SHERIFFDOM OF TAYSIDE, CENTRAL AND FIFE AT DUNDEE

[2016] SC DUN 75

A175/08

JUDGMENT OF SHERIFF S G COLLINS, QC

In the cause

IAN FRANCIS BRITTEN

Pursuer

Against

TAYSIDE HEALTH BOARD

Defender

Pursuer: McConnell, Advocate; RSB Lindsays
Defender: Fitzpatrick, Advocate; NHS Central Legal Office

Dundee, 28 September 2016
The sheriff, having resumed consideration of the cause:

FINDS IN FACT:

1. The pursuer is Ian Francis Britten who is now aged 60. He has been married since 2000, but lived with his wife for some years prior to that. They have three children, born 1990, 1992 and 1996.

2. The pursuer suffers from bipolar disorder. This condition is also known by other names, including manic depressive disorder and manic depressive psychosis. It is a mental condition relating to dis-regulation of a person's mood. It is characterised by an individual experiencing episodes of low mood and episodes of elated mood, mania or hypomania. The pattern of illness involves uncontrollable swings of mood from normal to low or high, or low to high, or high to low. Treatment is directed to management rather than cure, seeking to regulate the patient's mood at a more normal level for more of the time. It may involve medication, such as lithium, or psychological treatment, or a combination of both. Treatment response varies from individual to individual. Even if there has been a good response, the underlying condition remains dormant and the propensity for further relapses will always remain. Sometimes it is

possible to identify triggers which cause a person with bipolar disorder to relapse, and sometimes it is not.

3. The pursuer has suffered from this condition since around 1990, when he was first hospitalised in consequence of it. He was hospitalised again in 1995 and early 1997. On each occasion his admission was of roughly three months duration. Bipolar disorder tends to affect the pursuer by elevating his mood, making him manic, rather than lowering it, and making him depressed. The pursuer was successfully treated following his hospitalisation in 1997 and his condition stabilised. In particular he was prescribed medication, namely lithium, and continued to take this drug thereafter. By the beginning of 2005 he had had no further relapses. Indeed he had been psychiatrically very stable for nearly eight years.

4. At the time of his hospitalisation in 1990 the pursuer was working as a spinner in a factory. He returned to work in 1997 in a different factory as a machine fitter but suffered from stress and left after a few months. He has not been in paid employment since. He is in receipt of disability benefits. His wife receives income support and carer's allowance.

5. In January 2001 the pursuer began to experience pain, photophobia and inflammation in his left eye. He attended his GP and was referred for treatment at Ninewells Hospital in Dundee. He was diagnosed with acute anterior uveitis in his left eye and a swollen optic disc. There was a query whether the swelling was due to drusen, a benign condition characterised by chalky deposits within the optic nerve head, and found in one or two per cent of the population. The pursuer was successfully treated with topical steroid eye drops over a period of around three months. In February 2003 the pursuer had a recurrence of anterior uveitis in his left eye. Again he attended at Ninewells and again he was successfully treated with steroid eye drops.

6. Uveitis is inflammation of the uvea. The uvea are tissues which encircle the eye, inside the sclera but outside the retina. They comprise the iris, the ciliary body and the choroid. Uveitis is often characterised differently, depending on which part of the uvea is affected. Anterior uveitis describes inflammation of the front of the eye. It is also known as iritis, because it is associated with the iris. Posterior uveitis describes inflammation mainly located of the back of the eye. It may affect the choroid or the optic nerve, or both, but is not confined to any specific structure within the eye and may also involve the retina and vascular chamber as well. Intermediate uveitis tends to describe inflammation of the ciliary body behind the iris, and is characterised by inflammatory cells within the vitreous cavity. However all these terms – anterior, posterior and intermediate – are really just descriptions of the main location of inflammation within the eyeball, and are not used uniformly. Pan-uveitis is a way of describing uveitis in which inflammation can be detected throughout the eye, and is not mainly located within the anterior, intermediate or posterior parts. It is a serious condition. If left untreated, or if treatment is ineffective, there is a significant risk of permanent impairment of sight in the affected eye, even blindness.

7. In January 2005 the pursuer experienced further problems with his left eye. In particular he experienced pain, reddening of the eye, impairment of vision and photophobia. On 5 January 2005 he again attended at Ninewells. He saw Dr David Knight, then a senior house officer who

had 11 months experience in ophthalmology. The visual acuity in the pursuer's right eye was measured at 6/4 and in his left eye at 6/9. In the light of his symptoms and the nature of his eye problems in 2001 and 2003 he was diagnosed with recurrent iritis and was again prescribed steroid eye drops.

8. Visual acuity measured as 6/6 is regarded as normal vision. It equates to being able to read the sixth line down on a Snellens eye chart at 6 metres distant. Where a person is measured as having 6/9 vision it means that that person can see with that eye at 6 metres distant what a person with normal vision can see at 9 metres distant. It represents a significant impairment of vision.

9. A follow up appointment was made for 19 January 2005, but that was later cancelled and the pursuer next attended at Ninewells on 26 January 2005. Again he was seen by Dr Knight. The vision in his left eye had not improved by treatment with steroid eye drops. Indeed it had significantly worsened since 5 January 2005, to 6/36, and measurement using a pin hole device did not improve this reading. On examination Dr Knight noted the presence of tortuous vessels in the pursuer's left eye. He noted the presence of some vitreous cells in the body of the eye, causing the view of the optic disc to be hazy. He noted that the optic disc was swollen, possibly due to uveitis, but also that there had been a query as to whether the pursuer had previously been found to have drusen. Initially he wrote in the medical records that the pursuer had post (posterior) uveitis, given the inflammation at the back of the eye. However having recognised that inflammation was present all through the pursuer's eye, and not just at the back, he overwrote 'post' with 'pan', thus indicating that in his view the pursuer had pan-uveitis. In the light of his concerns about this condition he then consulted his more senior colleague, Dr Paul Johnstone, then a specialist registrar.

10. Dr Johnstone looked at the pursuer's medical records and noted that the triage nurse had written down that he was on lithium. He examined the pursuer and confirmed Dr Knight's findings. He too diagnosed the pursuer as suffering from pan-uveitis in the left eye. This was the correct diagnosis. He spoke to the pursuer and advised him of the seriousness of his condition and the treatment options. In particular he told him that if left untreated there was a serious risk or indeed likelihood of permanent loss of vision in the eye. He told the pursuer that the way that this condition was treated was with steroids.

11. Continued treatment of the pursuer by way of steroid eye drops was no longer appropriate, given that the condition of his left eye had deteriorated notwithstanding three weeks of such treatment. Furthermore, steroid drops cannot penetrate to the back of the eye and so deliver steroid to an inflammation in the area of the retina or choroid. Treatment by way of oral steroids was, then and now, the standard recommended treatment in Scotland for the condition with which the pursuer presented on 26 January 2005. It was the treatment most likely to be effective to resolve this condition and so preserve sight in the affected eye. In particular, pan-uveitis being a systemic disorder of the body's immune system, albeit focussed in the eye, it is generally regarded as most appropriately treated with systemic, i.e. oral, steroids. These enter the patient's bloodstream and by this means also reach the vasculature in the affected eye.

12. Dr Johnstone asked the pursuer why he was on lithium and the pursuer told him that he suffered from manic depression. Dr Johnstone asked him about the history and control of this condition, and told the pursuer that there was a risk that treatment of his eye with steroids could cause psychosis. Dr Johnstone was keen to impress this risk on the pursuer, and so brought the conversation back to it several times.

13. Treatment with oral steroids was and is well recognised as being associated with adverse psychiatric events. This occurs in around 5 to 15% of cases. Such treatment has the potential side effect of elevating a patient's mood and in extreme cases can promote mania or hypomania. In the case of a person who suffers from bipolar disorder there is a risk of exacerbation or precipitation of an episode of this condition. There is also a dose response relationship: the higher the dose of oral steroids, and the longer the period for which they are taken, the higher the likelihood of a psychiatric event occurring.

14. That the pursuer had a history of bipolar disorder and was taking lithium did not make treatment by oral steroids inappropriate on 26 January 2005. There is no consistent evidence that patients with psychiatric disorders are more vulnerable to adverse psychiatric events from treatment by oral steroids than those without such a history.

15. That treatment by oral steroids is standard recommended treatment for sight threatening pan-uveitis is supported by the Scottish Uveitis National Managed Clinical Network Treatment Guidelines. Although not published until 2010 they resulted from a meeting of Scottish ophthalmologists in January 2005 convened for the purpose of delivering a more uniform manner of care for patients with sight threatening uveitis. Dr Stuart Roxburgh was one of the contributors. The Guidelines accordingly reflect knowledge and practice as it had developed in Scotland at the time the pursuer was treated at Ninewells in January and February 2005. They emphasise the importance of acting with expediency and to provide an adequate quantity of the appropriate immunosuppressant therapy, which includes steroid treatment, so as to seek to bring inflammation rapidly under control. Under-treatment at an early stage carries a risk of poor outcome, including partial or complete loss of vision. In the pursuer's case, given the diagnosis of sight threatening pan-uveitis, application of the Guidelines supported a relatively aggressive approach to treatment at an early stage, by administration of oral steroids, as the well-established and most appropriate treatment for this condition.

16. Treatment of uveitis by way of a steroid injection was and is an alternative to treatment by oral steroids, and which could reasonably have been prescribed for the pursuer for the condition with which he presented on 26 January 2005. There are different ways of administering such injections. Sub-tenons administration involves laying the patient on a bench, giving anaesthetic drops to the front of the eye, then making a small pocket underneath the eye with forceps and scissors. A blunt canula is then slipped around the globe of the eye and the steroid is injected so that it is sitting on the outer wall of the sclera.

17. Administration of steroid by injection is thought to carry a lower risk of precipitating an adverse psychiatric event than taking oral steroids. The extent of this lower risk has not been quantified by any controlled studies. However it is not thought to be a zero risk, and steroid

injection also carries other risks. In particular ten per cent of patients will have raised pressure in the eye, which does not come down after the injection. Local surgery may accordingly be required in order to prevent glaucoma, itself a blinding condition, but such surgery is not always effective. There are more minor risks from steroid injection of causing cataracts, or of the penetration of the eyeball in the course of the injection itself. Additionally, however, the steroid will remain around the eye for about six to eight weeks, and so treatment cannot be stopped during this period if side effects – including psychiatric side effects – occur. By contrast oral steroid treatment can if necessary be stopped more quickly. Some patients are also squeamish about the prospect of an injection into/around their eye. However the principal potential risk of a steroid injection is that it is less likely to be effective in treating pan-uveitis, and so preserving sight in the affected eye, than oral steroids. In particular there is a risk that the amount of steroid administered to the patient at the critical, early stage of treatment may be insufficient to prevent significant and irreparable visual loss.

18. The pursuer was not advised by Dr Johnstone of the possibility of treatment by steroid injection as an alternative to treatment by oral steroids. He was not advised of the relative potential risks and benefits as between these two treatments. This advice was not given because having advised the pursuer of the potential risk to his mental health from oral steroids, the pursuer was dismissive of this risk. He made clear to Dr Johnstone that he just "wanted the problem [with his eye] fixed". In the light of all this, on 26 January 2005, Dr Johnstone prescribed 30mg of an oral steroid, prednisolone, to be taken once daily. A standard dose would have been 1 mg per kg of body weight, or 70mg per day in the pursuer's case. A restricted dose was prescribed given, in particular, his pre-existing mental health condition and the potential risk of relapse. A follow up appointment was made for two days later, 28 January 2005.

19. The pursuer took the prednisolone as prescribed. On 28 January 2005 he attended at Ninewells and again saw Dr Knight. His mental state was assessed by Dr Knight and he was asked about this. It was noted that he was sleeping 'OK' at night and that his mood was euthymic i.e. normal. Treatment with prednisolone was continued, but was reduced to 20mg per day for one week, then 10mg per day for a further week. Dr Knight considered at this stage that the pursuer's condition was likely to be improving. He did not on this date discuss the possibility of steroid injections as an alternative to continuing with treatment by oral steroids.

