Case No: HQ13X05534

Neutral Citation Number: [2017] EWHC 3147 (QB)
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 08/12/2017

Before :

HIS HONOUR JUDGE PETER HUGHES QC
SITTING AS A JUDGE OF THE HIGH COURT

- -

Between :

RAUL GUIU GALLARDO	**Claimant**
- and -	
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	**Defendant**

- -
- -

Conrad Hallin (instructed by **Hodge, Jones & Allen LLP**) for the **Claimant**
Richard Mumford (instructed by **Capsticks LLP**) for the **Defendant**

Hearing dates: 23rd, 24th, 25th, 26th and 27th October 2017, 8th November 2017

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Judgment

His Honour Judge Peter Hughes QC:

Introduction

1. Whatever uncertainty there may have been in the past, the requirement of informed consent to medical treatment is now a fundamental and settled principle of the law in both England and Wales and Scotland[1].

2. This case is concerned with what should happen following treatment and the duty to inform the patient of its outcome, the prognosis, and of any requirement for follow up and further treatment or monitoring.

3. The Claimant, Mr Guiu Gallardo (to whom I will refer throughout as "The Claimant") underwent major abdominal surgery at the Charing Cross Hospital in 2001. A malignant gastrointestinal stromal tumour (GIST) was removed. It is his case that he was never informed of the malignancy and the risk that it might recur. Neither was he told that he would need regular monitoring and CT scans.

4. The cancer did recur and, in 2011, he underwent further major surgery. His condition is now closely monitored, and he is likely to have another operation in the near future.

5. The Defendant's primary case is that the Claimant was properly informed after surgery of the malignancy and the risk of recurrence. The question of liability is further complicated, though, by the fact that in the post-operative period the Claimant moved from the NHS into a private room at the hospital and was thereafter treated by his surgeon, Mr Nikitas Theodorou, as a private patient.

6. Mr Theodorou died in 2014. He has played no part in these proceedings[2]. The Defendant contends that any breach of duty occurred when the Claimant was a private patient and that it is not the responsibility of the hospital trust.

7. The Claimant maintains that he should have been informed of the outcome of his surgery before he became a private patient, but even if this is not found to be so, it does not absolve the Defendant from liability.

Outline of the basic facts

8. The Claimant is Spanish. He is now 46 years of age. He came to the United Kingdom in 2000, at the age of 28 to work in the computer software industry.

9. In late November 2000, he was admitted to Charing Cross Hospital and treated for a gastric ulcer. He is recorded as suffering from chronic anaemia secondary to a peptic ulcer. He was discharged from hospital after 12 days, on the 12th December 2000.

10. On the 23rd of January 2001, he was re-admitted having fainted at work and been taken by ambulance to the Accident and Emergency Unit.

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[1] See Montgomery v Lanarkshire Health Board [2015] UKSC 11, and in particular Lady Hale at para 107.

[2] Late application was made to add him as a defendant. The application was refused by HHJ. Curran QC at a hearing on the 4th October 2017.

11. He was initially treated conservatively but on the 30th January 2001 a CT scan was carried out. This revealed a mass on his stomach. The radiological report concluded with the following comment: -

> "*The most likely diagnosis is that this is a GI stromal tumour. Particularly in the context of recurrent bleeding and non-healing ulceration."*

12. The Claimant was advised to undergo surgery. After some hesitation, and reflection overnight, he agreed to this. The operation was performed by Mr Theodorou on the afternoon/evening of the 31st January 2001 assisted by his surgical registrar, then Doctor, now Mr Umughele.

13. While recovering from the operation, the Claimant suffered a rupture of the appendix and developed peritonitis. On the 6th February 2001, he underwent a laparotomy and, three days later, a further operation to resection part of the small bowel. His condition was grave and he was moved into intensive care. For some time he was intubated and on a ventilator. His family came over from Spain to be with him. It was an anxious period and there were fears that he would not survive.

14. The Claimant left intensive care and returned to the ward on the 5th March 2001. He was still in pain and had a wound infection that was resistant to treatment, but gradually he regained his strength and was allowed to mobilise. On the 30th March, he was moved to the private wing of the hospital, on the 15th floor, after it had been realised that he had private health insurance.

15. As a private patient, the Claimant continued to benefit from the nursing and other services provided by the Defendant, but was billed for these services[3]. Mr Theodorou charged separately for his services.

16. The Claimant was finally discharged from hospital on the 9th April 2001. His GP records include a copy of the proforma issued on discharge by the hospital. It is dated the 9th April and bears a received date stamp of the 12th April. The form is signed by Mr Theodorou. It reads –

> "Diagnosis:
>
> (1) Gastric leiomyosarcoma
>
> (2) Post op acute perforated appendicitis
>
> (3) 2 laparotomies for sepsis/obstruction
>
> Recommendations for Future Management
>
> See us in 10/7
>
> 3/12 B12 1000ug injections please

[3] To keep its provision of services to private patients distinct from its NHS services, it charged for them through a subsidiary company.

Drugs to be continued Folic Acid"

17. The form shows the Claimant as being discharged from the 15th floor, but this is the only indication on its face that he was a private patient.

18. Also in the Claimant's GP records is a letter dated the 19th April 2001. It is on NHS notepaper, and is addressed in capital letters 'TO WHOM IT MAY CONCERN'. The author of the letter was Mr Umughele, but it was signed on his behalf by someone else. The signature appears to be that of Mr Theodorou. An unsigned copy of the letter is in the Claimant's NHS hospital records.

19. The letter gives a brief description of the Claimant's admission and treatment. It refers to a diagnosis of "malignant gastric stromal tumour", but later, in reciting the details of his treatment and stay in hospital, it includes the statement –

> "*CT scan carried out on admission showed a large stromal tumour about 7cm, the appearances were compatible with malignant leiomyosarcoma. He went on to have a sub total gastrectomy.*"

20. It goes on to state that the claimant was discharged on the 9th April 2001, and continues

> "*On discharge his medication include three monthly vitamin B12, daily folic acid and multivitamin preparations.*"

21. It contains no reference to the need for regular check-ups or CT scans.

22. The Claimant saw Mr Theodorou privately, as an out-patient on the 23rd April 2001. Mr Theodorou advised him that he was now well enough to travel to Spain to continue his recuperation. He left on the 26th April 2001, returning to the UK in late June or early July and then resuming work.

23. The Claimant saw Mr Theodorou again on more than one occasion; possibly in September 2001 although no record of this has been traced, but definitely, on the 1st February 2002, and the 1st March 2002. Between the two appointments he had a further CT scan, and Mr Theodorou would have had the results of the scan at the consultation on the 1st March.

24. One outstanding non-urgent matter that needed to be attended to when the Claimant was well enough was an operation to repair a hernia. The Claimant wished to have the surgery in Spain. On the 1st March 2002, Mr Theodorou reviewed the new CT scan and advised the Claimant that he could now go ahead and arrange the surgery and to arrange to see him again on his return to the UK.

25. The operation was carried out in Zaragoza in July 2002. The Claimant believes that he saw Mr Theodorou for the last time when he came back to the UK[4].

[4] No record of this consultation has been traced but there is an entry in the hospital records that Mr Theodorou obtained the Claimant's medical notes from hospital records on the 20th June 2002. This suggests that he may have seen the Claimant shortly thereafter.

Outline of subsequent history and treatment

26. In the period between 2002 and 2006, the Claimant lived for periods in London, Barcelona, Helsinki, and from October 2004 back in London.

27. In August 2006, he attended A & E at Charing Cross Hospital with abdominal pain. Subsequently, his GP referred him to New Victoria Hospital. An ultrasound was performed. This revealed no cause for concern.

28. In August 2009, he moved back to Spain and started a new job based in Gibraltar. In July, the following year he attended A & E at La Linea de la Concepcion in Spain complaining of abdominal pain. He subsequently saw his GP in Gibraltar. The GP arranged blood tests and an MRI scan. The Claimant was given a diagnosis of Pseudo myxoma Peritonei[5].

29. Doubting the diagnosis, the Claimant referred himself, first to a hospital in Vitoria, northern Spain, where the diagnosis was confirmed, and then, still doubting it, to a specialist cancer hospital in the UK, the Christie Hospital in Manchester.

30. The Christie Hospital were concerned to have access to the records of the Claimant's treatment in 2001. By this time Mr Theodorou no longer worked at Charing Cross Hospital. It appears that contact was made with him and, on the 20th November 2010, he sent the Claimant the following message by email. I quote it in full because it is central to the Claimant's case.

> "I received a call last night from Charing Cross Hospital to let me know your notes have been retrieved from archives. They are extensive but clearly there are important areas of information of which, with your permission, your doctors should be aware.
>
> Perhaps you can let me know how best to communicate this information and to whom. I have already sent a copy of the histology of your appendix to Dr Deardon [the Claimant's GP] but in the light of the new information received I think it is unlikely to be helpful.
>
> We did not have the opportunity to discuss the nature of your current situation but in the light of the information I now have to hand it is possible that this might be related to the reason for your operation on the stomach in 2001 and it is important for your doctors to be aware that your original operation was for a large gastrointestinal stromal tumour (GIST).
>
> I would be prepared to communicate in any way you feel would be appropriate. Please feel free to discuss this with your doctors and let me know what you would like me to do. If they wish to call me please give them my mobile number. Alternatively, I

[5] Pseudomyxoma Peritonei is a relatively rare form of abdominal cancer

can prepare a short summary for them which I can forward by email."

