diagnosis is important as this dictates conservative management, surgery or treatment options.
>
> CT and MRI are the mainstay of radiological diagnosis for liver lesions, however diagnostic uncertainty is not uncommon as features on the scan may be atypical and the difficulty in accurate diagnosis is well recognised. The use of biopsy for diagnosis remains controversial and is not advocated in the surgical literature because of the risk of bleeding in vascular liver lesions, track seeding in potential malignancy and the poor correlation between biopsy interpretation and formal histology."

108. Mr Brooks also observed that "[t]he diagnostic difficulty distinguishing between FNH and adenoma results in many series of resected benign liver lesions reporting both adenoma and FNH with low morbidity, zero mortality good quality of life following surgery."

109. He added:

> "Management of liver adenomas in the UK can be controversial as some series advocate an expectant approach with close follow up, however the dominant surgical approach is to offer resection because of the reported incidence of bleeding and malignant transformation in liver adenomas. While there is evidence to support an association with size (greater than 5cm) and an increase risk if bleeding, there is insufficient studies to determine the association if size and malignant transformation and series have reported malignancy developing in adenomas less than 5 cm in size."

110. As to breach of duty Mr Brooks made the following particular points:

(1) The well-recognised challenge of accurately diagnosing benign liver lesions was reflected in the variability of the claimant's CT and MRI reports.

(2) A reasonable body of hepatobiliary surgeons would have considered there to be a significant risk that the lesion was an adenoma, and therefore offered surgical resection.

(3) It would have been unusual to find adenomatous transformation on the imaging. While some series advocate observation and monitoring of AFP this has been shown to be a poor indicator of tumour progression. The principle of surgical resection is to act prior to malignant transformation and remove the risk of cancer developing.

(4) Size of the lesion per se was not determinative of whether a reasonable group of surgeons would excise it. While risk of bleeding had been shown to correlate with size, malignant transformation had been reported in lesions of 4cm and there was insufficient evidence to determine the association of size with risk of malignant transformation. Surgery would be undertaken to remove the small risk of malignant potential and/or bleeding.

(5) A reasonable group of surgeons would therefore support resection of a 4cm lesion that on MRI imaging had been reported by the radiologist as likely to be liver adenoma.

(6) The risk of bleeding from adenomas is reported in the region of 20-40%. Surgery is undertaken to avert this risk.

(7) Pre-operative biopsy of liver lesions is not routinely undertaken in the UK for the reasons earlier mentioned. It is not advocated when liver resection is being considered. The MDT on 19 February 2013 did not recommend it because it is not

standard practice. A reasonable body of surgeons would not support it in a case where adenoma was a likely diagnosis.

(8) In this case although the CT scan had suggested that the lesions were likely FNH, the MRI scan, which is more specific, suggested they were more likely to be adenomas. The medical records do not support the assertion that the likelihood they were FNH was high. Both adenoma and FNH were in the differential diagnosis.

(9) The claimant's complaint of abdominal symptoms could be consistent with a centrally-located liver lesion. The claimant had mildly deranged liver function tests. One study reported a correlation between central location and such test results, as a result of compression of the liver ducts.

(10) Removal of the lesions probably would not have helped improve the claimant's symptoms of fatigue, her endometriosis, pernicious anaemia or hypothyroidism.

111. Mr Brooks considered that an offer of surgical resection would be supported by a reasonable body of surgeons in the claimant's case, given the diagnostic uncertainty, history of abdominal discomfort and mildly deranged liver function tests. The images were reviewed in the MDT meeting on 19 February 2013 where it appeared that the diagnostic uncertainty remained.

112. Commenting on Professor Williams' November 2016 report, Mr Brooks set out his areas of disagreement and agreement with Professor Williams in line with the foregoing points of his report. In the course of doing so, he noted that liver function tests were abnormal pre-operatively, not just gamma GT, and observed that it is recognised that alkaline phosphate and gamma GT rise in cases of obstruction. He also noted that Professor Williams had referred to the first CT scan, but not the MRI or second CT. MRI was regarded as "the imaging modality of choice for liver lesion diagnosis."