20. An appointment was made for the pursuer to have a fluorescein angiogram on 10 February 2005. A fluorescein angiogram is a procedure in which a fluorescent dye is injected into the bloodstream. The dye highlights the blood vessels in the back of the eye so they can be photographed using a specialist camera. A number of photographs are taken as the dye passes through the eye. This is a common procedure used by ophthalmologists in order to more accurately diagnose many retinal diseases.

21. When the pursuer attended at Ninewells on 10 February 2005 the angiogram machine was broken so this procedure could not be carried out. However he was seen by both Dr Knight and Dr Johnstone. His eye was noted to be comfortable, the pain to have settled, and his vision

to have improved slightly. Again he was asked about his mood by Dr Knight, who correctly recorded that it was 'low but OK'. On examination Dr Johnstone found continuing evidence of tortuous blood vessels and swelling of the optic disc in the pursuer' left eye, notwithstanding the treatment with oral steroids since 26 January 2005. He wrote in the medical records that the pursuer suffered from bi-polar disorder and that his mood was affected by steroids. His impression of the pursuer's eye was that he might have gross cystoid macular oedema, and that an increase in oral steroid to the normal dose of 1 mg per 1 kg in bodyweight might be necessary. A further angiogram appointment was made for the following day and no change in treatment was discussed or proposed pending that examination. Dr Knight had no further involvement with the pursuer's treatment after 10 February 2005.

22. The macula can be understood as being an area on the retina, at the back of the eye, which contains certain structures specialised for high acuity central vision. Cystoid macular oedema is a condition where, typically through inflammation, fluid leaking from blood vessels in the eye gravitates around the macula and forms cysts, or little bubbles. These are destructive to the travel of nerve impulses in this area and so also destructive to vision. Gross cystoid macular oedema is accordingly a serious condition, which may be caused by or in any event related to uveitis, and is likely to be sight threatening if left untreated. Indeed it is the most common cause of permanent loss of vision in patients with pan-uveitis.

23. On 11 February 2005 the pursuer again attended at Ninewells Hospital and had a fluorescein angiogram. This confirmed that he was suffering from pan-uveitis in his left eye and that it had not so far shown good response to the oral steroid treatment provided. Definite acute vasculitic changes to the retina of his left eye were noted. The swollen optic disc was confirmed to not be as a result of drusen but inflammation. Gross cystoid macular oedema was confirmed as being present. Dr Johnstone again consulted with the pursuer. Given the seriousness of the condition, and the failure to respond to the lower doses of oral steroid, Dr Johnstone prescribed an increased dose of 70mg per day. There was no contra-indication to such an increased dose at this stage as regards the pursuer's mental state. However the pursuer was again told of the seriousness of his condition by Dr Johnstone and again warned regarding the potential effects of oral steroids on bipolar disorder. The pursuer accepted Dr Johnstone's prescription. A follow up appointment was made for 15 February 2005.

24. The pursuer was not offered the alternative of a steroid injection by Dr Johnstone on 11 February 2005. Dr Johnstone was of the view that such an injection would have been unlikely to have effectively treated the pursuer's eye condition, which remained severe notwithstanding more than two weeks of treatment with oral steroids. However a steroid injection remained an alternative treatment which could reasonably have been prescribed, and in relation to which the potential risks and benefits should have been discussed and compared with the potential risks and benefits of the substantial increase in the dosage of oral steroids which was in fact prescribed.

25. The pursuer again took the oral steroids as prescribed. He attended the appointment on 15 February 2005. He was seen by a Dr Sharpe. The pursuer reported that he was having difficulty sleeping and was feeling agitated. This was noted in the medical records, as was a

query as to whether this was due to the high dose of prednisolone. The pursuer was told to reduce the dose to 60mg per day for one day, then to 50mg the following day, then to 40mg. If his mood was stable on 40mg per day he was to continue on this dose but otherwise he was told to further reduce the dose to 20mg per day. A review appointment was arranged for 22 February 2005.

26. The pursuer again took the prednisolone as prescribed, over three days, but then stopped taking it. On 22 February 2005 he attended again at Ninewells. On this occasion he saw Dr Stuart Roxburgh, a consultant ophthalmologist. He reported feeling increasingly mentally unwell, in that he was not sleeping at night and was increasingly agitated and panicky. He and his wife had been sufficiently worried by these symptoms to stop taking the oral steroids and to contact his GP on 20 February 2005. On examination Dr Roxburgh diagnosed systemic steroid exacerbated psychosis. However the pursuer had some continuing symptoms of uveitis in his left eye, albeit that this condition showed signs of having responded to the treatment to this point. Dr Roxburgh accordingly administered a 40 mg sub-tenons steroid injection. This was a reasonable treatment at this stage, given the continuing symptoms of uveitis, but that further treatment with oral steroids was not appropriate due to presence of psychosis. A follow up appointment was arranged for seven days later.

27. On 24 February 2005 the pursuer became increasingly mentally unwell and delusional at home. His wife became concerned and phoned NHS 24 and then the pursuer's GP. The police attended at his home. He was then admitted to the Carseview Centre, a mental hospital, initially as a detained patient, where he remained until discharged on 18 April 2005.

28. The relapse in the pursuer's bipolar disorder and his consequent admission to Carseview were caused by the oral steroid treatment which he received for his uveitis in January and February 2005. It was not caused or materially contributed to by the steroid injection given to him on 22 February 2005. The rapid onset of the pursuer's symptoms, their emergence following the increase of the dose to 70mg per day on 11 February 2005, and the time-course in relation to the administration of oral steroids, are all consistent with this. It is not possible to say whether the pursuer's relapse would have been prevented if he had stopped taking oral steroids before he did, or had taken them at a lower dose than he did. However the steroid injection which the pursuer received on 22 February 2005 did not cause his relapse, which had already been precipitated by this date.

29. The symptoms which led to the pursuer's admission to Carseview were very distressing for both him and his family. He had been delusional, for example, and had experienced seeing dead bodies lying in the snow outside his house. The admission to Carseview was itself also very distressing for him. The pursuer was heavily medicated in order to treat his mental disorder, and was constantly sleepy as a result. He was placed in a locked ward initially, surrounded by other persons suffering from acute mental illness. He was witness to acts of aggression, sudden outbursts, bawling and shouting by other patients. His own behaviour deteriorated as a result of his mental disorder and he had to be subject to restraint on several occasions. He was also witness to restraint being applied to other patients. He missed his wife

and family, with whom he is close. Only as he recovered was he moved to a less secure ward, and so was able to go out for a walk with his wife on occasions.

30. During his admission to Carseview the pursuer's wife travelled to visit him every day. She provided him with emotional support, which was of therapeutic importance to him in his recovery. She would sometimes take a taxi or the bus but would otherwise walk as the pursuer's home was not too far away from Carseview. The pursuer's wife does not drive a car. The total additional cost to her of travelling to and from Carseview in the two months of the pursuer's admission in 2005 is likely to have been around £200. The pursuer's wife would bring him toiletries and fruit. She also brought him cigarettes, his consumption of which increased during his admission to around 40 a day. This increased consumption cost around £4 a day or around £200 over the course of the admission.

31. Prior to his admission to Carseview the pursuer did domestic chores around his house including cooking, shopping, gardening, painting and decorating, and walking the dog. On average he would spend an average of around an hour per day on such domestic chores. In his absence the pursuer's wife did the cooking, shopping and some light gardening, for example, by way of picking up leaves. Following his discharge the pursuer gradually resumed his domestic chores, and was fit to do so within three months.

32. The pursuer's uveitis largely resolved within a few days after he was given the steroid injection by Dr Roxburgh on 22 February 2005. The injection did not in itself bring about the resolution of the pursuer's condition, albeit that it may have contributed to this outcome, in combination with the three weeks of treatment by oral steroids which were principally responsible for it.

33. The day after his discharge from Carseview, on 19 April 2005, the pursuer attended at Ninewells and again met with Dr Roxburgh. It was noted that his left eye was slightly red, and that the vision was slightly reduced. However it was also noted that the eye had made a reasonably good response to treatment and the pursuer was listed for review in 6 months. In subsequent correspondence to the pursuer's psychiatrist on 4 May 2005 Dr Roxburgh advised that in the event of recurrent problems he would be keen to give the pursuer a further depot steroid injection rather than further systemic (oral) steroids. When the pursuer attended for review on 13 November 2005 his vision in his left eye had returned to normal and he was discharged.

34. The pursuer had further recurrences of acute anterior uveitis in 2007 and 2009. On these occasions he was successfully treated with topical steroid eye drops and steroid injections, without significant adverse effect on his mental health.

35. Had the pursuer been told, on 26 January and 11 February 2005, that treatment by way of a steroid injection was available as an alternative to treatment by oral steroids, and had the potential and relative risks and benefits of these two treatments been fully explained to him, he would still have chosen to have treatment by way of oral steroids, as was in fact prescribed for him on these dates.

FINDS IN FACT AND LAW:

36. The failure to advise the pursuer on 26 January and 11 February 2005 of the availability of steroid injection as a reasonable alternative treatment for the condition of pan-uveitis of the left eye from which he was suffering, and to fully explain to him the potential and relative risks and benefits thereof as against treatment with oral steroids, was a breach of their duty of care towards the pursuer by the doctors concerned.

37. The said breach of duty did not cause the pursuer loss, in that even if it had not occurred the pursuer would not have opted for the said alternative treatment, but would still have opted for the treatment by oral steroids which he in fact received, and with the same consequences.

THEREFORE:

Sustains the second and third pleas in law for the defenders and grants decree of absolvitor; repels all other craves for both parties; reserves all questions of expenses meantime.

NOTE:

Introduction

[1] Evidence was led in this case over five non-consecutive days between 2 and 16 March 2016, and I heard submissions at a hearing on 23 May 2016. It has had a lengthy, if largely uneventful, procedural history. It relates to events in early 2005. The initial writ was not lodged until 2008. The case was then sisted 'for the pursuer's legal aid application' – until September 2012. Three months later, in December 2012, the case was sisted again, 'for negotiations' – this time until March 2015. It is only since then that there has been any significant procedural activity in the litigation.

[2] Initially it was part of the pursuer's case that Drs Knight and Johnstone were under a duty to consult with a more senior ophthalmologist and seek the advice of a psychiatrist before prescribing oral steroids. By November 2015 further averments had been introduced, in effect, setting out claims that the pursuer had been negligently misdiagnosed with sight threatening pan-uveitis and negligently mistreated with oral steroids. All the averments of duty relative to these various claims were then deleted by minute of amendment lodged in February 2016. All that remained at proof was a claim – which in fairness had been present from the outset – that there was a breach of duty in that there had been a failure by the treating doctors to advise the pursuer of the risks to his mental health of treatment by oral steroids, and of the availability of treatment by steroid injection as an alternative.

[3] For the pursuer, I heard first from Dr Colin Rodger, a consultant psychiatrist. Then the pursuer himself gave evidence. Thereafter evidence was led on his behalf from the treating doctors, Dr David Knight and Dr Paul Johnstone. I then heard from Dr Alastair Adams, an independent consultant physician instructed by the pursuer, and from the pursuer's wife. For the

defenders, I heard from Dr Stuart Roxburgh, the treating consultant, and from Dr Alan Mulvihill, an independent consultant ophthalmologist instructed by the defenders.

Submissions

[4] Both counsel provided helpful written submissions, which were supplemented by oral submissions at the hearing on 23 May 2016.

[5] In summary, counsel for the pursuer submitted that the relevant law was now as set out in *Montgomery v Lanarkshire Health Board* 2015 SC (SC) 63, and in particular paragraphs 87 to 91. He submitted that there was a clear obligation on the treating doctors to advise the pursuer of material risks of treatment, that the risk to mental health from oral steroids was a material risk, and that the pursuer should therefore have been advised of this. It was accepted that whether or not he had been so advised was a question of fact. The pursuer had said that he had not been. I was invited to prefer his evidence to that of Drs Johnstone and Knight and the entries in the medical records on which they relied. It was submitted in particular that it had never been put to the pursuer directly in cross examination that he was not telling the truth in this regard.