31. It is the Claimant's case that the he was not aware of his diagnosis before receiving this email. He says in his witness statement, "I was shocked, angry and also confused, as I had spent years thinking that my problem was with stomach ulcers."

32. In March 2011, the Claimant wrote to the Defendant's Chief Executive. The relevant parts of the letter read as follows: -

> *In 2001 I was treated at Charing Cross Hospital and recently discovered that I was not fully informed about the nature of my condition and therefore the necessary follow-ups were not arranged. I am writing this letter to find out how this could have happened…..*
> *I had an operation at Charing Cross Hospital. I was told that part of my stomach was removed because of a bleeding ulcer. While recovering in hospital my appendix exploded necessitating further surgery and a stay in intensive care.*
> *At my follow-up consultation with the doctor, after leaving hospital, I was told that I would need to take vitamin B12 and Folic acid because part of my intestines were removed. No other follow-ups were arranged and no other advice given….*
> *In July 2010 I suffered extreme abdominal pain. My current GP arranged blood tests and an MRI and I was initially diagnosed with Pseudomyxoma Peritonei. At the request of my current doctors I contacted the consultant – Mr Nikitas Theodorou – who treated me in 2001. He requested my notes from Charing Cross Hospital and in December 2010 he informed me that in 2001 I had a large gastrointestinal stromal tumour (GIST) removed. He pathologist's report stated that this tumour was malignant. After receiving this information and doing further tests, my current medical team agree that I have another GIST which has recurred at exactly the same site as the previous one removed in 2001. Because of its size (12cm) and location they have told me that it is too risky to perform surgery and I have recently started taking Glivec.*
> *The oncologist who is treating me informs me that I should have been monitored regularly following the removal of the GIST in 2001. If this had happened the current tumour would have been detected before growing to its present size of 12cm…..*
> *Who should have been responsible for informing me about the GIST and advising me about follow-up care and why was this not done?*
> *Did Charing Cross Hospital send all necessary information to my GP?*

33. The letter made no mention of the period when the Claimant was being treated as a private patient. Neither did the reply, dated the 21st September 2011, which followed an investigation and review of the records by a consultant surgeon, Mr Krishna Moorthy. From its wording, it gives the appearance of having been written in ignorance of this fact.

34. In answer to the questions raised by the Claimant, the reply is as follows: -

> "There is a letter dated the 19th April 2001, which is most likely to be a discharge summary. This has been addressed "To Whom it may concern. Thus I am not sure if a copy of this letter went to your GP or not. This has been done by one of the doctors working for Mr Theodorou. The letter does state that 'appearances were compatible with malignant leiomyosarcoma'. The letter does not state that you have been discharged from the clinic. However, it also does not state if there were any plans to review you again.
>
> We apologise unreservedly for this communication breakdown, we would normally expect a doctor to notify a secretary or a GP to refer to a consultant or clinic to book an outpatient appointment, due to the time lapse we cannot ascertain who's responsibility this was, we are very sorry, your records do not hold this information….
>
> Mr Moorthy is extremely sorry to hear that you have now developed a recurrence of the tumour. **From the notes he cannot determine why you were not reviewed again in the clinic. Ideally with a diagnosis of malignancy you should have been reviewed in the clinic on a regular basis, we are sincerely sorry for this oversite** (sic)[6].
>
> *Mr Moorthy can only surmise that the reason this did not happen is that in 2001, we did not know much about these tumours. It is only in the past 10 – 15 years that we have really started to understand these tumours and their behaviour. Nowadays we would discuss a case such as yours in a cancer multi-disciplinary team (MDT) meeting with oncologists and clinical teams. As we have become aware of the possible risk of recurrence we now keep patients such as you under close observation and follow up.*"

35. Fortunately, the new tumour was not inoperable. In June 2011, the Claimant had surgery at the USP Hospital de Marbella. The operation, carried out by a team of surgeons, led by surgeon from Barcelona who specialises in the treatment of GISTs, took between ten and eleven hours. Excision of the tumour involved re-sectioning of the caudate lobe of the liver, an extended left hemihepatectomy[7], removal of the gall bladder, and reconstruction of the portal vein using the left renal vein.

36. Since the operation, the Claimant has been monitored regularly with CT scans every six months. He has also been on medication - Gleevec until May this year, and Sutent since. In 2016 three areas of recurrent disease were detected, and the most recent scan has shown further metastatic GIST disease. A 3.5cm mass close to the inferior vena cava has been identified.

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[6] The emphasis is mine

[7] The operation involved the removal of the four sections comprising the left side of the liver and partial removal and revision of one of the four sections of the right side of the liver. A section of the portal vein had to be removed as the tumour was attached to it. Complications were encountered in reconstructing the vein using the renal vein because it had a tendency to tear.

37. There has been understandable concern about the risks involved in attempting further surgery. The Claimant's condition has, though, been responding to treatment, and the expectation is that he will undergo surgery led by the same surgeon as in 2011, and that this will take place in the near future.

Gastrointestinal stromal tumours

38. GISTs are a relatively rare form of tumour found in the digestive system. They can be benign, but are nearly always malignant. They are found in only a small percentage of the population. Estimates vary, but the figure for large tumours is no more than about 4 – 5 cases per million population per year. As a result, general surgical teams are likely to encounter cases only infrequently.

39. In recent years the characteristics of GISTs have become much better understood. At one time, they were considered to be leiomyomas or leiomyosarcomas of the stomach[8].

40. It is now recognised that there are a several molecular subtypes of GISTs. This was not understood in 2001. At that time, it was a grim diagnosis, particularly for a young person, and life expectancy was severely curtailed.

41. The Claimant, fortunately, has a form which is known as a 'wild' type GIST. The cancer is less aggressive and the tumour described as towards the indolent end of the spectrum. Life expectancy, although reduced, is not so severely curtailed. Hence, the fact that the Claimant has already survived for more than sixteen years since his initial treatment.

42. Significant advances have, also, been made in developing new drug therapies to treat GISTs. One widely used drug, Imatinib, became available in the UK in 2004. With further understanding of GISTs, it has been recognised, though, that wild type GISTS do not respond well to Imatinib. Other drugs have since become available, such as Sunitinib and Regorafenib, which can be of benefit.

The pleadings

43. As amended, the Particulars of Claim make the following allegations of negligence –

    a) *Failed to inform the Claimant of the potential diagnosis of malignancy in relation to the CT scan of the 29th January 2001.*

    b) *Failed to inform the Claimant of the confirmed diagnosis of malignant GIST following histopathology results reported on the 16th February 2001 or discuss the implications of this diagnosis with him.*

    c) *Failed to refer the Claimant for surgical and/or oncological follow-up and/or refer him to a specialist sarcoma centre (such as the Royal Marsden hospital) following diagnosis of malignant GIST, or to offer the Claimant such referral.*

[8] This is the description given by Mr Theodorou on the discharge proforma of the 9th April 2001. It also appears in the "To whom it may concern letter" but so also does "malignant gastric stromal tumour"

d) *Failed to provide regular clinical surveillance following the diagnosis of malignant GIST.*

e) *Lost the Claimant to follow-up following the diagnosis of malignant GIST*

44. The defence case, as pleaded, disputed the allegations and asserted that the Defendant had no continuing responsibility once the Claimant had ceased to be an NHS patient. It accepted that the Royal Marsden was already a specialist cancer centre in 2001, but stated that it was not standard practice at the time to refer to a specialist centre[9]. Further, it contended that the responsibility for lack of follow-up was the Claimant's own responsibility for failing to make appropriate arrangements for the monitoring of his condition.

The issues in the case in more detail

45. The issues for the Court to determine can be defined as follows: -

a) Was the Claimant informed in 2001 of his diagnosis of malignant GIST and of the need for regular clinical surveillance?

b) Whose responsibility was it to inform him?
c) When should he have been informed?
d) Did the NHS have any continuing duty to the Claimant after he became a private patient?
e) Did the Claimant become aware of his diagnosis before he received the email from Mr Theodorou in 2010? If so, is his claim statute barred?
f) Had the Claimant had regular follow up and monitoring, would the recurrence of GIST have been discovered and treated earlier?

g) Would earlier treatment have benefitted the Claimant in terms of his future prognosis and treatment?

46. There is common ground between the parties that the Claimant had the right to be informed that he had a malignant GIST, to be told what the prognosis was for his condition, and to be advised of the need for clinical surveillance.

47. The parties' surgical experts, Mr Gardner-Thorpe for the Claimant, and Mr Deakin for the Defendant, are agreed that arrangements should have been made for CT scans at six monthly intervals for two years and annually for at least five years.

48. Although there are references to malignancy and GIST in the records, nowhere is the need for regular follow up and what it should comprise set out. Neither is there is anything to confirm that this was communicated to either the Claimant or his GP. Mr Theodorou did arrange one follow-up CT scan, but that was not until a year after the Claimant's discharge from hospital.

49. Where the expert witnesses part company is as to timing; more specifically, as to when the Claimant should have been given all the information to which, by rights, he was entitled. Mr Gardner-Thorpe's position is that it should be done as soon as the patient is sufficiently recovered to understand. Mr Deakin's position is that it is

[9] This allegation was not pursued at trial

perfectly proper to wait until the first follow-up appointment after discharge. He says that patients recovering in hospital may not take in properly what they are being told, in any event. Each recognises, though, that clinical practice varies and is dependent on the circumstances including the patient's own anxiety to be told.

50. Linked to the question of timing is the question of whether, if the right time was after the Claimant became a private patient, that absolves the Defendant of any responsibility for a later failure to inform.