113. Professor Williams and Mr Brooks met and produced a joint report dated 20 June 2018. There was no significant movement in terms of most of the areas of disagreement and agreement. However, they did agree that the risk of malignant transformation of the largest lesion was low, and that, had it been an adenoma, that risk would have been in the region of 5%. They also now agreed that biopsy was not indicated prior to the resection that was performed, although their reasons for reaching that conclusion differed.

114. Mr Brooks' opinions did not alter during the course of his live evidence.

Particulars of Alleged Breach of Duty

115. The Particulars of Breach of Duty set out in the Amended Particulars of Claim began with the following headline allegation:

> "The Defendant was negligent in that he failed to correctly diagnose the following condition and advised the patient to undergo surgery when it was not needed or required."

116. The following further particulars were then set out, referring to the 2016 reports of Professors Williams and Heaton:

> "(a) The likelihood of the lesion in segment IV found on the initial imaging being an adenoma was small and this should have been recognised by the Defendant.
>
> (b) There was no question of adenomatous malignant transformation.
>
> (c) The size of the lesion was less than the accepted 5cms for possible surgical removal and there was no evidence that the lesion had bled.
>
> (d) No Multidisciplinary Meeting was carried out prior to the surgery.
>
> (e) Before surgery for an adenoma is undertaken particularly where there is no relationship to the patient's symptoms, liver histology to assess HN1 and beta catenin mutation expression should have been carried out.
>
> (f) The likelihood of the lesion being focal nodular hyperplasia (FNH) was high.
>
> (g) Removal of FNH lesions surgically is not indicated unless the lesion can be shown to be the cause of the patient's symptoms.
>
> (h) It is very unlikely that the surgical removal of the lesion would have helped the Claimant with non-specific symptoms.
>
> (i) There were no indications for surgical resection of the lesion.
>
> (j) The histology confirmed that the lesions in the liver were focal nodular hyperplasia.
>
> (k) Whilst adenoma is within the differential diagnosis the lesions had the appearance of focal nodular hyperplasia.
>
> (l) A formal radiological report should have been obtained prior to surgery.
>
> (m) Both lesions were under 5cms in size and it is judged if the lesions were focal nodular hyperplasia the indications for surgery would be less firm.
>
> (n) The symptoms that she presented with of severe lethargy on a background of hypothyroidism and pernicious anaemia continue unchanged and the surgery has not resolved the claimant's original complaint."

Breach of Duty – Discussion and Conclusions

117. I consider first what approach I should take to Professor Williams' evidence.

118. Ms Campbell-Clause submitted that Professor Williams' opinion on breach of duty was not admissible as expert evidence at all. Pursuant to section 3(1) Civil Evidence Act 1972 the opinion of a witness is only admissible if he is "qualified to give expert evidence on the matter in question."

119. Professor Williams was not qualified to give expert evidence on whether it was a breach of duty to have advised the claimant to have liver surgery, because, eminent and distinguished a hepatologist though he was, he was not a liver *surgeon*. In *Bolam* the court referred to the opinions of medical men "skilled in that particular art"; in *Maynard* Lord Scarman referred to a doctor's "special skill" and the "ordinary skill of his specialty." In *Sansom v Metcalfe Hambleton & Co* [1998] PNLR 542 the court referred to the need, ordinarily, for evidence from those within the "same profession". She also referred to the guidance, to which PD35/1 refers, which indicates, at [24], that experts must not express an opinion outside the scope of their field.

120. In their joint report the experts had identified that the experience required in this case is "to be able to advise patients as to the options for and against liver resection and the risks of performing that surgical procedure." It was noted that Professor Williams "has regularly attended hepatobiliary multi-disciplinary meetings where such patients are discussed for many years." But he was not a surgeon. Mr Brooks *is* a surgeon, and, as the report recorded, "counsels and consents patients for liver surgery on a daily basis. He has undertaken in the region of 500 liver resections."

121. In this case the Master had given the claimant permission to serve a report of a "consultant hepatobiliary surgeon or physician". But, even if this was intended to allow her to serve a report from Professor Williams (who, Ms Campbell-Clause nevertheless noted, was not a hepatobiliary physician, but a hepatologist), it still fell to me to decide whether his opinion evidence was admissible as expert evidence at this trial.