[6] In any event it was submitted that treatment of the pursuer by steroid injection was a reasonable alternative to treatment by oral steroids. It was submitted that all the medical witnesses had, to one degree or another, expressed the view that it was. Insofar as it might be argued for the defenders that the pursuer did not ask about alternative treatments, or that he expressed a wish to have the most effective treatment for his uveitis, it was submitted that this did not render treatment by steroid injection unreasonable. The pursuer was only in a position to make a true choice if he was told about the possibility of treatment by steroid injection. To hold otherwise would run counter to the decision in *Montgomery*.

[7] Assuming that steroid injection was a reasonable alternative treatment and therefore that the pursuer should have been told about it, counsel for the pursuer submitted that the court should hold that as a matter of fact he was not. It was pointed out that the pursuer gave clear evidence to this effect. It was submitted that the only evidence suggesting a contrary position was that of Dr Johnstone, who ultimately thought that he would have told the pursuer about the possibility of injection but had no specific memory of it. I was invited to prefer the pursuer's evidence in the circumstances. In particular it was not challenged in cross examination, consistently with the defender's position on record, which was that steroid injections were not proposed because they were not an appropriate alternative treatment.

[8] On causation, counsel for the pursuer accepted that he required to establish (a) that if the pursuer had been told about the risks of oral steroids and the option of treatment by injection he would have opted for injection, (b) that the treatment with oral steroids caused the pursuer's psychiatric episode and consequent admission to Carseview, and (c) that steroid injection would not have caused this episode. Points (b) and (c) were uncontroversial, in the sense that all the evidence pointed in the pursuer's favour on these matters. As for point (a), it was submitted that the pursuer's evidence should be accepted. He had said that he would have chosen to have a steroid injection. He was not shaken from this position in cross examination. It was coherent, in that having previously experienced unpleasant in-patient psychiatric treatment and having a young family he would have chosen to avoid treatment which would put him at risk of mental ill

health. There was no suggestion that anything other than a 'but for' test was appropriate in relation to causation.

[9] On quantum, counsel submitted that in the circumstances solatium was reasonably assessed at £10,000, all to the past, being within the moderate range of injury per paragraph (c) of chapter 4A of the *Judicial College Guidelines for the Assessment of General Damages in Personal Injury Cases* (13th Edition). Interest should be awarded at the judicial rate from 1 May 2005 to the date of decree. An award should be made for past necessary services rendered to the pursuer by his wife, namely emotional support when visiting him in hospital, and an average of two hours per day of domestic tasks which he was unable to do until July 2005. An hourly rate of £6.50 should be assumed, making an award of £1,859 plus interest. Outlays, to include interest, were said to be reasonably assessed at £400.

[10] On the whole matter I was asked to sustain the second and third pleas in law for the pursuer and grant decree for the sum of £21,837 or such other sum as seemed appropriate.

[11] For the defenders, there was no dispute that the relevant law was as set out in *Montgomery*. On the facts, counsel submitted that it was common ground that treatment of the pursuer by oral steroids was likely to have been implicated in precipitating his psychiatric episode. I was reminded that there was now no case of fault associated with allegations of misdiagnosis or mistreatment, but that in any event it was clear on the evidence that the pursuer was correctly diagnosed with sight threatening pan-uveitis and appropriately treated with oral steroids. Insofar as Dr Adams had given evidence to the contrary this should be rejected in favour of the clear and consistent evidence of Drs Johnstone, Knight, Roxburgh and Mulvihill. Diagnosis, contrary to the pursuer's submissions, was the first thing the court had to consider. Only in the light of diagnosis can the court consider treatment, and in particular whether possible alternative treatments might be reasonable alternatives or not.

[12] On the question of the available treatment options, counsel for the defenders submitted that the opinion of all these doctors was that the standard treatment for the pursuer's diagnosis was oral steroids, consistent with national Guidelines. Dr Adams' views to the contrary should be rejected, being predicated on a failure to recognise the clear evidence for a diagnosis of pan-uveitis. It was submitted that steroid injections were a possible alternative treatment, but (a) were not the standard treatment (b) were likely to be less effective and thus carried the risk of permanent visual loss, even blindness, and (c) that they were therefore not a reasonable alternative treatment for a patient who, like the pursuer, had made clear that he wanted the optimal prospect of a cure. The pursuer had been dismissive of the risk to his mental health from oral steroids. There was therefore no obligation to offer an alternative treatment whose only likely benefit was a lesser risk of a problem that the pursuer had already indicated he was unconcerned about in relation to the standard treatment. The pursuer had given Dr Johnstone information which made steroid injections not a reasonable alternative treatment for him.

[13] On the question of whether the pursuer gave informed consent it was submitted that the evidence of Dr Johnstone should be preferred. The credibility of the pursuer's evidence had been put in issue. It had been put to him that his version of events was absurd and thus implausible in the light of the medical evidence and in particular the entries in the medical records. In any event credibility was a matter for the court to assess. It should be held that the pursuer had been told about the potential risks to mental health from oral steroids at the relevant times but he was

dismissive of this risk. In view of his attitude, and the perceived inferiority of injection as an alternative treatment, it was submitted that it was likely that this option was not extensively discussed, although it would have been had the pursuer expressed any interest in it. It was submitted further that the pursuer's evidence that there was no discussion of the risks of treatment to mental health was neither credible nor reliable and should be rejected.

[14] On quantum, counsel for the defenders submitted that solatium was reasonably assessed at £4,500, per paragraphs 4A(c)/(d) of the Judicial College Guidelines. As to services, nothing should be awarded. As regards emotional support, in particular, the pursuer's wife did no more than keep him company in hospital, which she would have done at home anyway. Nor should any award be made for outlays. In particular there was no evidence or thus good basis to conclude that any increased consumption of cigarettes by the pursuer was caused by his illness rather than as representing a choice by him to smoke more.

[15] On the whole matter it was submitted that I should repel the pursuer's pleas in law, sustain the second and third pleas in law for the defenders, and grant decree of absolvitor.

The law: Montgomery v Lanarkshire Health Board

[16] In *Montgomery* the pursuer was pregnant and suffered from diabetes. As a result there was a risk (9 to 10%) that her baby would suffer shoulder dystocia if she gave birth to him vaginally. The doctor responsible for the pursuer's care did not advise her of this risk, nor that the alternative of birth by caesarean section was available, which did not carry a risk of shoulder dystocia. The pursuer elected to give birth vaginally and her baby was born with cerebral palsy and a brachial plexus injury due to complications associated with shoulder dystocia. At proof, the doctor gave evidence that in her estimation the risk of such grave problems for the baby from shoulder dystocia was very small (less than 1%), and that it was therefore not her practice to discuss it. She said that if the risks had been discussed, almost all diabetic mothers would choose to have a caesarean section, which was not in the maternal interest.

[17] The Lord Ordinary held, following *Sidaway v Board of Governors of Bethlem Hospital and the Maudsley Hospital* [1985] AC 871, that the test for a breach of the duty of care in cases of failures to warn of inherent risks in treatment was the usual *Hunter v Hanley* test. Given the expert evidence led at proof, he concluded that the decision not to tell the pursuer about the risks of shoulder dystocia and the alternative of a caesarean was accepted as proper by a responsible body of medical opinion. Accordingly no breach of duty had occurred. He also held that the pursuer had not established causation, because even if she had been warned of the risks of shoulder dystocia by vaginal birth, she would still not have elected to give birth by caesarean section. The Inner House upheld the Lord Ordinary's decision.

[18] The Supreme Court, allowing the pursuer's further appeal, departed from the decision in *Sidaway* and reversed the Lord Ordinary's conclusion on causation. It held that "the correct position", in relation to the risks of injury involved in treatment, is as follows:

> "[87]… 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.

[88] …

[89] Three further points should be made. First, it follows from this approach that the assessment of whether a risk is material cannot be reduced to percentages. The significance of a given risk is likely to reflect a variety of factors besides its magnitude: for example, the nature of the risk, the effect which its occurrence would have upon the life of the patient, the importance to the patient of the benefits sought to be achieved by the treatment, the alternatives available, and the risks involved in those alternatives. The assessment is therefore fact-sensitive, and sensitive also to the characteristics of the patient.

[90] Secondly, the doctor's advisory role involves dialogue, the aim of which is to ensure that the patient understands the seriousness of her condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that she is then in a position to make an informed decision. This role will only be performed effectively if the information provided is comprehensible. The doctor's duty is not therefore fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form.

[91] Thirdly, it is important that the therapeutic exception [withholding information on the grounds that disclosure would be seriously detrimental to the patient's health] should not be abused. It is a limited exception to the general principle that the patient should make the decision whether to undergo a proposed course of treatment: it is not intended to subvert that principle by enabling the doctor to prevent the patient from making an informed choice where she is liable to make a choice which the doctor considers to be contrary to her best interests."

Applying these principles to the facts of the case the Court held that the pursuer should have been advised of the risk of shoulder dystocia in a vaginal birth. This was because of the nature and extent of this specific risk, which was in itself a major obstetric emergency with likely traumatic consequences for the pursuer, quite apart from the much smaller risks of grave injury to her baby. The pursuer should also have been advised of the alternative of an elective caesarean section, given that the contrast in risk in such a procedure was stark – for the mother extremely small, and for the baby virtually non existent. The Court also held on the evidence – and in particular the clear and unequivocal evidence of the treating doctor – that the only reasonable conclusion was that had the pursuer been so advised she would probably have elected to have had a caesarean section, and the baby would have been born unharmed. On the question of causation, therefore, the pursuer was entitled to succeed applying the 'but for' test, and the Court did not require to consider whether causation could have been established on some other basis.

[19] The Supreme Court's discussion of the legal and social background to its conclusions on the applicable principles is illuminating. In the first place there is endorsement of Lord Scarman's starting point in his speech in *Sidaway*, that the patient's right to make his or her own decision about treatment can be seen as a basic human right, protected by the common law. Accordingly the failure to warn the patient of risks known to be inherent in a recommended operation constitutes a failure to respect this right. The doctor's concern in making the recommendation is achieving the optimal medical objective in relation to the particular condition. But the patient may have in mind other objectives and values, which he may reasonably not want to disclose to the doctor, and which might cause him to wish to choose an alternative to what is being recommended. Accordingly, and in the second place, the scope of the duty of the doctor to warn the patient of material risks in treatment is ultimately a legal question, to be determined by the court taking the viewpoint of a reasonable person in the patient's position, and not a medical question, to be determined by reference to a responsible body of medical opinion. Thirdly, putting an onus on the patient to question the doctor, in order to trigger the right to be warned of any risks, is recognised as profoundly unsatisfactory. That is because the patient may not know that there is anything to ask about, and those who have less knowledge may be those most in need of information. Additionally, it is logically incoherent to trigger a duty of care to inform on there being prior questioning by a patient, while maintaining that the duty is a medical one: that a patient asks about risk does not alter whether a responsible body of medical opinion would not disclose it.

[20] Fundamentally therefore, as the Supreme Court explains:

> "[81] The social and legal developments which we have mentioned point away from a model of the relationship between the doctor and the patients based upon medical paternalism. They also point away from a model based upon a view of the patient as being entirely dependent on information provided by the doctor. What they point towards is an approach to the law which, instead of treating patients as placing themselves in the hands of their doctors (and then being prone to sue the doctors in the event of a disappointing outcome) treats them so far as possible as adults who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices."

To see matters from this rights based perspective, and to recognise that the patient's exercise of this right does not depend exclusively on medical considerations, points to a fundamental distinction between the doctor's role in diagnosis and treatment, and his or her role in providing information and advice to the patient on risks and alternatives. The former is a matter for professional skill and judgment, to be judged by reference to the expertise of the medical profession; the latter is a question of determining the nature and extent of the patient's rights, for which responsibility ultimately lies with the Court.

[21] In saying all this, the Supreme Court does acknowledge that just as a patient has the right to be informed of the risks and alternatives, so he or she also has the right to not be so informed. A doctor is therefore not obliged to discuss the risks of treatment with a patient who makes it clear that she would prefer not to discuss the matter. Deciding whether that is indeed the patient's

position involves judgment by the doctor, but not one that is dependent on medical expertise or to be judged by medical standards. Medical judgment only arises where the doctor is of the view that providing information about risk and alternatives would itself be detrimental to the patient's health, but that exception to the general rule is, as noted above, limited, and cannot be used as means to avoid the general duty to inform the patient, so acknowledging and respecting her right to choose, and placing on her the ultimate responsibility to do so.