51. In 1998 the General Medical Council issued guidance on the giving of consent to investigation and treatment[10]. No reference was made to the guidance by either expert in their reports. It was first referred to in the note of their joint meeting a week before trial, and then again extensively during the hearing itself.

52. Although some passages have wider application. The guidance is primarily concerned with issues of consent to prospective treatment, where timing will often be constrained by circumstances, and not to post-operative treatment, where there may not be the same degree of urgency. The guidance was revised and replaced by the present guidance[11] in 2008, extended and redrafted in a form approved by Plain English.

The parties' submissions

53. Mr Mumford makes three basic submissions –

a) That the Court can be satisfied that that Claimant's diagnosis was duly explained to him before and after surgery and that this conclusion is supported by the numerous references to malignancy in the records.

b) That there was no requirement for this discussion to take place before the Claimant became Mr Theodorou's private patient.

c) Continued surveillance by CT scanning would have made no material difference. Further surgery would not have been avoided. It would have merely taken place earlier and the prognosis for future treatment and life expectancy would have been unaffected.

54. He also contends that, even if there was a breach of duty on the part of either the Defendant or Mr Theodorou personally, the Claimant must have learnt of his condition at some stage before 2010 during his subsequent treatment, and consequently the claim is statute-barred.

55. Mr Hallin submits that –

a) There was a failure to inform the Claimant of his diagnosis, prognosis and the risk of recurrence, and of the need for regular surveillance and follow-up.

[10] "Seeking patient's consent: The ethical considerations; November 1998
[11] "Consent: patients and doctors making decisions together; June 2008

b) The Claimant had a right to be given this information as soon as was reasonably practicable, and that this duty arose before the Claimant moved to the private wing.

c) Had he been appropriately informed, he would have appreciated the significance of what he was being told and would have made sure that he had regular check-ups.

d) Had he had regular check-ups the recurrence of the GIST would have been discovered much earlier and the operative treatment would not have been as complicated.

56. In both his opening and closing written submissions, Mr Hallin refers at length to the Supreme Court decision in **Montgomery** and argues that the **Bolam**[12] test, which was held in that case not to apply to the obtaining of consent to treatment, does not apply also to the provision of information post-operatively or post-treatment.

57. I propose to deal with the issues under the following four broad headings –

(i) What was the Claimant told and when?
(ii) When should he have been told?
(iii) What responsibility, if any, does the Defendant bear?
(iv) Causation

58. Attached as an annex to this judgment is a chronology extracted from the medical records. It is not intended to be comprehensive but to include entries that are of relevance to the issues. Certain entries are highlighted because of their possible significance. I am indebted to both counsel for their work on preparing their own chronologies on which the one attached is heavily based.

What was the Claimant told and when?

59. It is easy, on first impression, to form the view that the Claimant must have known before the email from Mr Theodorou in 2010 that he had been operated on for the removal of a malignant GIST. There are a number of entries in his medical records that refer to his diagnosis. There is also, though, a consistent pattern of him saying, when asked about his medical history, that he had had a gastrectomy followed by appendicitis. Had he known that he had a malignant tumour removed, that it was liable to recur, and that he needed to have regular check-ups, there is no sensible reason why he should have wanted to conceal this fact. He is someone who regularly sought medical attention when he experienced abdominal pain. It is incomprehensible that he should do so, but yet hold back vital details of his medical history.

60. It was information that should, ideally, have been given in a planned and sensitive way, with support available from family and friends. It would have been bound to have a profound impact on the recipient. It is not something that any patient is likely to forget.

61. There are a number of features of the evidence that have lead me to the firm conclusion and finding that the fact that the Claimant had been treated for the removal

[12] Bolam v Friern Hospital Management Committee [1997] 1 WLR 582

of a gastrointestinal stromal tumour, that there was a significant risk of recurrence, and that he would need regular surveillance in the form of CT scans was never properly explained to him at the time, and further that he did not subsequently become aware of the true nature of his diagnosis and its implications until the email from Mr Theodorou in November 2010.

62. The features of the evidence that have drawn me to this conclusion are multifarious but include the following: -

a. The possible diagnosis of a GIST first appears on the CT scan report of the 29th January 2001. There is no reference in the report or the records though to suspected malignancy. Although there are notes of pre-operative discussions with the Claimant, there is nothing to indicate that he had been advised of the possibility of malignancy. Indeed, the notes state that there was discussion of the risks of conservative management and that the Claimant was reluctant to have surgery, his reluctance being described, significantly, by Mr Theodorou as "understandable". Had it been properly appreciated that he had what might be a malignant tumour, one would have expected that he would have been advised in the strongest terms that operative treatment was essential and that it should be carried out without delay, and that this discussion would have been clearly recorded, especially if he was reluctant to follow the advice.

b. Until the histopathology report became available on the 16th February 2001, there was no firm diagnosis that the tumour that had been removed was a malignant GIST. By that time the Claimant was in the ICU and by common consensus too ill for any meaningful discussion about his condition.

c. There is no reference in the records to any post-operative discussion with the Claimant prior to his admission to intensive care apart from an entry on the 1st February. This refers to Mr Theodorou, on his ward round, having explained that he had had a lump removed from his stomach. The entry is significant as the word "tumour" has been crossed out and the word "lump" substituted. Why this was done is unclear. It would not be right to speculate, and Mr Theodorou is not available to assist. There is nothing in the entry, though, to indicate that the Claimant was advised that the lump might be cancerous or malignant.

d. After the 16th February 2001, there is no entry in the records of any detailed discussion with the Claimant whether as an NHS patient or a private patient about his treatment and prognosis prior to his discharge from hospital on the 9th April 2001.

e. The discharge letter on the standard pro-forma used at Charing Cross Hospital[13], in Mr Theodorou's handwriting, under the heading "Diagnosis" does not refer to a GIST but to gastric leiomyosarcoma. This had been the description used before GISTs were recognised as a distinct type of tumour.

[13] Ms Howson gave evidence that the proforma was produced in triplicate, one copy going to the GP and one to the Pharmacy. The copy to the Pharmacy was on a different coloured paper for private patients, no doubt to indicate that the patient was liable to pay for his own medicines and that they were not supplied on the NHS. The only thing otherwise to indicate that the patient was a private patient was the reference to the part of the hospital from which he was being discharged, in the case of the Claimant – "15th Floor South"

f. The "To whom it may concern" letter dated the 19th April 2001, on NHS notepaper, written by Mr Umughele and signed on his behalf by Mr Theodorou does makes specific reference to the presence of a "malignant gastric stromal tumour", although it also refers to malignant leiomyosarcoma. It makes no mention, though, of the need for check-ups and regular CT scans. The evidence as to how this letter came to be written and how it came to be in the Claimant's GP records is unclear. The likelihood, in my view, is that it was written in that form because the Claimant wanted to go home to his family in Spain as soon as possible and it was handed to him so that he could provide it to whoever was treating him. He did not leave for Spain until ten days later, and the likelihood is that the letter was handed in to his GP when he attended the surgery before leaving for Spain[14]. This conclusion is supported by the fact that the letter is not date stamped, unlike other communications received by the GP surgery by post or fax. It does not follow that the Claimant was aware of the contents. He says that he has no recollection of the letter at all, and I accept his evidence. In my view, it is likely that the letter was in a sealed envelope, having regard to the sensitive nature of its contents, and there is no record of the GP discussing its contents with the Claimant.

g. There is reference in the records to discussion of the Claimant's condition with members of his family, and in particular his sister. Her English appears to be described as limited in a note of the 6th February 2001. In evidence, although he was heavily reliant on the records, Mr Umughele said that he believed that he would have told the Claimant's sister that her brother had a malignant tumour removed and advised her as to the likely prognosis and treatment. This piece of evidence has to be considered alongside his evidence that in 2001 he knew little about stromal tumours, and contrasted with the account of the sister, Noelia Guiu Gallardo, that she was not told that her brother had had surgery to remove a tumour. I did not find Mr Umughele to be a satisfactory or convincing witness. At times, his evidence appeared confused and rambling. Had he tried to give any detailed explanation to the sister, the language barrier is, also, likely to have contributed to the difficulty in communication. Mr Umughele's note for the 18th February 2001, which refers to the patients' condition and the operative findings being discussed with the sister, also refers to the presence of an unnamed friend of the patient. Although, Mr Umughele said that the practice of discussing a patient with family was less restrictive in 2001 than today, I doubt whether it was so casual even then as to permit disclosure of such sensitive information to a non-family member without the authority of the patient.[15]

h. Although Mr Theodorou saw the Claimant on a number of occasions after his discharge from hospital, there is no record of any detailed discussion with the

[14] There are entries in the GP records which indicates that he saw his GP between leaving hospital and going to Spain, in particular an entry for the 26th April 2001

[15] Mr Umughele was also responsible for providing the Claimant with an explanation of the proposed surgery and obtaining his written consent. A curious feature of the consent form is that the words "gastric tumour" appear to have been written almost as an after-thought. They appear at the end of the description of the surgery, with insufficient space left to fit them into the box, and the word "tumour" seems to have been partially over-written. It was suggested to Mr Umughele that he added the words later and that they did not form part of the consenting process. He denied this. Unfortunately, the original of the form was not available for inspection. Although the entry is curious, the evidence is equivocal, and I feel unable to come to any conclusion about its authenticity.