122. The claimant, for her part, said that a report from Professor Williams was within the scope of what the Master had permitted. Further, the allegation in this case was not about the conduct of the surgery itself, but about the diagnosis and recommendation. Professor Williams was, she submitted, well placed to express an opinion on that. Ms Campbell-Clause responded by referring to Mr Brooks' respectful evidence that, if an issue concerned with liver lesions had come to Professor Williams' attention in his practice, he, Mr Brooks, would have expected Professor Williams to refer the patient to a surgeon to advise further. Further, Professor Williams would not have been able to manage the obtaining of consent to surgery.

123. Ms Campbell-Clause also submitted that I should in any event give little or no weight to Professor Williams' report, for a number of reasons. It was not clear from his original report exactly what records he had seen. More particularly, it appeared that he had not seen the MRI, or, if he had, he did not consider it, because he did not refer to it in his original report. He did not make any reference to the literature, or situate his opinion by reference to other opinions reflected in the literature. He was a treating clinician, who had also been retained on a private basis, so he was not entirely independent. Finally, because he had died, his evidence had not been tested in cross-examination.

124. The claimant emphasised Professor Williams' enormous experience in the field, and undisputed eminence. Given that, and as her clinician, he was in an unrivalled position

to give an opinion. She vigorously resisted any suggestion that his role as a treating clinician risked the appearance of lack of objectivity.

125. My conclusions on this aspect are as follows. First, notwithstanding that the order should have referred to "hepatologist", and not "hepatobiliary physician", I have no doubt that the Master's order was intended to encompass the option of the claimant relying on Professor Williams as an expert. The defendant has been professionally represented throughout (including, at that hearing before the Master, by counsel); and it would have been open to him to appeal that permission if so advised, at the time. Had such a challenge been successful, and resulted in a revised order permitting the claimant only to rely upon an expert surgeon, she would then have had ample opportunity to procure such evidence.

126. That being so, and as the point has only been raised at trial, I decline at this stage effectively to overturn the Master's order. However, I do consider that Professor Williams would not be as well placed to opine on advice about whether or not to recommended surgery, as a surgeon. I accept from the evidence, that he would have been familiar with signs that might indicate that the possibility of surgery needed to be considered; and he would have had further exposure to this aspect from his involvement in MDTs. But it was not his professional role to advise on surgery as such; and it seems to me plain that an actual surgeon must be better qualified to advise on such a decision.

127. This aspect does therefore affect the weight that I can attach to Professor Williams' opinions, as compared with those of Mr Brooks. The fact that Professor Williams did not, at least initially, see, or at any rate refer to, the MRI, the lack of grounding of his opinions in the literature, and the fact that there was no opportunity to cross-examine him, all also affect the weight that I can attach to his views. I do not, however, see any sign that the fact that he was a treating clinician affected his appraisal.

128. Mr Brooks is a surgeon who has very extensive experience of advising patients with liver lesions, and of performing this procedure. The analysis he put forward in his evidence was coherent and reasoned. It referred to the literature and properly recognised where there were areas of uncertainty and rival views, giving his reasoned opinion on the better view. He properly couched his opinion in terms of the *Bolam/Bolitho* test. He did not veer from his opinion in the course of live evidence. It carried considerable weight. I found it more convincing and persuasive than that of Professor Williams.

129. Turning to each of the lettered sub-paragraphs of the particulars of breach of duty, my observations and conclusions are as follows. Where I conclude that an opinion held by the defendant was one which would be shared by a responsible body of relevant experts, even if another such body of experts might disagree, I shall refer to this as a *Bolam*-compliant opinion.

130. As to (a), in light of the MRI scan report, and the opinion of Mr Brooks, I conclude that the defendant's opinion that the largest lesion was, of the three types of benign liver lesion, most likely to be an adenoma, was *Bolam*-compliant.