[22] Without of course seeking to take issue with what is said by the Supreme Court at paragraph 87 of *Montgomery*, quoted above, I would respectfully suggest that making the patient aware of any material risks involved in any recommended treatment and any reasonable alternative treatments will in most cases not be the starting point for discussion. The starting point will likely be the doctor, after examination and consideration of the presenting symptoms, giving the patient a diagnosis. Having done so, the doctor must normally explain in a comprehensible way for the particular patient the nature, effect and severity of the condition. That is necessary because in order to make an informed decision about whether to consent to receiving medical treatment the patient needs to know what the doctor thinks will likely happen if he receives no treatment at all. Put another way, he needs to know whether *not* receiving medical treatment is a reasonable alternative open to him, and the material risks attached to such a choice. On that information platform can be placed, first, the treatment recommended by the doctor and a discussion of the potential risks and benefits of it, and second, information about any reasonable alternative treatments, and the risks and benefits of them, relative to both the recommended treatment, and the likely course of the condition if left untreated.

[23] The second observation I would make in relation to the Supreme Court's decision is on the question of alternative treatments. As is clear from paragraph 87 of the judgment, the duty on the doctor is to make the patient aware of "any reasonable alternative or variant treatments". Who is to decide whether an alternative treatment is or is not 'reasonable', and by what standard? The starting point in this regard is that the doctor will be recommending a particular treatment, and it can be supposed that it will be the treatment which in his or her view is that which is most likely to be efficacious in treating the immediate medical condition from which the patient is suffering. Even if there are in theory alternative treatments, the doctor may not consider them to be reasonable ones. Hence he may not tell the patient about them, nor of the risks associated with them. At first blush, therefore, the question of whether an alternative treatment is a reasonable alternative may seem to be a medical one. Accordingly it might be argued that if a responsible body of medical opinion existed to the effect that a given alternative was not reasonable, the doctor would not be in breach of duty by not informing the patient of it. But on this view the *Hunter v Hanley* test would return by the back door, and given the strong, patient focused thrust of the Supreme Court's judgment, I am not willing to reach that conclusion. It seems to me that the question of whether an alternative treatment is or is not reasonable must be a matter for the Court to assess, on the basis of the evidence presented to it. That will include the views of medical experts, but also the evidence of the pursuer, so as to determine whether a reasonable person, in the pursuer's position, might reasonably consent to such treatment. If the pursuer might reasonably regard the alternative treatment as reasonable for him in the circumstances, he must be advised of it, and so be given the opportunity to consider whether he might want to receive it.

[24] A further aspect of this discussion arises from paragraph 90 of the Supreme Court's judgment. Here the Court explains that the doctor's advisory role involves dialogue with the patient, not a monologue. The process is therefore dynamic and interactive. It might be argued – as indeed was suggested in this case – that which if any alternative treatments might be reasonable, such as would require them to be mentioned and discussed by the doctor, may therefore depend on how the dialogue progresses. If, in particular, the patient clearly expresses the view that he wants the most efficacious treatment for his immediate condition, is the doctor then entitled to take the view that other, less efficacious treatments are therefore not reasonable in the circumstances, and therefore do not need to be mentioned or discussed? Again, it seems to me, that to accede to such an argument would be to run counter to the clear direction of travel of the Supreme Court's decision in *Montgomery*. A patient may express a view that he wants a particular treatment, or treatment outcome, but unless he knows what the alternative treatments are, and how their risks and benefits compare, his view will not be properly informed. If he is fully advised as to the alternatives, his initial views stated in ignorance of these alternatives may change, even if they had been strongly expressed. The Court acknowledges at paragraph 85 of *Montgomery* that a patient may make clear that she does not wish to be informed about the risks of the proposed treatment, in which case no duty arises, and the same must be the case in relation to alternative treatments. However I would expect that to be the exception, not the rule, and I would expect that the court will hesitate to make a finding that no breach of duty arose on this basis without clear evidence that full and proper efforts were made to inform the patient of all reasonable alternative treatments, but that he had positively refused to hear about them. As Dr Adams put in evidence in this case, it is the doctor's job to explain the alternatives whether the patient wants to hear them or not, and a response to the effect 'you decide, doctor', does not absolve the doctor of this responsibility. Or put another way, and to pick up the language of rights in *Montgomery*, any waiver of the right to be fully informed – for in essence this is what it would be – must be clear and unequivocal before the defender will be entitled to rely on it.

[25] In my view it is also necessary to remember that consent to treatment is not necessarily a once and for all decision. It is not necessarily sufficient for the doctor, in order to comply with his or her duties as described in *Montgomery*, to merely outline and discuss the available treatment options with their relative risks and benefits at the outset of treatment. Questions of consent may require to be revisited. Where the treatment is not a one off procedure, but a course of medication, for example, there may be a subsequent need for a decision to make changes as regards the type of drug or its dosage. This in turn may significantly alter the balance of risk and benefit between the available treatment options from that which had existed when the initial treatment decision was made. In principle, it seems to me, the ultimate decision on whether to make such changes in such circumstances is for the patient to make. That being so, he or she must again be given the information regarding the available alternatives sufficient to enable him or her to give properly informed consent to what is being proposed. Of course, just as the risks and benefits of available treatment may have altered since the initial treatment decision was made, so the alternatives reasonably available may have changed. What was a reasonable alternative treatment at the outset may no longer still be reasonable, if the disease has since taken an adverse course. Or alternatively, an alternative treatment which was not reasonable at the outset might now be reasonable if the disease had since taken a favourable course. Additionally, of course, there may come a time

when, even if no positive change is being proposed to the prescribed treatment, a decision still has to be taken whether to continue to take it. In other words the balance of risk and benefit may have changed simply by the passage of time since the patient started taking the treatment.

The evidence

[26] I confess that I have some difficulty understanding why so much oral evidence was led, standing the nature of the claim which was being contested and the eventual position of the pursuer as submitted to the court through counsel. In particular, and as noted above, as a result of amendment shortly prior to the proof the pursuer was making no claim that there had been a breach of duty on the grounds of negligent misdiagnosis or mistreatment. However while the averments of duty in this connection had been deleted, the factual condescendence relative to them had not. There was thus at least some foundation on record for leading evidence regarding the correctness of the diagnosis of pan-uveitis and the appropriateness of treatment with oral steroids. Dr Johnstone was therefore examined and cross examined on these matters without objection. Evidence was then led from Dr Adams which appeared to be principally directed to criticising Dr Johnstone's evidence regarding diagnosis and treatment. There was a suggestion at one point that a Dr John Olson, a consultant ophthalmologist who had produced reports in 2007 and 2008, then retired from medico legal practice, might also give evidence for the pursuer on these matters. His name appeared on the pursuer's witness list, but ultimately he was not called. Dr Mulvihill was then led by the defenders, in part it seems, to seek to rebut Dr Adams' evidence on diagnosis and treatment.

[27] Overall there seemed at times to be a lack of clarity and/or a changing focus in what the pursuer was trying to achieve as the proof went along. By contrast, the pursuer's counsel's written submissions were clearly and helpfully focused on the *Montgomery* issue, but made no mention of the above diagnosis and treatment issues which had been so extensively canvassed by him with the witnesses, and to which the defenders were then obliged to respond. Even having heard oral submission on these matters there did not ultimately appear to be any serious challenge to the correctness of the diagnosis of the pursuer as having sight threatening pan-uveitis, nor that treatment of this condition with oral steroids was the standard, appropriate treatment, consistent with recognised clinical practice. Counsel said that he did not necessarily accept the diagnosis of pan-uveitis as correct but that it was not important. I disagree. In my view diagnosis is relevant to the case and is important. I agree with the defender's counsel that it is the starting point in understanding what treatment is appropriate and whether alternative treatments are reasonable or not. And importantly in this case a misunderstanding by the patient as to the appropriateness of the treatment which he received may also affect his evidence on the question of causation, a matter to which I will return below. I simply note at this point that if ultimately the pursuer was not intending to invite the court to reject the defenders' contention that the pursuer was correctly diagnosed with sight threatening pan-uveitis for which oral steroids were the standard recommended treatment, then the proof might have been somewhat shorter than it was.

Dr Colin Rodger

[28] Dr Colin Rodger is a consultant psychiatrist of more than 20 years experience, working in the NHS and latterly in private medico legal practice. He has produced numerous psychiatric

reports for the purpose of legal proceedings and has given evidence in court on many occasions. I had no hesitation in accepting him as an expert witness. He spoke to his own report dated April 2013, and to a report by Professor Ian Reid, consultant psychiatrist, dated June 2009. Dr Rodger explained that he had been instructed by the pursuer's solicitors following the death of Professor Reid.

[29] Dr Rodger's evidence was largely uncontroversial. He explained the nature of bipolar disorder, and in particular that it is a chronic condition in which the sufferer is susceptible to periodic relapse. He explained that while it is not always possible to identify the trigger for a particular relapse in a particular individual, there is a well recognised risk that treatment by oral steroids might precipitate an adverse psychiatric event in the patient. Accordingly in the case of a person with bipolar disorder this might mean a relapse in their condition. In the pursuer's case Dr Rodger, agreeing with the view of Professor Reid in his report, was of the opinion that it was highly likely that the relapse which he experienced from February 2005 and which led to his admission to Carseview was caused by the oral steroids which he was given for uveitis. This opinion was not challenged and I accepted it.

[30] The only significant point on which I hesitated to accept Dr Rodger's evidence was on the question of whether there was a greater risk of an adverse psychiatric event from treatment with oral steroids in the case of a person with a history of psychiatric disorder. From his own clinical practice he was inclined to think that there might be, but he was happy to agree with Professor's Reid's view expressed in his report that there was no consistent research evidence to this effect. In these circumstances, and with all due respect to Dr Rodger, I was not prepared to make a finding to the effect that the pursuer was at greater risk of an adverse psychiatric event than a patient who did not have a history of mental disorder. The more important issue remains that there was a well recognised – if relatively low – risk to his mental health. Dr Rodger, like Professor Reid before him, did not suggest that this meant that the pursuer should not have been treated with oral steroids, merely that he should have been properly informed of the risk and that he should have been monitored with a plan of management in place should an adverse psychiatric event occur. On the basis of the medical records Dr Rodger was of the opinion that these issues were considered and reasonably addressed by the treating ophthalmologists.

The pursuer

[31] I did not find the pursuer to be credible and reliable in a number of respects, and was unable to accept his evidence on a number of important matters.

[32] The pursuer was adamant that he was never told, on any occasion prior to seeing Dr Roxburgh on 22 February 2005, that there was a risk to his mental health from treatment with oral steroids. The difficulty with this position is not merely that it is contradicted by or inconsistent with an isolated note by a single doctor in an entry in the medical records. It is that it is contradicted by and inconsistent with a series of notes in different entries in the records, made over a number of consultations on different days, and by a number of different doctors. These entries indicate either expressly or by implication that the pursuer's pre-existing mental health condition was discussed with him prior to his being prescribed oral steroids; that it was explained to him that this treatment carried a risk of relapse in his mental health; that conscious of this risk he was

initially given a restricted dose of oral steroids; that for the same reason he was kept under review by giving him frequent appointments at short intervals; that he was asked questions at these review appointments directed to assess whether there had been any deterioration in his mental health; that prior to increasing the dose of steroids (to the standard dose) in the light of the results of the angiogram he was again warned of the potential effects of this treatment on his mental health; that when he first presented with symptoms of a relapse the dosage of oral steroids was immediately reduced; and that he himself stopped taking the oral steroids when his mental condition continued to deteriorate. Against this background the pursuer's continuing denial that he was at any point advised of a potential risk to his mental health from oral steroid treatment is in my view so implausible as to be simply not credible.