Claimant about his treatment and prognosis and explaining the importance of regular reviews and CT scans. If Mr Theodorou kept such records they have not been obtained and disclosed into these proceedings. The GP records contain three follow-up letters from Mr Theodorou. It is right to note that in the second, dated the 1st February 2002, he refers to "there being nothing to suggest the recurrence of the original gastrointestinal stromal tumour" and that he had advised the Claimant "to undergo routine haematological and biochemical screen, CT scan and then be reviewed". The third and last letter, dated the 1st March 2002, reports on the results of the scan and other tests, and recommends that the Claimant to see him again later in the year after his hernia operation. The Claimant's evidence is that he did see Mr Theodorou again. The fact that Mr Theodorou made a request for the hospital records in June 2002 provides support for this. There is, though, no letter on the GP file reporting on this consultation. The agreed position of the experts is that Mr Theodorou should have advised CT scans every six months for the first two years and then annually for at least five years. Nowhere is there any record of him advising either the Claimant or his GP in these terms. The limited available evidence suggests that he did not perceive the need for such regular screening. The only follow up scan he arranged was the one a year after discharge, arranged after he saw the Claimant in February 2002.

i. I found the Claimant to be open, straight-forward, and sincere in his evidence. In 2017, he speaks good, accented, and generally fluent English, although he can have difficulty with some expressions. He met his English partner in late 2001 and they have been together since. Although he studied English at school and spent a year in Seattle doing casual work in 1998/9 before coming to the UK, in my view it is likely that his ability to speak and understand English was more limited in 2001 and probably similar to that of his sister. He was extremely ill and under intensive care for an exceptionally long time. At times, his survival was touch and go. In my judgment, it is likely that such explanations about his condition and prognosis that were given to him were given in the simplest language, and that at no time was the opportunity taken, as it ought to have been, to give him a full and detailed explanation of what had happened to him, his prognosis, and the importance of regular screening and CT scans for the years ahead. Once he had been discharged from hospital and ceased to see Mr Theodorou, although the information about his condition was there on his medical records, it was assumed by those with access to them that he was aware of his diagnosis and there was no need to talk about it. Hence, the news came to him as a grave shock when he received the email from Mr Theodorou in 2010. To say that the Claimant was "lost to the system" as alleged in the particulars of negligence is not in the circumstances inapposite.

63. Finally, I should add that even if I had come to a different conclusion as to what the Claimant was told about his condition, there is no evidence at all that either he or his GP was appropriately advised of the need for future check-ups and CT scans. This information was vital both for the patient, for his GP, and for those caring for him in the future. The omission to set this out in writing is, in my judgment, a glaring failure in itself.

64. The question is who bears responsibility for what was a double failure in communication; a failure to inform the patient about his true condition, and a failure to advise him of the need for future check-ups?

When should he have been told?

65. Because of their respective positions, a good deal of attention was focussed by counsel during the hearing on the issue of timing.

66. Mr Mumford contends that the Defendant is not at fault because the responsibility for deciding when to provide the Claimant with a full explanation about his condition, prognosis, and the need for check-ups and regular CT scans was that of his consultant, Mr Theodorou, and that the appropriate time for that discussion to take place was not until the patient was well-enough which was close to the time of his discharge from hospital or at the first post-discharge appointment as an out-patient. By then, the Claimant was Mr Theodorou's private patient and not, submits Mr Mumford, the responsibility of the Defendant.

67. Mr Hallin contends that the discussion should have been held before the Claimant left NHS care to become a private patient. In addition, he submits that regardless of when it should have been held, the Defendant is still liable. Relying on the decision of the Supreme Court in **Montgomery** he argues that the **Bolam** test has no application in this case.

68. There are two distinct aspects to the question of timing.

69. The first concerns the fundamental point of principle, decided in **Montgomery,** that the patient has the right to decide what, if any treatment, to consent to. In the exercise of this right, the patient must be informed of the material risks inherent in the proposed treatment and what reasonable alternative treatment options are available, if any. It is only in exceptional circumstances that a doctor is entitled to withhold information because disclosure would be seriously detrimental to the patient's wellbeing.

70. By analogy, the same principle applies to the post-treatment discussion. It is the patient's right to be informed of the outcome of the treatment, the prognosis, and what the follow-up care and treatment options are. Information should only be withheld in exceptional circumstances and for clear and persuasive therapeutic reasons.

71. In **Montgomery**, Lord Kerr, delivering the main judgment, said at paragraph 75 –

> "*One development which is particularly significant in the present context is that patients are now widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession. They are also widely treated as consumers exercising choices: a viewpoint which has underpinned some of the developments in the provision of healthcare services.*"

72. At paragraph 81, he continued –

> "*The social and legal developments which we have mentioned point away from a model of the relationship between the doctor and the patient 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 their 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.*"

73. The second aspect relates to the question of when the discussion with the patient should take place. Plainly, prior to treatment, the timeframe for the discussion is constrained by the need for the patient to give informed consent before the treatment can take place. Following treatment, though, there is less urgency and a more flexible approach may be justified. It remains, though, the patient's right to be informed.

74. There are several factors that may affect timing; for example, the anxiety of the patient to be told of the outcome, the patient's condition and ability to participate in the discussion, the seriousness of the information which the doctor is obliged to impart, and the availability of close family members to offer support and comfort when difficult news has to be given. It may be appropriate in some cases for there to be a discussion in broad terms about the outcome of the treatment and a more in-depth discussion at a later stage about prognosis and follow-up.

75. Such decisions involve the exercise of judgment but it is not a judgment that turns on the exercise of expert medical learning or experience alone. The decision must be made with due regard to the patient's right to be told.

76. In another significant passage in **Montgomery**, which has relevance beyond cases about consent to treatment, Lord Kerr said at paragraphs 83 and 84 –

> *"83. …The doctor's advisory role cannot be regarded as solely an exercise of medical skill without leaving out of account the patient's entitlement to decide on the risks to her health which she is willing to run (a decision which may be influenced by non-medical considerations). Responsibility for determining the nature and extent of a person's rights rests with the courts, not with the medical professions.*
>
> *84. Furthermore, because the extent to which a doctor may be inclined to discuss risks with a patient is not determined by medical learning or experience, the application of the **Bolam** test to the question is liable to result in the sanctioning of differences in practice which are attributable not to divergent schools of thought in medical science, but merely to divergent*

attitudes among doctors as to the degree of respect owed to their patients."

77. The point is well-illustrated by the evidence in this case. During the hearing, I heard evidence from both Mr Gardner-Thorpe and Mr Deakin as to their own (differing) practice and what they each consider to be acceptable.

78. In his report of the 19th April 2017, Mr Gardner-Thorpe said –

> "*29. In my opinion, it would have been standard practice for this discussion [concerning the Claimant's diagnosis] to take place during the long inpatient stay. The Claimant would probably have been seen by a medically-qualified person every day while he was an inpatient.*
>
> *"30. In principle, there is no reason why the discussion could not have taken place in the outpatient setting. In my opinion, it would be unreasonable for a surgeon to have seen the Claimant in the first outpatient visit after discharge and not to have told him the diagnosis even then.*
>
> *31. There seem to have been many opportunities both as an inpatient and outpatient when he could have been sensitively informed of his diagnosis.*
>
> *32. About the timing, my opinion is that the diagnosis should have been conveyed to the Claimant during the second half of March 2001. There may be a range of opinion about this. In my opinion, no reasonable body of surgeons would say that delay beyond 23rd April 2001 would have been acceptable. That was the date of the outpatient consultation with Mr Theodorou.*
>
> …
>
> *36. If it is a fact that the diagnosis of malignant GIST was not conveyed to the Claimant between 14th March and 23rd April 2001 then, in my opinion, that failure would be a clear and serious breach of duty."*

79. This passage demonstrates the scope for differing approaches to the timing of what can be a highly sensitive discussion.

80. Plainly, though, it is a discussion which must be held. It ought not to be postponed for longer than necessary without good reason. Otherwise the doctor risks losing the patient's trust and confidence, and the patient's right to be informed is not respected. The approach is in danger of becoming unduly paternalistic.

81. In the vast majority of cases, from a legal perspective, the point is academic. This is because, so long as the outcome of treatment and the patient's needs for the future are properly explained and discussed with the patient, delay in holding the discussion will

not be causative of any loss. Its relevance in this case arises because the patient left NHS care and the Defendant seeks to rely on that in its defence.

82. In **Montgomery**, in a short supplementary judgment, Baroness Hale quoted a passage from *Medical Law and Ethics*[16]:

> "*the issue is not whether enough information was given to ensure consent to the procedure, but whether there was enough information given so that the doctor was not acting negligently and giving due protection to the patient's right of autonomy.*"

Baroness Hale continued, at paragraph 109:

> "*An important consequence of this is that it is not possible to consider a particular medical procedure in isolation from its alternatives. Most decisions about medical care are not simple yes/no answers. There are choices to be made, arguments for and against each of the options to be considered, and sufficient information must be given so that this can be done.*"

83. The fact is, on my analysis of the available evidence, that such a discussion did not take place in this case. There were two essential things which should have been made clear to the Claimant. First, that he had had a malignant tumour removed and that there was a risk of recurrence, and, secondly, that he therefore needed to have regular check-ups and screening by CT scan. It would have been a painful and difficult discussion as it would have involved telling the Claimant that his life expectancy was likely to be substantially reduced.

84. The discussion ought, it appears to me, to take place as soon as the patient is well enough to take in what he needs to be told and to participate fully in the discussion. It ought not to be delayed on therapeutic grounds unless it would be seriously detrimental to the patient's health. It should be clearly recorded, to avoid future uncertainty, and it ought to be communicated in writing to the patient's GP so that it is on the patient's records.