131. As to (b), I understand this to mean that that lesion was not, at the time, malignant. As to that, the defendant did not consider that it was. His opinion was that there was a risk of it being an adenoma, and hence a risk of it turning malignant if not removed; and

that this risk was a consideration supporting pre-emptive surgery. In light of the evidence of Mr Brooks, that was a *Bolam*-compliant opinion.

132. As to (c) the defendant's approach was that there is no hard and fast rule that a lesion which is less than 5cm need not be operated upon. He noted that the scans indicated the size of the largest lesion in this case to be 4 to 4.4cm, and was of the view, given the claimant's young age, that, if left in place, it would, over time, grow to an unacceptable size. That was a *Bolam*-compliant view.

133. As to (d) I have found that the claimant's case *was* considered by the MDT. Further, though the claimant did not plead that the MDT (if held) advised against surgery, the defendant pleaded that it endorsed his recommendation of surgery. The claimant's criticisms of the record-keeping, and her concerns as to the content of the 19 February 2013 record, were, in my view, entirely understandable. But, on examination of all the evidence, I have found that the MDT did in fact endorse the defendant's advice. I have also not found that the MDT considered the largest lesion to be FNH. On balance I have concluded that the claimant probably was told that the MDT had green-lit surgery; but, given my finding that it indeed did so, I would not in any event have considered a failure to share that information with her to be a breach of duty.

134. As to (e) I conclude in light in particular of Mr Brooks' evidence, that the decision not to carry out a pre-surgical biopsy in this case was *Bolam*-compliant. I note that, in the joint experts' report, Professor Williams in fact changed his mind on this point.

135. As to (f) and (k) the defendant's view was that the lesion was more likely an adenoma than an FNH. Although Professor Williams considered that some features, such as the central scarring, pointed to it being more likely an FNH, Mr Brooks' opinion was that the two were hard to distinguish, and that he would defer to the radiological report on this issue, and in particular the gold standard MRI scan. That is precisely what the defendant did, and his approach, and view, was *Bolam*-compliant.

136. As to (g) the defendant's view was that, even if the lesion might turn out to be an FNH, other indicators pointed to its causing, or risking, an obstruction of the drainage of the liver through the common bile duct. That approach was also supported by the evidence of Mr Brooks and was *Bolam*-compliant.

137. As to (h) there was largely consensus on this point, among the defendant, Professor Williams and Mr Brooks. This surgery would not have assisted with the general symptoms of tiredness, or others caused by the claimant's pernicious anaemia and hypothyroidism. However, the defendant never recommended the operation on the basis that it would alleviate those symptoms. For the same reason, the point made at (n) is not indicative of any breach of duty. I say that there was "largely" consensus, because the defendant *was* of the view that the epigastric fulness might be a sign of some obstruction, which might then be alleviated by surgery. That view was supported by the evidence of Mr Brooks and was *Bolam*-compliant.

138. As to (i), the defendant's view was that surgery was indicated in particular by the risks that (a) the largest lesion was an adenoma, which, if not excised, risked turning cancerous; (b) even if it was an FNH, there were signs that it was causing obstruction, and a risk that, if not excised, it would grow, so that the problem of obstruction would become worse over time. In light of the evidence I had about the risks associated with

the operation, the MDT guidelines, the claimant's age, and the evidence of Mr Brooks, the view that these features supported a recommendation of surgery as the preferred option was a *Bolam*-compliant one.

139. As to (j), this is correct, but this information, obtained only after the event, does not show that the advice in favour of surgery was in breach of duty, particularly given that the advice was properly against attempting a pre-surgical biopsy. See the discussion in *Maynard*. The claimant, fairly, in closing submissions, fully acknowledged this point, and said she did not seek to advance her claim on the basis of being wise after the event. I again repeat that the evidence of pressure on the common bile duct also supported surgery, even on a possible FNH.

140. As to (l), a recent ultrasound, two CT scans, and an MRI scan had been obtained. The reports were available to the defendant, and to a radiologist from his hospital, who was a mandatory attender at the MDT meeting. In light of all of that, it was not a breach of duty not to commission a further scan at that time before proceeding to surgery.