[33] For example, in the notes for 26 January 2005 Dr Johnstone wrote: "For oral prednisolone, 30mg od [once daily] NB previous mental health problems on Lithium. Watch for psychosis – explained to patient." The pursuer accepted that this entry was accurate in so far as it recorded that he had mentioned to Dr Johnstone that he had had previous mental health problems and was on Lithium. He sought to explain the final six words of the entry by saying that it was he, the pursuer, who had told the doctor that he would have to 'watch for psychosis', given his mental health problems. In my view this is implausible. It makes no sense for the pursuer to have said this to Dr Johnstone unless he, the pursuer, was already aware of a risk to his mental health from taking prednisolone. But that is plainly inconsistent with his position that he was never told that there was such a risk. In my view it is more probable that the entry accurately reflects the terms of Dr Johnstone's evidence, namely that he did explain to the pursuer on 26 January 2005 that there was a risk of psychosis from taking oral steroids which both doctor and patient would have to watch for as treatment progressed.

[34] By way of further example, in the entry in the medical records for 11 February 2005 Dr Johnstone, having prescribed the pursuer an increased dose of 70mg prednisolone, wrote that he was "warned again [re] effects of steroids on bipolar disorder." This is not only consistent with Dr Johnstone's oral evidence that such a warning was given on 11 February 2005, but also (the use of the word 'again') that he had already given such a warning previously, that is, on 26 January 2005. Confronted by this entry in the records the pursuer simply denied that it was true, and maintained his position that he was never on any occasion warned about the potential adverse effects of steroids on bipolar disorder. No plausible reason was suggested as to why the record would contain such an unambiguous entry if it was flatly untrue. Having seen and heard him give evidence I was not prepared to accept that Dr Johnstone had falsified the record. I was again driven to the conclusion that the pursuer's position was so implausible as to lack credibility.

[35] There were also significant question marks over the reliability of the pursuer's evidence. Given the number of appointments which the pursuer attended and the passage of time since, he did not claim to remember all the details of what had taken place. For example he could not specifically remember meeting with either Dr Knight on Dr Johnstone on 26 January 2005, yet it is clear from the medical records and from these doctors' evidence that both of them saw him on this day. Indeed the pursuer had no recollection of meeting or being treated by Dr Johnstone at all, although in my view this clearly did happen. These admitted failures of memory caused me to doubt the reliability of the pursuer's evidence in other important respects, for example in relation to what he said that he was and was not told, and when. For example he was adamant that he was

never told that there was a risk of permanent damage to his eyesight if his condition was left untreated, but given the diagnosis and the evidence of Drs Knight and Johnstone to the contrary, I was unable to accept that his memory was reliable on this matter.

[36] My concerns as to the pursuer's credibility and reliability extended to his evidence on causation. He was adamant that if he had known about steroid injections he would have chosen this as an alternative to oral steroids. However in my view the pursuer's present conviction that he would have made this choice is based on a false understanding of the risks and benefits of the alternative treatments for the sight threatening pan-uveitis with which he had been diagnosed. Essentially his assessment of what he would have done was based on two strongly held beliefs. Firstly, he believed that he was given the 'wrong' treatment (oral steroids) by Drs Knight and Johnstone. This derives in particular from his evidence that Dr Roxburgh had told him on 22 February 2005 that he should 'never have been prescribed oral steroids'. He described this statement as the "catalyst" for his claim. Secondly, the pursuer believes that that it was the steroid injection given by Dr Roxburgh on this date, and not the earlier course of oral steroids, which was responsible for the resolution of his uveitis. This derives in particular from the fact that when he had further problems with uveitis in 2006 and 2007 he was successfully treated with steroid injections. Accordingly when asked why he would have chosen not to have oral steroids, he said that "to spend three or four months and put my family through the hell of being in a psychiatric unit is a lot worse to me than getting an injection in the eye."

[37] In my view, while they are consistent with the opinions of his expert, Dr Adams, neither of the pursuer's above mentioned beliefs is well founded on the whole evidence now before the court. On the whole evidence, oral steroids were not the 'wrong' treatment in January and February 2005, standing the nature and severity of the pursuer's pan-uveitis at that time. On the contrary they were the standard recommended treatment which gave the greatest prospect of preserving the sight in the pursuer's left eye. Dr Roxburgh himself denied saying to the pursuer that he should 'never have been prescribed oral steroids', and clearly he did not think that it was wrong of Dr Johnstone to prescribe this treatment. Further, the steroid injection which the pursuer was given on 22 February 2005 was unlikely, in itself, to have been responsible for resolving his condition. The great weight of evidence – Dr Adams being alone in taking the contrary position – was to the effect that it is more likely that resolution was achieved as a result of the whole course of steroid treatment which the pursuer had received after 26 January 2005. Accordingly but for the oral steroids which he had already received prior to 22 February 2005 the steroid injection administered on that date would likely not have been effective.

[38] Accordingly I consider that the pursuer's characterisation of the choice which he would have had to make was based on false premises and was flawed. He was looking back at the decision which he would have had to make as regards consenting to treatment with oral steroids in the light of a misplaced conviction that in hindsight he was given the 'wrong' treatment (oral steroids), and that had he been given the 'right' treatment (steroid injection), his eye condition would have been resolved without any adverse effect on his mental health. I think that it is for this reason that he saw the choice which he would have had to make as being an easy one, and thus he was adamant that he would have chosen to have had a steroid injection.

[39] Correctly characterised, however, the choice which would have been before the pursuer would not have been so easy. He was correctly diagnosed with pan-uveitis, a condition which was

severe and from which there was a risk of permanent damage to the sight of his left eye, even blindness, unless effectively treated. He accepted in cross examination that he would have been concerned to know that there was a risk to his vision, and concerned to preserve his vision. Oral steroids were the standard treatment for pan-uveitis and were likely to be most effective to resolve the condition and so preserve the pursuer's eyesight. This treatment was the treatment being recommended – indeed strongly recommended – by the treating doctors. The pursuer accepted that he would expect the doctors to propose the most efficient treatment for his eye condition, and that he (like anyone else) would tend to go along with the clinical judgment of the doctor as to the most effective treatment. He accepted that he would have expected to be given the best treatment for his eye condition. Treatment by oral steroid carried a well recognised risk of causing mental health problems, but this risk was relatively small, and there is no consistent research evidence to say that he was at greater risk than someone who had not previously suffered from mental disorder. No doubt the pursuer's previous relapses in his mental condition had been traumatic for him and he would have wished to avoid a repeat of these, but he had had no such episodes for nearly eight years and was psychiatrically very stable in January 2005. I think it likely that it is for this reason that the pursuer was dismissive of the risk of psychiatric relapse when this was discussed with Dr Johnstone, whose evidence on this matter I accepted. Steroid injections, on the other hand, carried small risks of causing glaucoma, cataracts and/or perforation of the eyeball, but more importantly the risk that they would likely be less effective in treating the pursuer's pan-uveitis and so preserving his eyesight.

[40] In my view the pursuer's mistaken understanding of the choice which would have been before him undermines the reliability of his assessment of the decision which he would have made at that time. I am not prepared to hold that, had he been properly advised on 26 January and 11 February 2005 of the availability of an alternative treatment in the form of a steroid injection, and had the relative risks and benefits fully explained to him, he would have opted for this alternative treatment. I think it probable that he would still have chosen the treatment which he in fact received, being the treatment recommended for him by the doctors as having the best chance of effectively treating his eye condition and thus achieving the outcome which was his principal concern at that time.

Dr Paul Johnstone

[41] Dr Paul Johnstone is a consultant ophthalmologist with NHS Tayside, based at Ninewells. He qualified as a doctor in 1997 and was a Senior House Officer in Ophthalmology at Ninewells between 1999 and 2002. He became a member of the Royal College of Ophthalmologists in 2002. Between 2002 and 2004 he was a Clinical Teaching Fellow, continuing to hold a clinical appointment in ophthalmology at Ninewells, but undertaking a secondment at the Royal College of Ophthalmologists designing a new exam structure for trainees, and by distance learning gaining a Diploma and Certificate in Medical Education. In August 2004 he was appointed a Specialist Registrar in the Ophthalmology department at Ninewells, and it was in this capacity that he was involved in the treatment of the pursuer in February 2005. He was appointed a consultant in 2010 and now has expertise in conditions of the macula and interpretation of fluorescein angiograms.

[42] Dr Johnstone gave helpful and largely uncontroversial evidence about the nature of uveitis and associated conditions within the structures of the eye. He was then asked whether he had any

specific memory of treating the pursuer in January 2005. To the apparent surprise of the pursuer's counsel he replied that he did. He proceeded to give an account of examining and talking to the pursuer on 26 January 2005. He was clear that he had told him that he had a serious condition which was sight threatening if not treated, and that treatment with oral steroids was the most effective treatment. He was categorical that he had discussed his bipolar disorder and had told him of the potential risk to his mental health from taking steroids. He said that he had a fairly well rehearsed speech in relation to this. He said that he had a clear recollection of the pursuer being dismissive of the risks to mental health from treatment by oral steroids and clear that he 'just wanted his eye problem fixed'.

[43] Dr Johnstone's evidence was taken over two court days, more than a week apart. Initially, he had said that he had an actual recollection of not only telling the pursuer about treatment by oral steroids, but also that steroids could be injected round the eye as an alternative. He said that he highlighted that a steroid injection would have lesser side effects – in particular a lesser risk of triggering an adverse psychiatric reaction – but that it would likely not be as effective in treating the uveitis. However when he returned on the second day of his evidence his position altered somewhat about this. It became not that he had a specific recollection of telling the pursuer about the possibility of steroid injection, but that he thought that he would have done because this was part of his rehearsed speech. This caused me some doubt as to what in fact was said by him to the pursuer on this particular matter.

[44] This doubt was increased by a related chapter of Dr Johnstone's evidence, in which he was asked whether, if the pursuer had opted for a steroid injection in the light of what Dr Johnstone had told him, he would then have given him this treatment. His answers to this were to my mind rather evasive. He said that he would not necessarily have done so, and that further discussions would have been necessary. If he had still opted for an injection, Dr Johnstone would have wanted to counsel him further, and to advise him of further potential risks from this treatment. After repeated questioning on the point he was prepared to accept that treatment by steroid injection was a real and not a fictitious offer. But even this he qualified with the proviso "if, through the consent process we had both come to that agreement". All this I found unconvincing, and left me with the clear impression that Dr Johnstone – no doubt for worthy motives – was strongly of the view that treatment with oral steroids was the only appropriate treatment, and that if treatment by steroid injection was discussed at all, Dr Johnstone would have done everything he could to dissuade the pursuer from choosing it. His approach, as he made clear towards the end of his examination in chief, was that a steroid injection was not a reasonable alternative treatment given the pursuer's expressed wish for his eye to be fixed. Thus once the pursuer had expressed this wish I doubted that he would have seen the need to mention it to the pursuer, or at least to explain fully the relative potential risks and benefits of it.

[45] I also agree with counsel for the pursuer that it is appropriate to consider the defenders' position in relation to this matter. On record, they aver that (answer 6, page 6, lines 178 – 182):

> "Steroid injections were not proposed because the correct treatment in terms of the guidelines was oral steroids. Steroid injections would not have been the correct treatment to propose in terms of the guidelines and thus would not have been regarded as an appropriate alternative treatment to propose."

In line with these averments, the pursuer's evidence to the effect that he was never told about steroid injections as an alternative to oral steroids was not challenged in cross examination. Indeed Dr Johnstone's subsequent evidence that steroid injections were offered may have come as much a surprise to the defenders' counsel as to the pursuer's.

[46] In the light of all this I think that the most probable scenario is that Dr Johnstone did have a well rehearsed speech about treatment by steroids and their potential side effects. I would accept that this speech does make reference to the possibility of steroids being administered by injection as an alternative to taking them orally. However I am not prepared to accept that this alternative was offered to the pursuer, nor that the relative potential risks and benefits were properly explained to him as between the two treatments. I think that this is likely because, accepting Dr Johnstone's evidence on this point, the pursuer was dismissive when the risks to his mental health from oral steroids were explained to him, and was clear that his wish was for the most effective treatment for his uveitis. In such a situation, and against a background where Dr Johnstone was of the view that oral steroids were the clearly preferable option, one can well understand why he would not have felt the need to finish his prepared speech and thus to mention the possibility of steroid injection – or at least, to fully and properly set out the potential risks and benefits of this treatment *vis a vis* those involved with treatment by oral steroids.