85. Where the patient's operation is routine, the stay in hospital a short one, and the first follow-up appointment a matter of only seven to ten days later, it may well be reasonable to postpone the discussion to the first out-patient appointment, as appears to be the practice of Mr Deakin. Different considerations, though, apply where the patient is, as in this case, in hospital for a prolonged period.

86. To borrow the words of Lord Kerr, "the assessment is therefore fact-sensitive, and sensitive also to the characteristics of the patient"[17].

87. The Claimant was an inpatient post-operatively for over eight weeks before moving to the private wing, and he was out of intensive care for the last twenty-five days of that period. In my view Mr Gardner-Thorpe is right to say that the discussion ought to have taken place during that in that twenty-five day period. I do not consider that it would have been right to delay it further on therapeutic grounds.

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[16] Jonathan Herring: Medical Law and Ethics, 4th Ed, (2012) p170

[17] **Montgomery** para 89

88. It is in the context of that finding that I turn to consider the responsibility of the Defendant.

What responsibility, if any, does the Defendant bear?

89. The law on vicarious liability and non-delegable duties has been reviewed and explained by the Supreme Court in a number of recent cases[18].

90. In the most recent case of **Armes v Nottinghamshire County Council [2017] UKSC 60** the Supreme Court restated the principle that there are certain duties of care that are non-delegable. Lord Reed, giving the main judgment, said at paragraphs 31 and 32 –

> *"31. The expression "non-delegable duties of care" is commonly used to refer to duties not merely to take personal care in performing a given function but to ensure that care is taken. The expression thus refers to a higher standard of care than the ordinary duty of care. Duties involving this higher standard of care are described as non-delegable because they cannot be discharged merely by the exercise of reasonable care in the selection of a third party to whom the function in question is delegated.*
>
> *32. Tortious liabilities based not on personal fault but on a duty to ensure that care is taken are exceptional, and have to be kept within reasonable limits. Yet there are some well-known examples: it is well established that employers have a duty to ensure that care is taken to provide their employees with a safe system of work, that hospitals have a duty to ensure that care is taken, in the treatment of their patients, to protect their health, and that schools have a duty to ensure, in the education of their pupils, that care is taken to protect their safety. The question which arises in the present case is whether local authorities have an analogous duty to ensure that care is taken, in the upbringing of children in their care, to protect their safety*".

91. Mr Mumford contends that any such duty owed to the Claimant came to an end when the Claimant moved into the private wing of the hospital and that the duty thereafter was one owed only personally by Mr Theodorou.

92. I do not accept that submission. The Defendant owed the Claimant a duty to advise him of the outcome of his surgery, of his prognosis, and of the need for follow-up. The surgery had been carried out on the NHS. The histopathology report had been obtained on the NHS. The duty arose in consequence of his treatment. It was a necessary concomitant of it.

93. The duty had not been discharged by the time the Claimant moved to the private wing of the hospital.

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[18] See **Woodland v Essex County Council [2013] UKSC 66** and **Cox v Ministry of Justice [2016[UKSC 10**

94. It remained the Defendant's duty to provide him with the appropriate advice, regardless of whether it could have been given before the move or whether it was reasonable to postpone it until later.

95. Had the Claimant moved, not to the private wing of the same NHS hospital and continued to be treated by the same surgeon, but to a different hospital and a new medical team, it seems to me that it could not possibly be argued that this relieved the Defendant of its responsibility to advise him on the outcome of his surgery etc. It was, in my judgment, a continuing responsibility which, on the facts as I have found them was never discharged.

96. In any event though, as I have already found, in my judgment, the duty ought to have been discharged before the 30th March 2001 when the Claimant was moved to the private wing of the hospital. He had been out of intensive care since the 5th of March. All the facts were known to Mr Theodorou and the hospital staff; that he had had a malignant tumour removed, that there was a high risk of recurrence, and that he would need to be closely monitored for a number of years were known. It was unreasonable to delay communicating this to him until later than the 30th March.

97. To sum up, I find that the Claimant was entitled to be informed by the Defendant of the outcome of his treatment, of his prognosis, and of his continuing need for regular check-ups and CT scans, that he ought to have been so informed before the 30th March 2001, and that the Defendant had a continuing duty to him to so inform him which it failed to discharge.

Causation

98. Mr Gardner-Thorpe and Mr Deakin agreed in their joint statement that if CT scans had been done annually after the first two years, the recurrence of the tumour is likely to have been diagnosed in 2006 and further surgery would have taken place in 2007, in other words four years earlier.

99. The experts agree that in 2007 the tumour would have been smaller, but they disagree as to the difference in size and as to whether the operation in 2011 was more complex than it would have been if carried out four years earlier.

100. Mr Gardner-Thorpe's opinion is that the tumour in 2007 would have been significantly smaller than it was in 2011 and that the surgery would have been less extensive and complex. Mr Deakin accepts that the tumour would have been smaller but says that its growth is likely to have slowed and that by 2011 the blood supply was insufficient to support it and hence it would have stopped growing. He says that there would have been little significant difference in the surgery.

101. The surgery in 2011 was a highly complex major operation. It was complicated by the difficulties encountered in re-sectioning the portal vein. The whole operation took between ten and eleven hours.

102. I found Mr Gardner-Thorpe's evidence on this aspect more convincing. He gave a clear explanation of the surgery and what it entailed, from his own professional experience. He has consistently expressed the opinion that had it been detected earlier and operated on then, the operation would have been likely to involve a left

hemihepatectomy with caudate resection, and not to have involved an extended left hemihepatectomy and complex portal vein reconstruction.

103. The re-sectioning of the portal vein involved removal of the left renal vein to use as a graft to reconstruct the portal vein and re-suturing. Because of the growth of the tumour against the portal vein, some reconstruction of the portal vein may have been necessary whenever the operation had been carried out, but I am satisfied that the surgery would not to have been as extensive or difficult as it proved to be in 2011.

104. Mr Deakin appeared to me to struggle at times to justify his opinion that there would have been no material difference in the nature and complexity of the surgery between 2007 and 2011. He said in evidence that to be detectable the tumour would have had to be two – three centimetres in size, possibly four centimetres. With regular screening, it should have been detected at that stage of its development. By 2011 it was approximately twelve centimetres by six. Significantly, he conceded that although he might help plan and assist at such an operation, he did not have the experience in his own practice to take on the role of the lead surgeon.

105. It was necessary post-operatively to insert chest drains to remove fluid from the Claimant's pleural cavity. The Claimant gave evidence that he found this a particularly unpleasant and painful procedure. There was some debate between the experts as to whether it would have been a likely consequence of the further surgery whenever it had taken place. Again, on this aspect, I preferred the evidence of Mr Gardner-Thorpe. He said that it was the length and complexity of the surgery, particularly in relation to the re-sectioning of the portal vein and the interruption in the blood supply to the liver, that is likely to have led to the collection of fluid, making the procedure necessary.

106. Furthermore, had the surgery taken place in 2007 rather than 2011, the Claimant would have avoided four years of added pain and discomfort.

107. There was a claim for reduced life expectancy resulting from the delay in surgery, but this was not pursued in the light of the most recent and more optimistic medical evidence.

Quantum

General damages: Pain, suffering and loss of amenity

108. Mr Mumford rightly recognises in his closing written submissions that there are no easy comparators.

109. I have had regard to the fourteenth edition of Judicial College Guidelines. They provide little by way of assistance but I have reminded myself of the suggested range of awards for cases involving the digestive and renal system.

110. Mr Hallin has referred me to a number of reported awards. They have the disadvantage that they are all out-of-court settlements, but they illustrate the sort of settlements that have been agreed in cases of delayed diagnosis and treatment. In none of the cases was the delay in treatment as great as in this case.

111. The award must, in my view, properly reflect the following –

(a)The profound shock and distress of being told of the true position, when it ought to have been explained some nine years earlier;

(b) The additional pain and discomfort between 2007 and 2011, which should have been avoided, had the recurrence of the GIST been detected in 2006 and operated on in the next year;

(c) The anxiety and inconvenience caused to the Claimant in 2009 and 2010 in trying to discover the true nature of his condition;

(d) The need for more complex surgery and a more difficult post-operative recovery period in consequence of the delay in surgery.

(e) The greater challenges for future treatment resulting from the need for more complex surgery.

112. Taking account of all these factors, I have come to the conclusion that the appropriate figure for general damages is £27,500.

Loss of employment prospects

113. In 2011, the Claimant was short-listed for a position as a Softwear Reliability Engineer with Google.

114. It was a highly attractive career opportunity. The Claimant got through the first competitive round of interviews and was one of the candidates chosen for the final selection exercise. This involved an intensive five-hour interview. At the time, he was still recovering from the extensive surgery on his liver.

115. The Claimant's written evidence, which was not challenged, was that he "*was not fit enough for the effort. I was weak and I could not eat full meals.*" Inevitably, he feels that had he been fully fit, he would have been successful in his application for what he describes as a "dream job".

116. Having got as far as he did, the Claimant had a more than speculative chance of success in his application. His prospects would have been materially hampered by the fact that he was not fully recovered from surgery.

117. Mr Hallin submits that this loss of a chance is one that can properly be compensated by a modest lump sum award[19]. He suggests a figure of £7,500 is appropriate. Mr Mumford did not challenge the legal basis for making an award but submitted that the claim was speculative and the evidence to support insufficient. It is difficult to see, though, what further evidence the Claimant could have adduced.

118. I accept that it is probable that his performance at interview would have been materially affected and that this is likely to have reduced his chances of being selected.