141. As to (m) the premise (as stated in the particulars of claim) is that two lesions were removed, but in fact only the largest of the three was removed. For reasons already stated, the fact that it was not larger than 5cm did not, in the context of all the circumstances of this case, mean that it was therefore not *Bolam*-compliant to recommend surgery.

142. In his witness statement the defendant said, in summary that, at the consultation on 6 February 2013, he considered that the indicators for surgery were (a) the MRI indicated that adenoma was more likely than FNH; (b) the location of the largest tumour gave rise to a risk of obstruction; (c) the symptoms of fullness could well be alleviated by surgery; (d) the raised liver enzyme test results were in keeping with there being pressure on the biliary system. The risk of obstruction was a particular concern given the claimant's young age, and even if the lesion might be an FNH.

143. I have accepted that this was indeed the defendant's view, that it was *Bolam*-compliant and that it was also supported by the MDT. There were, of course, risks associated with surgery, but the evidence I had was that those risks were all very low, and the operation was very frequently performed, and had very good outcome rates, including, on the defendant's uncontradicted evidence, excellent outcome rates in his unit. The risk of death was less than 5% and he had never had a patient aged under 40 die. The risk of wound infection was 10%. Mr Brooks' evidence supported this general picture of low morbidity and risk of death and good quality of life following this surgery.

144. Returning to the headline complaint of breach of duty, I conclude that, though it turned out following the operation that the lesion was FNH, the defendant was not negligent in failing pre-operatively to diagnose it as such, nor was he in breach of duty in advising surgery. Nor, given in particular its location, and the claimant's age, would it have been negligent to advise surgery, had the claimant believed it to be most likely an FNH.

145. The claim must therefore be dismissed. In view of that conclusion, strictly I do need to determine the issue of causation. But I will say something about it.

Causation

146. As I have noted it was, of course, not disputed that the surgery had left the claimant with a scar. Nor was it disputed that, at a certain point, the wound became infected. But it was not accepted that it had caused the other ill health or medical difficulties experienced by the claimant in the years following. Ms Campbell-Clause made the point that a claim of medical causation usually required medical evidence to support it. That was absent in this case.

147. I have summarised in my earlier findings of fact, the various health difficulties and symptoms that the claimant experienced over the years following the operation, the investigations and assessments that were carried out, the treatments that were given, and the views of the clinicians who saw her from time to time. It appears to me that, probably, whatever was causing the persistent tiredness prior to the operation, may, together with the operation, have contributed to the debilitation which meant that the claimant used a wheelchair on departing from hospital. But I do not think that the evidence supports the conclusion that the persisting or recurring general symptoms, or the new symptoms which developed, and then persisted, such as of pain and discomfort in the claimant's shoulder and ribs, were caused by the operation.

148. For completeness I note that, in closing submissions Ms Campbell-Clause suggested that the claimant's pleading was deficient because she had not set out her case as to what would have happened if the defendant had advised that the better course was to "wait and review", and the surgery had then not gone ahead in February. I do not agree with that approach. The claimant's case as to causation was, in principle, properly advanced on the basis of what *did* happen. It would have been up to the defendant, if so advised, to advance a case on causation (without prejudice to disputing liability) as to any counter-factual scenario, had the claimant not had surgery when she did.

Outcome

149. It is not hard to understand the claimant's sense of frustration and despondency that she has experienced the various health problems that she has, over such a long period of her adult life. Mrs Doyle has plainly acted at all times from a passionate commitment to her daughter's well-being. It is apparent that how events unfolded over time following the operation caused them to wonder whether the claimant had been given the right advice. In due course their misgivings were supported by Professor Williams. It is clear from a number of observations she made during evidence that Mrs Doyle in particular, has also carried out a good deal of her own research, and her convictions about this matter have, it appears to me, become entrenched.

150. However, what the court has to decide, is whether, in light of all the information and evidence available to him, the defendant's recommendation of surgery in February 2013 was negligent. For all the reasons I have given, I am satisfied that a respectable and responsible body of specialists in his field would, as he did, have recommended surgery in this case. He was therefore not in breach of his duty to the claimant. This claim is therefore dismissed.