[47] To my mind there is a logic to this scenario. If the pursuer had made clear that he was dismissive of the level of risk to mental health associated with oral steroids, and wanted the most effective treatment for his eye, Dr Johnstone might well have felt that there was no point then telling him about an alternative which carried a *lower* level of risk to mental health and was likely to be *less* effective in treating his eye – or at least in fully explaining the relative risks and benefits. It seems to me that the law required him to do so. But as an issue of fact, I am not prepared to accept that Dr Johnstone advised the pursuer on 26 January 2005 that steroid injection was available as an alternative treatment, nor that the relative risks and benefits of this treatment were sufficiently explained to him. On this matter I was prepared to accept the pursuer's evidence, unchallenged as it was.

[48] I am also unable to accept Dr Johnstone's approach to the question of whether the alternative of a steroid injection was reasonable. As noted, he thought that it was not, because the pursuer had made it clear that he wanted his eye problem fixed. To ask whether steroid injection was a reasonable alternative separate from the treatment outcomes sought by the patient was for him an abstract conversation. The difficulty with this, it seems to me, is that it would undermine the approach taken by the Supreme Court in *Montgomery*, for reasons I have already touched on above. Every patient's likely starting point will be to want the most effective treatment for the particular and immediate medical problem at hand. But for him to express a wish for this without knowing what alternatives are available and the relative potential risks and benefits of them, is also an abstract conversation. Accordingly in my view such an initial expression of view by the patient, even when clearly stated, cannot absolve the doctor of the responsibility to properly present and discuss the available alternatives. I consider that that is so even if these alternatives are ones which the doctor considers may have sub-optimal prospects of effectively treating the particular problem, assuming that they are ones which for other reasons the patient might reasonably choose. Only in the light of knowledge of the available alternatives and their relative risks and benefits can the patient express a properly informed view about the treatment outcomes

which he wants, and so chose the treatment which for him is likely to best achieve those outcomes. That is not to say that there will not or should not be a two way conversation in this regard. And it is also not to say that there will not be cases where the patient simply does not want to hear the alternatives and will not do so. But in the present case I am not satisfied that the pursuer's expression of desire to 'just have his eye condition fixed' and apparent lack of concern regarding his mental health, rendered treatment by steroid injection an unreasonable alternative, and thus one which Dr Johnston was not obliged to discuss fully with him on 26 January 2005.

[49] There is no dispute that the pursuer was not offered the alternative of a steroid injection by Dr Johnstone on 10 or 11 February 2005. On 10 February this was because Dr Johnstone was awaiting the results of the angiogram which could not be performed that day because the machine was broken. On 11 February it was because Dr Johnstone did not consider it to be a reasonable alternative treatment at this stage, standing his assessment in the light of the angiogram results that the pursuer's condition was still sight threatening but had not responded positively to the more aggressive oral steroid treatment which he had received since 26 January 2005. Ultimately I consider that the weight of medical evidence is against Dr Johnstone's conclusion that steroid injection was not a reasonable alternative treatment on 11 February 2005. Certainly the factors cited by him suggested that oral steroids were the more appropriate treatment in order to seek to resolve the pursuer's uveitis. But to increase the dose substantially would also be to increase the risk of mental relapse. Accordingly there was a material change in the balance of risk and benefit to the pursuer from the two treatments since 26 January 2005. In my view this required to be revisited and explained to the pursuer in order for him to give properly informed consent to the treatment prescribed on 11 February 2005.

[50] As I have already indicated counsel for the pursuer challenged Dr Johnstone in examination in chief as regards his diagnosis that the pursuer had pan-uveitis. This prompted counsel for the defender to cross examine Dr Johnstone on the photographs of the pursuer's eyes taken in the course of the fluoroscein angiogram on 11 February 2005, so as to defend his diagnosis of sight threatening pan-uveitis with gross macular oedema made on the basis of this procedure. The macular oedema in particular Dr Johnstone described as "absolutely obvious barn door". That this diagnosis was correct was supported by the evidence of all the other medical experts, with the exception of Dr Adams, and I had no difficulty accepting it. Counsel for the pursuer also appeared to challenge the appropriateness of Dr Johnstone's decision to treat the pursuer with oral steroids, seeming to suggest that it was the sub-tenons injection which had led to the resolution of the problem and pointing to successful treatment of the pursuer by steroid injection in 2007 and 2009. However I also had no difficulty accepting Dr Johnstone's evidence that the pursuer's treatment by oral steroids over the period between 26 January and 22 February 2005 was likely to have been largely responsible for resolving the uveitis, and that it is mistaken to think that it was the sub-tenons injection administered by Dr Roxburgh on the latter date which was wholly or mainly responsible. Dr Johnstone agreed that the injection was appropriate on that date given that by this stage the pursuer's eye condition was improving but his mental state was deteriorating. I accepted his evidence that this did not mean that this sub-tenons injection would have been effective to treat the uveitis absent the earlier oral treatment, nor that a sub-tenons injection on 26 January or 11 February 2005 would have been effective to do so on those dates.

Dr David Knight

[51] Dr David Knight is a consultant ophthalmologist based at Raigmore Hospital, Inverness. He has a subspecialist interest in uveitis. He completed a training certificate involving a secondment in Bristol for eight or nine months to gain more experience and knowledge of this condition and its treatment. He tends to see more patients with uveitis than other ophthalmologists, including on referral from his medical colleagues. In January 2005, however, he was a relatively inexperienced senior house officer in ophthalmology based at Ninewells Hospital, a post he had held for only 11 months. It was in that capacity that he had involvement with treatment of the pursuer.

[52] It is apparent from the medical records that the pursuer was seen by Dr Knight on 5, 26 and 28 January 2005, and again on 10 February 2005. However Dr Knight accepted that he had only a vague recollection of these meetings. Having re-read the notes he remembered seeing the pursuer at the beginning of January and prescribing him topical steroid treatment for anterior uveitis, bringing him back for review a week or two later. He remembered that when reviewed the pursuer's condition had deteriorated into pan-uveitis, and that because he was quite inexperienced at the time he sought advice from Dr Johnstone as his more senior colleague in the department.

[53] Dr Knight gave evidence, contrary to the pursuer's recollection, that Dr Johnstone had come and spoken to the pursuer and confirmed a diagnosis of pan-uveitis. Dr Knight said that he assumed that thereafter there had been a discussion of treatment with the pursuer, led by Dr Johnstone, including the risks to mental health from oral steroids. He could not remember all of the detail of what was said or by whom, but could recall that the discussion involved the issue of steroids and psychosis. He was "quite convinced… certain" that the pursuer was told of the risks. He gave evidence that the common practice would be to discuss not having treatment at all, having steroid drops, oral steroids or steroid injections into or around the eye, explaining the risks and benefits of each. Dr Knight could not say that this had in fact all been said to the pursuer prior to prescription of oral steroids on 26 January 2005, although he said he was "fairly sure it [steroid injections] would be mentioned" although "not… sold as a great treatment". He was clear however, then and now, that the pursuer had pan-uveitis and that treatment by oral steroids was the optimal treatment. However he accepted that a steroid injection was at least potentially a reasonable alternative treatment which should have been discussed with the pursuer.

[54] It was clear – and Dr Knight himself was candid about this – that he was at the time a relatively inexperienced ophthalmologist. He accepted that through inexperience he may have made mistakes, for example in recording the visual acuity in the pursuer's left eye at 6/6 (i.e. normal) on examination on 28 January 2005, and in forming the initial impression on 10 February 2005 that the pursuer's condition was improving. However to his credit Dr Knight recognised and acknowledged his limitations at this stage of his career and took the appropriate step of consulting Dr Johnstone, deferring to his greater knowledge and experience. Looking back with hindsight and a further 11 years of relevant experience, including three years with specialist training and experience in uveitis, he was satisfied that Dr Johnstone's diagnosis of pan-uveitis and cystoid macular oedema was correct, was confirmed by the angiogram, and that oral steroids were the optimal and correct treatment for this condition.

[55] Overall I had no difficulty in accepting Dr Knight as an expert witness insofar as he was asked to express his opinion on the questions of the pursuer's diagnosis and treatment in 2005.

Indeed given his consultant status and that uveitis is now, and has been for some three years, an area of special interest and experience for him, he is particularly well qualified to express such opinions. I was also prepared to accept him as a credible and reliable witness to the facts of his own clinical involvement, insofar as he was able to recall these. I thought him measured and fair in his evidence in this regard. However he was candid that he had no clear recollection of the pursuer being told, by him or by Dr Johnstone, of the possibility of steroid injections as an alternative to oral steroids. His evidence went no further than that he should have been told and probably would have been told. In my view, however, it is likely that it was Dr Johnstone who took the lead in the discussions with the pursuer, once Dr Knight called him in. I do not accept, for the reasons I have given, that Dr Johnstone told the pursuer of steroid injections as an alternative treatment or properly discussed the relative risks and benefits of this treatment. If he did not, I doubt that Dr Knight would have done so, either on 26 January or 10 February 2005, standing his junior position *vis a vis* Dr Johnstone at that time. He also accepted that injections would not have been discussed by him on 28 January 2005 when Dr Johnstone was not present.

Dr Alastair Adams

[56] Dr Alastair Adams is a retired consultant ophthalmologist. He was in practice as a consultant between 1979 and retiring in 2006. He has general expertise in ophthalmology based on his long experience as a consultant, but has no special interest or particular experience in inflammatory eye disorders such as uveitis. He is not an expert in this condition. Such expertise as he has is in cornea disease. Since 2007 Dr Adams has worked in private medico-legal practice, having prepared to date around 300 reports in legal proceedings, for both pursuers and defenders, albeit that less than 50 of these concerned clinical negligence, the last of which was two or three years ago, and none of which involved uveitis. Dr Adams prepared eight reports for the present litigation, between 2012 and 2016. The proof was the first time that he had given evidence in court.

[57] Dr Adams expressed the firm opinion, from his consideration of the medical records, that the pursuer did not have sight threatening uveitis in January and February 2005 and that the prescription of high dose oral steroids was not necessary. In short, his reports and oral evidence were to the effect that the pursuer had been misdiagnosed and mistreated by Drs Knight and Johnstone. In his opinion, the pursuer had had nothing more than acute anterior uveitis which could and should have been further treated with steroid drops, or if need be a steroid injection. In this regard he was taken at length through the records and other experts' reports in examination in chief and cross examination.

[58] Dr Adams was articulate, plausible, familiar with the records and other material, and resolutely defended his opinions on these highly complex medical matters. That said he was prepared to concede – reluctantly – that the examining clinicians would have been in a better position to judge the severity of the condition of a particular patient than he was from reading the records, and that some ophthalmologists might, in accordance with the Scottish Uveitis Guidelines, treat sight threatening pan-uveitis with oral steroids. Nevertheless, he still thought that Drs Johnstone and Knight had been wrong in both diagnosis and treatment of the pursuer.

[59] While Dr Adams was clear and determined in his opinions, he was ultimately in a minority of one out of the five consultant ophthalmologists who gave evidence. Indeed there was often

glaring disparity between his opinions on the one hand and all of the other four consultants on the other. For example, although Dr Adams was strongly of the view that the pursuer's angiogram did not show that he had cystoid macular oedema on 11 February 2005, Drs Johnstone, Knight, Roxburgh and Mulvihill were all adamant that it clearly did – "barn door" clearly, as Dr Johnstone put it in evidence. Individually – particularly in the case of Dr Roxburgh – and collectively, these doctors' expertise and experience on the specific condition suffered by the pursuer was clearly greater than that of Dr Adams. Furthermore, in the case of Drs Knight, Johnstone and Roxburgh, they had had the benefit of direct involvement in the treatment of the pursuer at the relevant time, and were not simply reviewing the medical records, as Dr Adams had done. Insofar as there might be said to be a positive advantage of bringing an independent view to bear on the records – the 'fresh pair of eyes' – Dr Mulvihill had also done this, yet he too disagreed strongly with Dr Adams' conclusions on diagnosis and treatment. Overall, for these reasons, I had no hesitation in preferring the majority opinion on these matters to that of Dr Adams and in making findings accordingly.