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[19] See **Allied Maples Group Ltd v Simmons & Simmons [1995] 1 WLR 1602** and **Langford v Hebran [2001] EWCA Civ 361**

119. I award £5,000 under this head.

Expenses incurred in medical investigations

120. These expenses relate to travel and accommodation costs involved in the misdiagnosis in Spain of Pseudomyxoma Peritonei and the referral to the Christie Hospital in Manchester.

121. These expenses would have been avoided had the Claimant been properly informed of his condition, and had he received regular check-ups and undergone further surgery in 2007.

122. The claim comes to £798.77 in respect of Vitoria and £1,139.98 in respect of Manchester.

123. The claim in respect of travel and accommodation in relation to the surgery in Marbella is not allowable as it has not been established that similar expenditure would not have been incurred had the treatment taken place in 2007.

124. A claim in respect of the cost of future medical treatment and ancillary travel and accommodation costs was not pursued. The need for future treatment is caused by the Claimant's condition and the risk of recurrence, and not by the delay in treatment.

Other heads of claim

125. I do not allow the claims for loss of earnings and for gratuitous care. Had the Claimant had surgery in 2007 rather than 2011, he would have had a period off work and would have been cared for through his recovery by his partner and other family members.

126. He was off work in 2011 for two months. This was a creditably short period. Indeed, the evidence was that he returned to work remarkably quickly after such difficult surgery and could legitimately have taken a longer period off work. Although the surgery would have been less complex in 2007, there is no evidence that the period in 2011 was materially longer than it would have been had the operation taken place in 2007 or that he would not have needed the same amount of care.

The subrogated claim

127. This relates to the sums paid out by the Claimant's insurers, AXA PPP, on his behalf for his medical treatment in 2011. The Claimant is required to bring the claim on AXA's behalf and to repay the amount expended on his behalf if successful.

128. The amount claimed comes to £83,940.09 plus interest.

129. I have no comparative evidence of what the treatment would have cost had it been carried out in 2007. I am told that the Claimant did not then have private health insurance, and that the likelihood is that he would have been treated in Spain under the Spanish health care system. That is the basis on which the claim is pleaded in the schedule of loss.

130. Mr Mumford submits that the evidence to support the claim is slender and insufficient, especially so, when one takes account of the sizeable amount claimed.

131. There is force in that submission. AXA have simply asserted a right of subrogation in correspondence. They have played no active part in the proceedings.

132. It seems to me that there is a fundamental difficulty in the claim as it is put. To succeed, it must be established that it is the Defendant's negligence that has caused the loss.

133. Had the Defendant discharged its duty, the Claimant would still have needed to undergo further surgery in the future. He would have been under an obligation to disclose his known pre-existing medical condition to any prospective health insurer.

134. The point was not explored in evidence, but it is self-evident that this would have been likely to have a material bearing on his ability to access health insurance. He may well have been unable to obtain health cover for treatment for a recurrence of his GIST. If cover was available, it might well have been subject to a hefty premium. Certainly, there is no evidence before me that it would not have affected his ability to access health insurance.

135. The claim has not been put forward on the basis that AXA were misled into providing insurance by the Defendant's breach of duty and entitled to recovery through the Claimant on that basis. Such a claim, if advanced, might have raised some interesting legal issues.

136. Accordingly, it appears to me that the subrogated claim cannot succeed on the basis on which it has been advanced. It is not a loss that flows from the Defendant's negligence.

137. What the Claimant can claim, though, in the alternative, if there is evidence to support the claim, is the additional cost of his private treatment in 2011 over and above what it would have cost had the treatment been carried out in 2007. Mr Hallin referred to this briefly in his closing submissions.

138. The supporting evidence is very limited. I have reviewed the material in volume F of the trial bundle. This section of the voluminous documentation was hardly referred to in the hearing. The identifiable evidence appears to be restricted to the cost of the treatment to drain the pleural cavity[20]. This comes to a total of £4,292.37. There may well be other charges resulting from the need for more complex surgery but these have not been clearly identified.

139. To this limited extent I allow the claim.

Conclusion

140. Accordingly, there will be judgment for the Claimant.

141. The damages comprise –

[20] See pages 16 and 17 in volume F

General damages (PSLA)	£27,500
Loss of Employment Opportunity	£5,000
Medical expenses	£1,938.75
Additional costs of surgery	£4,292.37

142. I invite counsel to calculate the claim as to interest and to draw up the order. Unless there are any outstanding issues, it will not be necessary for anyone to be in attendance when judgment is handed down.

ANNEX

CHRONOLOGY OF MEDICAL RECORDS

Date	**Eve**	**Ref[21]**
30/11/2000	C attends CXH A&E During admission queried "??Gastric / oesophageal Ca" [59]	49
1/12/2000	GP: "Admitted to 8 South"	8
12/12/2000	D/C letter CXH "Chronic Anaemia [secondary] to peptic ulcer". Plan for f/u gastroenterology clinic for rpt OGD 6 weeks, Gastro f/u clinic 8 weeks." "Needs an OP appointment – Yes" Drugs to continue: Omeprazole and ferrous sulphate	33
22/1/2001	Histopathology: no evidence of dysplasia or malignancy	264
23/1/2001	C attends CXH A&E having "fainted at work" Admitted to ward 9 South [91]	89
24/1/2001	Request for Specialists Opinion to "Mr Theodorou's Firm" Notes "has been poorly compliant with PPI therapy" Signed by Gastroenterology HO	101
24/1/2001	"discussed with NAT [Theodorou] _> agrees for theatre"	103
29/1/2001	Gastro HO "Long discussion Pt aware that compliance with medication + advice is crucial, and that non-compliance may ultimately be fatal due to bleeding / perforation. Pt tells me he will be fully compliant from now on."	108
29/1/2001	CT scan with contrast: "There is a 7cm rounded mass related to the lesser curve of the stomach. This has mixed attenuation areas, in places. enhancing,	258-259 983

[21] References are to pages of Vols E1-3 of the Trial Bundle unless otherwise stated

Date	Eve	Ref[21]
	but in other areas being of markedly low density. It does appear to be part of the gastric wall with a nodular component extending into the gastric lumen. This lies closely applied to the cranial aspect of the neck and body of the pancreas and it extends to and deforms anteriorly the antrum. No local lymph node enlargement. No other abnormality - related, to pancreas, kidneys or spleen. The liver appears normal although is indented by this mass. The only other finding of note relates to the appendix which contains two large laminated appendicoliths although there is relatively little in the way of inflammatory change around the appendix. **COMMENT: The most likely diagnosis is that this is a GI stromal tumour. Particularly in the context of recurrent bleeding and non-healing ulceration."**	
30/1/2001	WR [Gastroenterologist?] "…Long discussion Aware of risks of conservative management and that emergency surgery carries higher risks than elective surgery Pt adamant he does not want to undergo surgery {Plan} Conservative {management} Mr Theodorou's team will review"	114
30/1/2001	WR Umughele "…patient shown ulcers on photos 30/1/1 SpR explained – may need operative mx after -Discussion multidisciplinary -physicians -surgery -Radiology Surgery likely option if bleeding continues…"	114-115
30/1/2001	Theodorou note: "…I have advised him that he should undergo elective surgery. He is understandably reluctant. Nevertheless he is at risk of major haemorrhage. Further local treatments are contraindicated as they risk possibly complicated surgery. He should consider overnight."	115
31/1/2001	Joint WR Gastro/Gen Surg SpR (Dr Dove-Edwin and Mr Umughele) "Pt has thought about it overnight & has agreed to surgery. **CT scan reviewed [with] Dr Blunt -> ~ 7cm stromal tumour, mainly outside of stomach 'tip of iceberg' in stomach** Pt given the opportunity to ask questions, CT scan result	116

Date	Eve	Ref[21]
	explained. Plan / anaesthetic review X match Surgery today = 4pm? Consent”	
31/1/2001	Consent form “TYPE OF OPERATION, INVESTIGATION, TREATMENT OR ANAESTHETIC … Laparotomy + partial gastrectomy for Bleeding gastric ulcer + gastric tumour EXPLANATION OF OPERATION, INVESTIGATION, TREATMENT OR ANAESTHETIC - Bleeding - Pain - infection - scar” Signed by C [118]	117
31/1/2001	Op note: “OPERATION LAPAROTOMY – PARTIAL GASTRECTOMY [with] ROUX EN Y ANASTOMOSIS (& [illeg] entero anastomosis) SURGEON NAT Umughele L. Richardson DESCRIPTION OF OPERATION UML [=umbilical?] 10 CM tumour mid lesser curve. No obvious nodal disease apart from (1) subpyloric nodes, (2) Unrelated lymphadenopathy prox. Small bowel mesentery. Vascular adhesions of [illeg] in lesser omentum. Appearances of malignant leiomyosarcoma. [illeg] clean [?clear]. Nil else. [?Resection] of tumour and omentum [with] closure of duodenal stump TA55(3.6):[illegl] [with] 3/0 vicryl. L gastric A [illeg] ligated at origin on coeliac axis. L gastric vein ligated at pancreas. Lesser curve nodes stripped on to specimen [with] [illeg] performed. Very little clearance. Margin of tumour from G.A.T. Hence resection as follows.” [diagram]	120