[60] The principal question of course is not whether the pursuer was misdiagnosed or mistreated, but whether, given that he was in fact diagnosed with sight threatening pan-uveitis and treated with oral steroids, he was told of the risks of such treatment and made aware of the possibility of treatment by steroid injection. On these matters, Dr Adams could, of course, add nothing to the medical records. He had himself, for example, not met with or examined the pursuer. The one relevant matter on which he could offer an opinion was whether treatment by steroid injection would have been a reasonable alternative treatment for the pursuer. On this he was, unsurprisingly, of the view that it was. In that regard only he found himself, albeit for very different reasons, aligned with the majority view, namely that the availability of this treatment and the relative risks and benefits of it should have been discussed with the pursuer prior to any treatment with oral steroids. To that extent I was prepared to accept his evidence, albeit not for the reasons he advanced.

Gillian Britten

[61] The pursuer's wife gave evidence, corroborating some details of his account of their family circumstances and the events of early 2005. She confirmed that he was going backwards and forwards to the 'eye department' at Ninewells, and that sometimes she went with him. She could not remember how many times she went. Sometimes she also went into the consulting rooms with him, but not always. She had no recollection of any doctor saying that the pursuer had a blinding condition. Nor had the pursuer ever told her that he had been told that, and she was sure that if it had been said to him he would have told her. She did not know what types of treatment were discussed with the pursuer.

[62] Mrs Britten spoke about the pursuer becoming mentally ill towards the end of February 2005, about attending his GP, about the police being called, and of his admission to Carseview. She also spoke to the pursuer's "awful" experience while an in-patient, and in particular his great upset at being parted from his family. She spoke to the claims for services which the pursuer had been unable to do while ill, namely domestic chores such as gardening, decorating and cooking. She estimated that he would do these four hours per day in the good weather. She had to do these things when he was in Carseview, and he did not really do his share of the chores again for three

years afterwards. She also spoke of services which she said she had to provide to him while he was ill, namely visiting him twice a day in hospital to provide support, and of the cost, maybe £20 a day, of some toiletries but mainly cigarettes, which she took to him.

[63] In cross examination, Mrs Britten accepted that as neither she nor the pursuer were employed, they would have been in each other's company each day whether or not the pursuer was in hospital. She seemed to accept that the only gardening she did instead of the pursuer was to pick up leaves. She accepted that they decorated the house no more than once a year. She said that the pursuer usually cooked the evening meal. She also accepted that the pursuer would have smoked even if he was not in hospital, although she said that he smoked more when he was there.

[64] Mrs Britten's evidence was relatively brief and, in general, I found it rather unconvincing. She was vague and therefore unreliable in relation to the pursuer's attendances at hospital and when she had or had not attended with him. Although she was strongly of the view that he would have told her if he had been told that he had a sight threatening condition, I did not accept that he had not been told this by Dr Johnstone, for the reasons already given. In my view if Mrs Britten did not know about it, then that is because the pursuer did not tell her, and she was therefore wrong to assume that he would have done.

[65] In relation to the pursuer's experience of becoming mentally ill and his hospitalisation in Carseview, I can readily accept Mrs Britten's evidence that this will have been a very unpleasant experience for him, and indeed for his whole family. I was prepared to accept her evidence that while in hospital the pursuer was unable to do his share of the domestic chores, but thought her estimate of the amount of time he spent doing such chores was likely to be exaggerated, and similarly I did not accept her evidence that he was rendered incapable of fully resuming his chores for three years after his discharge. Plainly Mrs Britten provided support to the pursuer by visiting him in hospital, but as far as I could tell this in practical terms involved keeping him company much as she would have done had he been at home. As for her evidence about additional costs arising from hospitalisation, I was prepared to accept – for what it was worth – that he smoked more, with additional cost.

Dr Stuart Roxburgh

[66] Dr Roxburgh is a retired consultant ophthalmologist. He was appointed a consultant in 1981, worked full time with NHS Tayside until 2010, and then held a locum appointment until retiring in 2013. He was an Honorary Senior Lecturer in the Department of Ophthalmology, University of Dundee Medical School, between 1981 and 2010. He was head of the University's Department of Ophthalmology between 1991 and 1996, teaching undergraduates and organising research. In particular he taught junior doctors in the interpretation of fluorescein angiograms, in which he had a particular interest. He was Senior Vice President of the Royal College of Ophthalmologists in 2003-4, and also held at various times a number of posts in the College's Examinations' Committee. This Committee ran all the examinations for all ophthalmologists regarding their training for progressing to consultant posts. He had involvement at a national level in the Scottish Intercollegiate Guideline Network, whose role is to develop guidance for all clinicians including hospital doctors across a range of diseases. In particular he was involved in the production of the Scottish Uveitis Treatment Guidelines, as chairman of the stakeholders on the committee. In his clinical practice he had special interest in macular pathology and medical retinal

disease, and dealt regularly with patients with uveitis. He was based at Ninewells in 2005. As the most experienced clinician on the unit he would tend to be referred the more difficult cases of uveitis. He met with and treated the pursuer on 22 February, 19 April, 7 June and 13 December 2005.

[67] Dr Roxburgh was taken through the pursuer's medical records. He agreed that standing Dr Knight's findings on 26 January 2005 there was evidence that the pursuer's condition had deteriorated. In particular he agreed that there was then evidence of inflammation at the back of the eye, and that further treatment with steroid drops was – contrary to Dr Adams' view – not appropriate. Dr Roxburgh regarded pan-uveitis as a relatively old fashioned term; it really just meant an inflammation involving all the layers of the uvea. He himself might have described the pursuer as having anterior uveitis complicated by cystoid macular oedema, but it came to the same thing as describing him as suffering from pan-uveitis. From the notes he considered the diagnosis and treatment of the pursuer by Drs Knight and Johnstone as at 26 January 2005 to be perfectly rational. He confirmed that an argument might be made for treatment by steroid injection but that treatment by oral steroids was the standard first treatment for sight threatening unilateral uveitis, at Ninewells and most other units in Scotland, and this was reflected in the national Guidelines later produced. In particular he explained that uveitis is a systemic disease affecting the body's immune system, although focussed on the eye. The argument for oral steroids is to treat the whole body's immune response. The main intention was to rapidly bring the inflammation under control with such steroids – "hit it hard" – and then reduce the dose very quickly. The counter argument for injection, targeting the affected eye with a longer term direct administration of steroid, Dr Roxburgh regarded as valid, but said it was a judgment call in relation to assessing benefits and side effects. His preference remained for treatment by oral steroids.

[68] In relation to the fluorescein angiogram carried out on the pursuer on 11 February 2005 Dr Roxburgh was of the view that this confirmed that Dr Johnstone's diagnosis of pan-uveitis and cystoid macular oedema was correct. Like Dr Adams he was taken through the various photographs. He described the images of the macular area of the pursuer's left eye as a "classical… textbook picture" of "very obvious" cystoid macular oedema. He indicated that it was so clear that the images had later been used in teaching postgraduate students about this condition. He firmly rejected the suggestion that the angiogram images showed benign drusen. He said, tellingly, that he would have failed a candidate in a fellowship examination if they did not recognise what was seen on the images as showing cystoid macular oedema. By implication, therefore, he would have failed Dr Adams, had he been sitting such an examination. Dr Roxburgh confirmed that cystoid macular oedema was the commonest cause of non-recoverable blindness in uveitis. He agreed that what was seen on the angiogram images was sufficient to justify a diagnosis of a severe sight threatening condition, and which required increased oral therapy.

[69] Dr Roxburgh then spoke to his own involvement with the pursuer's treatment on 22 February 2005 and afterwards. He did not reject outright the suggestion, with the benefit of hindsight, that the pursuer might have been successfully treated with a steroid injection at an earlier stage, but he thought that by 22 February 2005 the condition was already coming under control by treatment with oral steroids. He explained that he gave the pursuer an injection on that date as a means to taper off steroid treatment rather than to stop it suddenly, in the light of his

mental condition, which might in itself have led to adverse effects. He considered that the pursuer's condition had responded well to the injection, but just because this had happened after his having been given oral steroids, it did not mean that it would also have responded well had the injection been given at the outset. He described that as "pure conjecture". He supported the earlier treatment decisions which had been made by Drs Knight and Johnstone.

[70] In relation to providing information regarding the potential risks and benefits of steroid treatment, Dr Roxburgh said that he would have recommended oral steroids as being the most effective treatment. He would have responded to and discussed matters with the patient, and hoped that in the circumstances he would have mentioned the possibility of injections. He accepted that a patient with a previous history of mental disorder might reasonably want to prioritise his mental health over his ophthalmic health. Accordingly he accepted that the pursuer should have been told about the possibility of a steroid injection on 26 January 2005, as one of the reasonable alternative treatments which should have been presented to him.

[71] Dr Roxburgh was asked about the pursuer's evidence that at their meeting on 19 April 2005 he had said something to the effect that the pursuer 'should never had been treated with oral steroids and that he would make sure it would not happen again'. Dr Roxburgh disputed this account. His view, then and now, was that oral steroids were the standard and preferred treatment for the pursuer's condition, and that they were the right treatment to give him at the time they were prescribed. His recollection was that he had said that they would do their best to avoid treatment with oral steroids in the (likely) event of a recurrence of the pursuer's uveitis in the future, not that he had criticised their prescription in January and February 2005. He accepted however that it was likely that the oral steroids had caused the pursuer's mental relapse and admission to Carseview in February 2005.

[72] I mean no disrespect to the other doctors who gave evidence in this case but it is apparent that Dr Roxburgh had significantly greater expertise in relation to the medical matters with which this case is concerned. Collectively his long clinical experience, specialist interest in uveitis, university teaching experience, role as a medical examiner for the Royal College, and involvement in the development of the relevant Scottish national Guidelines, set him above the other experts and required that his opinions be given particular weight. I also thought him an impressive witness, measured and fair minded in his approach. In the light of this, and in summary, I accepted his evidence on all material points, and preferred it to the evidence of Dr Adams where these were in conflict. I therefore accepted his evidence that the pursuer was correctly diagnosed by Dr Johnstone as suffering from a sight threatening pan-uveitis, and that this was confirmed by the angiogram showing gross macular oedema. I also accepted his evidence that treatment by oral steroids was the standard and appropriate treatment for this condition, but that steroid injection was a reasonable, if less preferable, alternative treatment. It follows that the availability and potential and relative risks and benefits of steroid injections should have been discussed with the pursuer, prior to treatment with oral steroids.

Dr Alan Mulvihill

[73] Dr Mulvihill is a consultant ophthalmic surgeon based at the Princess Alexandra Eye Pavilion, Edinburgh. He has been a consultant since 2002, and is a Fellow of the Royal College of Surgeons Ophthalmology Edinburgh and Ireland. The treatment of patients with uveitis forms a

regular part of his general adult practice. He is frequently required to perform and interpret the result of fluorescein angiograms as part of this practice. He has also carried out medico legal work for over 10 years, providing around 50 reports per year, mainly in personal injury cases. He was instructed by the defenders in the present case to consider and provide an independent report on the management of the pursuer at Ninewells in January and February 2005. For that purpose he had reviewed the case notes, angiogram images, and other expert reports.

[74] Dr Mulvihill said he was quite certain that the pursuer had at the relevant time a very severe and sight threatening form of posterior or pan-uveitis, and that the treatment he received was, in his opinion, entirely correct. He spoke to his own report of 4 February 2016 in enlarging on this conclusion. He confirmed that the pursuer had presented initially with recurrent iritis, but that when he returned on 26 January 2005 his vision was markedly worse despite what should have been more than adequate treatment for this condition by steroid drops. It was apparent that there was a concern that he was developing inflammation at the back of the eye.

[75] The angiogram on 11 February 2005 demonstrated unequivocally, in Dr Mulvihill's opinion, that there was indeed severe inflammation at this location. He confirmed that the images confirmed moderate to severe pan-uveitis, carrying a risk of permanent vision loss if not adequately treated. He described Dr Adams' opinion to the contrary as "untenable", "impossible to reconcile" with the angiogram test results, and he completely disagreed with it.