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1/2/2001	0730: WR NAT (Theodorou) **"…NAT explained – ~~tumour~~ lump removed from stomach"**	126
6/2/2001	0730 (note in retrospect) WR NAT "patient looks unwell". Urgent bloods and CXR	131
6/2/2001	C undergoes OGD and laparotomy for perforated appendix performed by Mr Theodorou assisted by Umughele	139
6/2/2001	Nursing notes: "Visited by sister post-op but sister only speaks very [little?] English, but understand pt had abdo operation & on the ventilator"	593
6/2/2001	(ICU) Admission Summary "Patient underwent surgery on 31/01/01 which showed appearances of malignant leiomyosarcoma"	142, 269
7/2/2001	Nursing notes 1645: "Explained to the sister the condition of the patient and informed/explained about the operation to be done tonight"	594
7/2/2001	C undergoes laparotomy + washout abdominal cavity performed by Umughele	156
9/2/2001	Returned to theatre with ischaemic small loops of small bowel	166, 268
15/2/2001	Physio: "Pt more alert, eyes focusing & squeezing hand to command."	180
16/2/2001	Histopathology report "Gastrectomy specimen showing a large stromal tumour… The histological appearances are those of GIST (gastrointestinal stromal tumour)… **By virtue of its large size the tumour should be considered as malignant.**	266-267
17/2/2001	Umughele note "Full histology report not ready yet. Provisional report large stromal tumour ? malignant. Further staining and review by pathologist."	186
18/2/2001	Umughele note: "…Plan - Remove drains - Will review mane - To discuss with family – histology / prognosis 1050 Patients condition and operative findings discussed with sister and friend of patient."	191
24/2/2001	ICU nursing: "Communicating well but upset. Has spoken of wanting to die."	666
28/2/2001	ICU "tracheostomy removed on WR" [222]	221-222
5/3/2001	Discharged from ITU to ward	746
6/3/2001	WR NAT "returned from ITU yesterday	234

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	Problems currently (1) Wound infection – pseudomonas (laparotomy scar) (2) Fluid balance – req negative balance (3) TPN feeding"	
7/3/2001	Gastrograffin study shows anastomosis intact	236
8/3/2001	Probably UTI	237-238
9/3/2001	WR NAT "Wound site debrided this morning"	238
9/3/2001	US Chest "Bilat pleural effusions, clear fluid"	239
9/3/2001	Post-ITU follow up "…Appetite poor but eating"	240
10/3/2001	"feeling better"	240
11/3/2001	"continue diet / physio / mobilisation"	240
12/3/2001	WR NAT "apyrexial"	240
12/3/2001	Post ITU follow up "Continues to improve. Chest remains clear. I note correspondence re: pleural effusions. Now mobilizing well. No indication to continue seeing."	241
12/3/2001	Physio: "Pt reported walking to/from toilet in room "Holds on to table + chair". .. Mob + 2 to/from nurses station with rollator. Mob + 1 whole ward. + 1 to / from [illeg] room. … Improved gait / balance, mobility +++"	747
13/3/2001	WR NAT "…continue mechanical debridement…once infection free -> vacupack to be attached"	241
13/3/2001	Radiology "The patient has large un-loculated bilateral pleural effusion. I have marked the position (optimal) for drainage"	241
14/3/2001	Physio "Pt developed bilateral pleural effusion. Drains inserted appr. 1 hour ago, Pt finds them very painful. … Pt very agitated… No Rx [treatment]. R/v tomorr."	747
15/3/2001	Physio "Pt still feels a lot of pain. Chest drains removed. Pt tried to go to toil early morning [arrow up x 3] pain"	747
15/3/2001	WR NAT Post-drainage CXR "Plan: Plastics sister re/ vacupack dressing Diclofenac suppository Continue eat/drink Chest physio"	242
15/3/2001	Dietician "Oral intake down. Pt reports he is in too much pain & too hot to eat."	242
19/3/2001	"Patient c/o superficial pain in R foot"	243
19/3/2001	GP (tel): "In CXH now-since jan-was in ITU 1month wants to go private needs a form-in ward 8N-UNDER Mr Theodorou –	8, 13

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	recovering"	
20/3/2001	"CXR – residual bilateral eff"	243
20/3/2001	Neurology SpR review "…c/o Painful Paraesthesia dorsum both feet … Imp likely neuropraxis both common [illeg] [secondary] to prolonged ITU admission…Hopefully self limiting and will improve…"	244
21/3/2001	"C/o neuralgic pain dorsal aspect R foot"	243
22/3/2001	WR NAT "Pt c/o neuralgic pain dorsal aspect of R foot worse at night."	245
23/3/2001	WR SpR "still c/o foot pain worse at night"	245
29/3/2001	USS abdo normal	246
30/3/2001	WR NAT "Apyrexial Continue [with] eating For EMG mane"	246
30/3/2001	EMG "evidence of bilateral common peroneal neuropathy with features of entrapment across the fibular neck on both sides R > L. The patient states that he is already improving which is a relatively good prognostic sign."	246
30/3/2001	C admitted to "15 South"	35
31/3/2001	Nursing note "wound infection"	717
2/4/2001	Folic acid	549
3/4/2001	Referral to Riverside Community Health Care NHS Trust [district nurses] for daily dressings from 10/4/2001	755
4/4/2001	Prescriptions	551
4/4/2001	Nursing note: "S/B Mr Theodorou"	718
5/4/2001	Nursing note: "S/B Mr Theodorou"	718
7/4/2001	Nursing note: "S/B Mr Theodorou" 1100 "top wound debrided by Mr Theodorou" Mr Theodorou instructions re wound dressing [722]	718, 722
9/4/2001	Fax from Shaun O'Gara to Practise Nurse "Mr Guiu [sic] had partial Gastrectomy performed on 6/2/01 [sic] for bleeding gastric ulcer. Returned to theatre on same day [sic] for excision of perforated Appendix." Description of wound and dressing instructions "Wounds were debrided on the ward by Mr Theodorou on Fri 6th April."	757

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9/4/2001	"Discharge Letter" proforma written by Mr Theodorou. Stamped at received [by GP] 12/4/2001 **"Diagnosis:** **(1) Gastric leiomyosarcoma** (2) Post op acute perforated appendicitis (3) 2 laparotomies for sepsis / obstruction" "Recommendations for Future Management See us 10/7 [10 days] 3/12 [3 months] B12 1000µg injection please" Drugs to be continued "Folic Acid"	35
19/4/2001	Umughele letter: [C home address] Diagnosis: Malignant gastric stromal tumour. Treated by subtotal gastrectomy 31 January 2001. Perforated appendicitis. Treated by laparotomy and appendicectomy. Two other laparotomies. One for second look at washout of abdominal cavity. The other for lateral resection of small bowel. Mr Guiu was admitted to hospital on the 23rd of January via A & E with a history of a bleeding ulcer. Endoscopies revealed a gastric ulcer and attempts at hemostasis were unsuccessful. CT scan carried out on admission showed a large stromal tumour about 7cm, the appearances were compatible with malignant leiomyosarcoma. He went on to have a sub total gastrectomy. Following surgery he became unwell with abdominal pain and distension, four days post op. 48 hours later he went back to theatre for laparotomy as he remained unwell. The findings were that of perforated gangrenous appendix. He had a turbulent post operative period in ITU and went in for a second look laparotomy where he simply had a washout of his peritoneal I cavity. His condition remained unstable and he had to go back to theatre when a small piece of gangrenous small bowel was found and this was resected. He made good progress and was discharged on the 5th of March, after spending four weeks in ITU. He has made remarkable progress since surgery although he had a wound infection. His abdominal wound responded well to vacuum dressing and he was discharged on the 9th of April. On discharge his medications include three monthly vitamin B12, daily folic acid and multivitamin preparations."	36 759
20/4/2001	"Charing Cross Hosp Discharge Letter" entered onto GP system	7
23/4/2001	Letter Mr Theodorou to GP: "This gentleman is now making good progress following his difficult course in hospital. His wounds are making tremendous progress and he is eating well. He has gained weight and now	37

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	wishes to return to Spain for a short holiday. He should be allowed to do so. He will need to continue on Folic acid 5mg bd probably permanently and in addition will require Vitamin B12 injections at approximately three monthly intervals. I have asked him to let me know when he returns from his convalescence and arrangements will then be made to follow him up further." GP copy marked "I have seen him and given 13/52 cert"	
23/4/2001	GP: "MED3 issued to patient 13w-multiple abd ops"	7
23/4/2001	GP records: "Active Problems [M] Leiomyosarcoma NOS : of stomach" (see also Diseases or Operations)	4, 5, 7, 10, 11,13, 16, 17, 20
23/4/2001	GP: "Partial gastrectomy – subtotal…do Rx B12, folic please – needs dressings"	7
24/4/2001	GP: "Vit B12 due in June when he returns from Spain."	7
26/4/2001	GP: "Flying to Spain tonight for 2 months"	7, 13
28/6/2001	CXH notes issued to Mr Theodorou	48
28/6/2001	Routine Haematology	324
28/6/2001	Clinical Chemistry	410-411
2/7/2001	GP: "P: seen CXH – has appt September"	6, 12
24/1/2002	CXH notes issued to Mr Theodorou	48
31/1/2002	CXH notes issued to Mr Theodorou	48
1/2/2002	Letter Mr Theodorou to GP: "This gentleman is in good health following his difficult surgery last year. He is eating normally and there is nothing to suggest the recurrence of his original gastrointestinal stromal tumour. He does however have a moderately large incisional hernia. He has been advised to undergo routine haematological and biochemical screen, CT scan and then be reviewed. If his blood tests and scans are normal then he should be advised to undergo repair of the incisional hernia during the course of this year." Stamped received 16/2/2002	38
4/2/2002	C attends CXH for CT/Abdo scan with contrast (complicated by contrast extravasation) Report: "…Requesting Consultant: Mr N Theodorou…CT ABDOMEN & PELVIS (CAP) Exam Date : 2002.02.04 [sic – US-style date] CLINICAL HISTORY: January 1st gastrectomy (Roux en Y). Malignant GIST. Complicated by post op. appendicitis and sepsis with incisional hernia. CT ABDOMEN & PELVIS: Axial images through the abdomen and pelvis have been performed with oral and intravenous contrast. The liver appears normal. The spleen appears normal. There is normal excretion of	248 982