[76] Dr Mulvihill was of the clear opinion that standing the nature and severity of the pursuer's condition it would not normally be treated initially with steroid injections. He was of the view that at the time when the pursuer did receive an injection the oral steroids were certainly already working and controlling the uveitis, and that it was quite uncertain that an injection alone would have prevented permanent visual loss. The correct and normal treatment for the pursuer's condition was oral steroids. Increasing the dose to 70mgs was also appropriate in the circumstances, given the pursuer's body weight and the angiogram findings. In retrospect, indeed, the initial doses given were too little, because they failed to produce an adequate response. However Dr Mulvihill recognised that this may have been to minimise the risk of psychiatric side effects and demonstrated good judgment in the circumstances. Echoing Dr Roxburgh's evidence in this regard he emphasised that the pursuer's condition was systemic, and that treatment required to be not just to the eye but to body itself, which was best achieved with oral steroids. In Dr Mulvihill's view this form of administration resulted in a much quicker improvement in the clinical findings and a much lower risk of permanent vision damage. He said that injection of steroid was if anything less in fashion now than in 2005: "the reality is that it is just not as effective". Overall, Dr Mulvihill endorsed the management and treatment of the pursuer's condition.

[77] Notwithstanding this, Dr Mulvihill was prepared to accept that treatment of the pursuer with steroid injection was a reasonable alternative treatment, albeit one that he considered inferior. He accepted that patients should be told about realistic alternative treatments. Because he considered oral steroids to be the clearly preferable treatment he was not sure that he would even mention the possibility of steroid injections. Even though he might mention them if the patient voiced concerns about his psychiatric history, he would be careful to make clear that they were less than optimal treatment. He would certainly discuss the risks to mental health from steroids generally if there was a known history of psychiatric disorder.

[78] Like Dr Adams, Dr Mulvihill was able to give an independent view of the appropriateness of the diagnosis and treatment of the pursuer. He has no particular specialist knowledge or interest in uveitis, but is plainly an experienced ophthalmic consultant, currently in general practice. His views were very much of a piece with Drs Knight, Johnstone and Roxburgh, in being clear that the pursuer had a sight threatening uveitis, which was appropriately treated with oral steroids. Like these doctors, he rejected Dr Adams' views to the contrary, and in particular his interpretation of the results of the angiogram. In all these aspects he was a good witness, clear and articulate, and able to speak from experience of contemporary practice in an area of Scotland outwith that served by the defenders in this case. In so doing he added to the clear weight of numbers in the defenders' favour on the questions of diagnosis and treatment, without significantly adding to what had been said before. He may have been rather more over-emphatic about some aspects – for example, the ineffectiveness of steroid injections to treat pan-uveitis – than was justified by the available scientific evidence, but in general I was prepared to accept his evidence, in particular in preference to Dr Adams' evidence, insofar as is reflected in the findings in fact set out above.

[79] But yet again it is necessary to recall that these are not the principal disputed issues in this case, which centre on what the pursuer was or was not told about the treatment which he was prescribed and any reasonable alternatives. In this regard I had some reservations about Dr Mulvihill's approach. In summary this was that while he accepted that in principle steroid injection was a reasonable alternative treatment, he would have recommended oral steroids, and would only have discussed steroid injections if the patient had first asked him if there were any alternatives to what he was proposing. And if the patient had simply asked for the most effective treatment as regards his eye problem, Dr Mulvihill would not then have considered that steroid injection was a reasonable alternative treatment, given that it was less likely to achieve this result, and so would not have felt it necessary to mention or discuss it.

[80] In this regard Dr Mulvihill's approach had some similarity to that of Dr Johnstone, discussed above, and I am unable to accept it as consistent with the decision in *Montgomery*. What is or is not reasonable treatment for a particular patient is not to be measured solely by the extent to which it is likely to ameliorate or cure the particular condition for which it is prescribed. The doctor's duty to advise and discuss alternative treatments is not dependent on the patient first asking if there are any. An expressed wish by the patient for the best treatment for the immediate condition, made without knowledge of the available alternatives and their relative risks and benefits, does not absolve the doctor of this duty.

Discussion

[81] Seeking to apply the principles derived from *Montgomery* in the present case, it seems to me that in order to succeed in his claim the pursuer has, in summary, to establish (i) that he was not properly advised of the risks to his mental health of treatment with oral steroids at the material times; or (ii) that steroid injection was a reasonable alternative treatment which was available; but (iii) that the pursuer was not advised of this alternative nor of the potential and relative risks and benefits of such treatment *vis a vis* treatment by oral steroids; and in either case (iv) that treatment by oral steroids caused the relapse in his bipolar disorder and so caused him loss; and (v) that but for the failure to properly advise him of the availability of treatment by steroid injection and the

potential and relative risks of such treatment he would not have consented to treatment by oral steroids and so would not have sustained this loss.

[82] I agree with the pursuer's counsel that the first issue is simply one of fact, to be determined on the evidence. For the reasons which I have sought to explain in discussion of the evidence of the pursuer and Dr Johnstone, set out above, I do not accept that the pursuer was not properly advised that there was a material risk to his mental health from treatment by oral steroids. I consider, on the evidence which I have accepted, that this matter was discussed with him at both the critical treatment points, that is, on 26 January 2005, when he was first prescribed a daily dose of 30mg of oral steroids, and again on 11 February 2005, when the daily dose was increased to 70mg. I consider that he consented to these treatments in the knowledge that there was a material risk to his mental health.

[83] On the second issue, I agree again with the pursuer's counsel that treatment of the pursuer by steroid injection was a reasonable alternative treatment to treatment by oral steroids. I consider, for the reasons which I have sought to explain above, that this is a matter for the court to decide on the basis of all the available evidence, medical and otherwise. In my view a reasonable person in the pursuer's position, both at 26 January 2005 and 11 February 2005, might reasonably have opted for treatment by steroid injection, had they been made aware of the relative risks and benefits of this treatment *vis a vis* treatment by oral steroids. This is so standing in particular the previous history of mental health problems from which the pursuer had suffered, and which might have caused him to prioritise the risk to his mental health over the risk to his visual health. I do not accept that steroid injections ceased to be a reasonable alternative treatment for the pursuer because of anything he said to Dr Johnstone on 26 January 2005. As I have said, I do not accept that the evidence establishes that the pursuer, by being dismissive about risks to his mental health or by stating that he 'just wanted his eye problem fixed', had clearly and unequivocally waived his right to be properly informed of the availability of steroid injection as an alternative treatment.

[84] As to the third issue, this is again a question of fact, and again I agree with the pursuer's counsel, and for the reasons discussed in relation to Dr Johnstone's evidence, that the pursuer was not told of the availability of steroid injection as an alternative to oral steroids. He was not therefore properly informed as to the relevant risks and benefits of this treatment. In my view, again for the reasons discussed above, it was incumbent on Dr Johnstone to inform the pursuer of these matters both on 26 January 2005, prior to commencement of oral steroid treatment, and again on 11 February 2005, prior to the substantial increase in the dose which was prescribed on that date and the consequent material increase of the risk to the pursuer's mental health attendant on this. I do not accept Dr Johnstone's evidence to the effect that he told the pursuer about steroid injections on 26 January 2005, but in any event he accepted that he did not do so on 11 February 2005. It may be that in 2005 a reasonable body of responsible medical opinion would not have thought it necessary to tell the pursuer about the possibility of steroid injections, or indeed would have taken the view that on one or either of these dates that this was not a reasonable alternative treatment for him. However in the light of the decision in *Montgomery* I consider that this is not the correct test. In my view, on the evidence which I have heard, steroid injection was a reasonable alternative treatment and it was Dr Johnstone's duty to take reasonable care to properly advise the pursuer about it. He failed to do so and was accordingly in breach of that duty.

[85] The fourth issue is uncontroversial. The unchallenged medical evidence establishes that it is likely that the pursuer's treatment by oral steroids was the cause of the relapse in his mental health and consequent admission to and detention in Carseview from 24 February 2005.
[86] The fifth issue rests on accepting the pursuer's evidence as to what he would likely have done had he been properly informed of the availability of steroid injection at the material times, and in particular whether it is likely that he would have chosen that alternative. In this regard, he bears the onus of proving a counterfactual. In my view, and for the reasons explained above in discussion of his evidence, he has not done so. I reject his assertions to the contrary as based on false premises and as unreliable. The relevance of the evidence as to the correctness of the diagnosis of sight threatening pan-uveitis and the appropriateness of treatment by oral steroids in this context is that it shows that the pursuer approached this issue on the basis of false premises. He has as a consequence, in my view, failed to ask himself the right question as to what he would have done in the circumstances, and so fatally undermined the value of his answer. Accepting – as I do – that the correct premises were that the pursuer had a severe sight threatening condition for which oral steroids was the optimal treatment, I think it likely that he would have made the same decision even if he had been told about the possibility of a steroid injection.
[87] Unlike in *Montgomery*, the pursuer cannot point to evidence from any of the treating doctors to support his own evidence on causation. Indeed it should be borne in mind that while Dr Johnstone was duty bound to advise the pursuer of the alternative of steroid injection, he was not bound to give it equal weight or merit, or to seek to sell it to the pursuer with equal enthusiasm. It is clear that even if I had accepted that he had finished his 'prepared speech', and so told the pursuer of the relative risks and benefits of both treatments, he would still have strongly recommended the treatment which the pursuer did in fact receive. That is no doubt because Dr Johnstone wanted to do his utmost to preserve the pursuer's eyesight and strongly believed (and still believes) that treatment by oral steroids was clearly preferable as the means to do this. In all the circumstances I think it likely that even if the pursuer had been fully appraised of alternative treatment that he would still have accepted Dr Johnstone's recommendation and consented to the treatment which he did in fact receive. For these reasons he has not established causation and his claim fails.

Quantum
[88] Had I found in the pursuer's favour I would have assessed solatium at £10,000, all attributable to past loss, for the reasons submitted by his counsel. The pursuer suffered on any view a severe relapse in his mental state, which was the direct cause of him being admitted to and detained in a mental hospital for around two months. I have no doubt that this was a very considerable trauma for him and his family, for the reasons which he and his wife spoke to in evidence, and from which he took further period of time, in my judgment around three months, to fully recover. While he has an underlying mental condition which remains liable to relapse, there is no suggestion that the oral steroids which he received in January and February 2005 have had any longer term effect on his condition. In the circumstances it seems to me that the case falls towards the upper end of the moderate range of psychiatric injury in paragraph 4A(c) of the Judicial College Guidelines. I would have awarded interest on this sum at the judicial rate from 18 July 2005 (three months after discharge from Carseview) to the date of decree.

[89] As regards services, I would not have made an award for emotional support provided by the pursuer's wife to him while in hospital. I agree with the defenders that in practical terms this involved the pursuer's wife keeping him company while he was in hospital, which is what she would have been doing at home in any event. The value to him of having her emotional support may have increased, but I would not have been satisfied there was a material increase in such support properly attributable to the claimed breach of duty by the defenders. The pursuer's wife was not employed at the time, so there was no question of her losing income in order to provide the support which she provided to the pursuer, which is part of the context of such a claim for services: *Farrelly* v *Yarrow Shipbuilders Ltd* 1994 SLT 1350 at 1351F.

[90] On the other hand I accept that the pursuer was unable to perform his normal domestic chores for the two month period while he was in hospital and for a period of about three months afterwards. In my view the chores would have occupied the pursuer for around an hour a day during this period. His wife was required to do them. Assuming therefore 150 hours at a nominal wage of £6.50 gives £975.00, to which again I would have added interest at the judicial rate from 18 July 2005 to date of decree. I thought that both the pursuer and his wife likely overstated the time spent by him on the chores and the period of time it took him to fully recover such that he could perform them again.

[91] As regards outlays, I would have awarded £200, plus interest from 18 April 2005, the date of the pursuer's discharge from Carseview, to date of decree. This seems to me a reasonable estimate of the travel costs and additional sundry expenses arising from the pursuer's wife's daily visits to Carseview over a two month period, even bearing in mind that on occasions she was able to make this journey by foot. On the other hand I accept the defenders' counsel's submissions regarding increased cigarette consumption as noted above. I am not satisfied that any such increased cost is causally related to the pursuer's illness or detention rather than his choice to smoke more.

Expenses

[92] I was not addressed on the question of expenses. The appropriate motion can be enrolled in due course.