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	contrast from both kidneys that appear within normal limits. The region around the celiac axis appears bulky but I am sure this represents unopacified bowel. There is no evidence of para aortic lymphadenopathy. Incisional hernia identified incidentally. Within the pelvis there is no evidence of iliac lymphadenopathy. No abnormal fluid collections are identified. No focal abscesses identified. Reported By: Dr N Barrett [illeg] Transcription Date : 2002.02.08 [sic]" [982]	
7/2/2002	GP: receives incoming letter from Private surgery	6, 12
28/2/2002	CXH notes issued to Mr Theodorou	48
1/3/2002	Letter Mr Theodorou to GP: "Further to my last letter about this gentleman I am pleased to report that his CT scan showed no significant abnormality and his routine haematological and biochemical screen was satisfactory. His incisional hernia should now be repaired. He will prefer this to be done in Spain where he has the support of his family and I think that this is entirely reasonable provided it is done in a moderately large centre by a surgeon with the appropriate expertise. It is likely that he will have this done early in the summer and I have asked him to return to see me later in the year on his return from Spain."	39
8/3/2002	GP: receives incoming letter from Private surgery	6, 12
9/4/2002	Letter D to C "Thank you for your enquiry requesting information under the Data Protection Act 1998 / Access to Health Records Act 1990" Forms enclosed	760
1/5/2002	C requests data relating to: "Charing Cross 27/1/2001 to April 2001 [Wards?] 8, 9, 11, 15 [Consultant] Dr Theodorou"	761
13/5/2002	Mr Theodorou adds note to C DPA request "It may be simpler and acceptable to patient for us to forward a summary" Followed in notes by ITU d/c summary, referring to: "Patient underwent surgery on 31/01/01 which showed appearances of malignant leiomyosarcoma" [764] "2 laparotomies, the first was for a bleeding gastric ulcer secondary to a large (8cm) stromal tumour of gut autonomic nervous system" [765]	763
20/6/2002	CXH notes issued to Mr Theodorou	48
27/6/2002	GP: "is having incisional hernia repair done in Spain"	6, 12
4/7/2002	C undergoes procedure [incisional hernia repair?] at New	816

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	Quiron Clinic	
15/6/2005	C registered with GP in Richmond, Surrey	2
20/6/2005	Sees GP as new patient: "PMH: 2001 – stomach ulcer op -> peritonitis"	2
26/9/2006	C attends CXH A&E with L sided abdo pain	41
27/9/2006	Kingston Hospital blood test results, clinical details "Abdo pain, raised bilirubin"	29
8/11/2006	US abdo, noting "previous partial gastrectomy". No hepatic abnormality to account for abnormal LFTs	25
27/10/2006	GP: "seen 29/9/06…given hx gastric ulcer and gastric surgery, for referral – private. Still on ppi. Also for private uss re mildly raised bilirubin" **Computerised notes contain "Diseases or operations: 31.01.2001 Partial gastrectomy: malignant gastric stromal tumour"**	15A + B
1/11/2006	Referral by GP to gastroenterologist New Victoria Hospital, Kingston-on-Thames "He is keen to see a specialist given his past medical history of gastric ulcer with partial gastrectomy. He also has a history of acute appendicitis with peritonitis in 2001". No mention of GIST	43
8/11/2006	C undergoes US abdomen New Victoria Hospital (Kingston upon Thames) "No hepatic abnormality identified to account for the patient's abnormal liver function tests"	863
2/3/2009	GP: "yesterday had some bloating and upper abdo discomfort, seems to have settle today. NB pmh. … in light of PMH – cover with ppi"	21
22/5/2009	GP: "pain around epigastrum past few days"	21
27/7/2009	Has USS at Parkside Hospital on lump on left nipple – on form before USS in answer to question about previous operations says "stomach ulcer removal + peritonitis in post operatory."	45 45B
16/7/2010	C attends hospital Emergency Department La Linea de La Concepcion with "stomach pain". X ray reveals "great deal of fecal matter in colon and rectum"	968
20/7/2010	Abdo MRI report Spain Diagnosis: Suggestive of Pseudomyxoma Peritonei. No mention of GIST	784
21/7/2010	Referral GP in Gibraltar to Surgeon "Had a partial gastrectomy 10 years ago in London and in the immediate post-operative period had a ruptured appendicular abscess and needed to be opened up again." No mention of GIST	801

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6/8/2010	Deardon to GP Gibraltar. "I have reviewed the x-rays with one of the surgical team at USP Marbella and we both confirm the diagnosis was pseudomyxoma and indeed we met with Raul again to go through the possible treatment options with him and discussed the option of sending him to the UK to a specialist unit in Basingstoke or indeed to the specialist unit in Vitoria.." No mention of GIST There is a postscript that the Claimant had later asked for a second opinion from Christies.	802
10/8/2010	Letter of referral David Deardon MD FRCS to Christie Hospital – reference to possible diagnosis of right-sided supra mesenteric pseudomyxoma peritoneii, and to history of distal gastrectomy for bleeding peptic ulcer disease 9 years ago at Charing X. No mention of GIST	778
21/8/2010	Referral received to Christie Hospital NHST (as private patient)	777
2/9/2010	Christie Hospital – radiology MDT "MR scan undertaken in Spain reviewed. Complex rare cystic lesion at the coeliac axis. The hepatic artery is draped right round it. Further encysted areas scalloping the liver and a pleural effusion. Very unusual presentation and does not look like a standard PMP….will require a CT scan in order to further stage the situation."	777
20/11/2010	Email from Mr Theodorou to C following call	A2/4.1/9
26/3/2011	Letter of complaint to Chief Executive received. Includes "At my follow-up consultation with the doctor, after leaving hospital, I was told that I would need to take vitamin B12 and Folic acid because part of my intestines were removed. No other follow-ups were arranged and no other advice given."	766
13/6/2011	C undergoes surgical excision [in Marbella] of recurrent GIST arising in segment 1 of liver. See letter of 14/9/2011 for op description.	804 882 (op note)
14/9/2011	Deardon to GP Gibraltar: "Just a note to bring you up to date with Raul's progress. As you know he was diagnosed as having a recurrent GIST tumour arising from what appeared to be Segment I of the liver. There had been some confusion as to his previous surgery in the UK, ten years ago, but this transpired to be a tumour of the distal stomach which had resulted in him having a distal gastrectomy with roux on enY reconstruction. He has been under the care of Dr Aboal at USP Hospital whilst he has undergone a six month course of Glivec treatment to reduce the tumour load. Unfortunately this has not worked and therefore the decision was made to surgically remove the recurring tumour. The operation was performed on 13lh June 2011. We arranged for Professor Figueras, specialist hepatobiliary surgeon, to join myself and Dr Enrique Aycart to undertake Die operation. The	804

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	operation involved an upper "hockey stick" incision and exposure of the liver; a large tumour mass was evident in Segment 1, extending posteriorly adjacent to the vena cava and restricting the blood flow to the left lobe of the liver. There was also evidence of tumour spread over the anterior segment of the right lobe of the liver to the right of the gall bladder bed. Upon this basis we undertook a combined left hemi-hepactectomy with extension of the resection margin across the mid line into the right lobe of the liver. The resection included the gall bladder and involved complete removal of the tumour from the anterior surface of the vena cava. The left and middle hepatic veins were ligated and divided in order to achieve clear margins. Unfortunately during the dissection of the tumour off the portal vein it became clear that the vascularisation of the tumour had led to micro invasion into the wall of the portal vein and it was therefore necessary to sacrifice part of the portal vein to achieve clearance. Our attempts to repair this were unsuccessful and therefore the decision was made to replace the portal vein, in its entirety, from the superior border of the pancreas to the underside of the liver using a jump graft which was obtained from the left renal vein. His left kidney therefore now drains via the supra renal gland and the: testicular vein. The operation in total took 11 hours but Raul made a steady recovery. Unfortunately he was troubled with ascites and effusion in the right chest which was undoubtedly due to a fluid leak from the cut edge of the liver. This necessitated chest drainage on two occasions, however eventually this settled and the drain was removed. He remained in hospital for around two weeks but was discharged home well with regular out-patient follow up. I saw Raul two weeks ago in the Specialist Medical Clinic to sign his return to work certification. He has made an excellent recovery and his abdomen is healing well. He has regained some weight and his blood parameters have all been normal. He is also under review by the oncology team at USP Hospital, Marbella and has been reviewed there recently. A decision is due to be made regarding adjuvant Glivec Therapy which may reduce the risk of any further seethings of this tumour in his peritoneum. As far as we can tell from the specimens and the pathology reports we have, the surgery performed in June this year seems to have achieved clear margins in all directions and hopefully this will be associated with a long post-operative disease free period. Raul is aware that he will require further ongoing investigation and monitoring for at least five years before we can give any guarantee of long term success of this procedure. I will be reviewing Raul on a regular basis but I suspect he will be returning to you from time to time for various other treatments.”	
21/9/2011	D Senior Complaints Coordinator response to complaint letter	770