

1 Tuesday, 22 September 2026 2 (10.03 am) 3 PROFESSOR RICHARD HUXTABLE (continued) 4 PROFESSOR ANGUS MCNAIR (continued) 5 THE CHAIR: Good morning. 6 MR DAWSON: Good morning, sir. 7 THE CHAIR: Good morning. Ready to resume? 8 MR DAWSON: Yes, indeed, thank you. 9 THE CHAIR: Yes, if we could have the witnesses back, 10 please. Gentlemen, good morning. I think I can take it 11 that you can see and hear me all right. The formal 12 position, gentlemen, is that you remain subject to the 13 affirmation you gave yesterday. I'm going to hand you 14 back to Mr Dawson who will have some further questions 15 for you now. Thank you. 16 Questions by COUNSEL TO THE INQUIRY 17 MR DAWSON: Good morning. Can you hear and see me okay? 18 PROFESSOR MCNAIR: Yes. 19 PROFESSOR HUXTABLE: Yes. 20 Q. We finished off yesterday halfway through our 21 consideration of the World Federation of Neurosurgical 22 Society's "Statement of Ethics in Neurosurgery". We 23 were looking at aspects of that which you've helpfully 24 compiled and extracted in table 5, which is at page 72 25 of your report. Page 1	1 individuals and share with them information and 2 perspectives suited to their personal needs, enabling 3 them to understand their own medical situation, and to 4 knowledgeably participate in decisions about their own 5 care. 6 "We must work to ensure our own ethical 7 independence, and the independence of our scientific 8 conferences and publications." 9 So there's various aspects of that I'd just like to 10 touch on. It does say that the ethical guide is 11 designed to "remind ourselves and neurosurgeons 12 worldwide" of the various principles that are set out. 13 Does that tend to suggest that what this document is 14 achieving is bringing together a body of existing 15 neurosurgical principles into one internationally 16 recognised, useful guide? 17 PROFESSOR HUXTABLE: That would seem to be the inference, 18 yes. 19 Q. One aspect of this, which we will come on to in detail 20 in due course but I think it's neatly encapsulated 21 here -- we've already touched on this to an extent -- is 22 the extent to which it embodies ethical principles which 23 might be deemed to be derived from general medical 24 ethics which have been made more specific and perhaps in 25 certain places more specific still by this guide. Page 3
1 If I could just, for a particular purpose, take you 2 to the document itself from which these extracts are 3 taken. It's ELJ0002-00070. 4 This is the introduction to the document and further 5 on one can see the various sections from which you've 6 extracted the various extracts. On page 1, in 7 introduction in the second paragraph there's some 8 information given around what the authors of this 9 international document considered its purpose to be. 10 It says: 11 "Our focus in creating this ethical guide is to 12 remind ourselves, and neurosurgeons worldwide, of our 13 fundamental commitments to the patients and communities 14 we serve. These principles are applicable to all 15 neurosurgeons, in private practice as well as academic 16 settings. 17 "Above all, we are obligated not to harm our 18 patients, and to provide treatment that is of potential 19 benefit. This requirement may raise challenges in the 20 practice of neurosurgery, which has the potential to 21 leave patients substantially worse, or even disabled, 22 after treatment that may have achieved its surgical 23 goal." 24 Reading further down, missing out one paragraph: 25 "We must take time to get to know our patients as Page 2	1 Because it says "above all we are obligated not to harm 2 our patients" and Professor Huxtable, you mentioned that 3 derives from the opening part of the Hippocratic Oath. 4 So that's been around for a while, if I can put it that 5 way? 6 A. Yes, certainly. 7 Q. And then beyond that what the document seeks to do, 8 I think, is to try to take those basic principles but 9 particularise them to the field of neurosurgery and even 10 in the introduction it touches on particular features of 11 neurosurgery that might make the ethical rules 12 applicable to it, slightly different from what they 13 might be in other fields. Because what it talks about 14 here -- just as one example of the particular features 15 of neurosurgery, we'll come on to more -- is the fact 16 that it has the potential to leave patients 17 substantially worse or even disabled after treatment 18 that may have achieved its surgical goal. So just to 19 take that aspect of neurosurgery in itself, is it 20 correct to say that that feature, which may be shared 21 with other medical fields as well but perhaps not all, 22 is a very important starting point for considering what 23 the ethical standards are applicable to a neurosurgeon? 24 A. Yes, I think that's a fair assessment. 25 Q. And one aspect that I think I'll ask you many, many Page 4

1 times today, because this is really essentially what we 2 are interested in, in your evidence, is to ask you why 3 that's the case. You've set out all the rules for us, 4 we know what all the rules are, but what we're really 5 interested in is your opinion why that's the case. So 6 I'll ask you for the first time, why is that the case 7 that that aspect of this type of surgery means that 8 ethical considerations, ethical dilemmas, striking the 9 ethical equilibrium that we talked about may be 10 different than in different medical settings? 11 A. A very good and a very big question indeed, so I'll give 12 a brief answer but I can look to my notes and amplify 13 that answer if it would be helpful. 14 Q. Thank you. 15 A. But there are -- certainly in the academic community but 16 also the professional organisations would recognise 17 there are some distinctive features of surgery, first 18 and foremost, but secondly, neurosurgery distinctively 19 that suggest there are particular ethical 20 characteristics we should heed and address. So 21 an example, very quickly, for a neurosurgeon would be 22 the fact that we are dealing with fundamentally brains 23 and therefore cells, notions of the self. There's some 24 very big questions there about how one would carefully 25 seek to benefit the self, through procedures on the Page 5	1 their views and allow them to participate fully in 2 decision-making. 3 This aspect is particularly important because it 4 suggests, here, that what that involves, at least in 5 2007, although we've already established that this is 6 looking back and trying to consolidate rules that 7 already existed, is trying to take some cognisance of 8 patients' own perspective and personal needs. 9 Now, we'll come, in much more detail, to questions 10 of informed consent later, but again, in a general sense 11 what is important about that aspect when we're looking 12 at neurosurgical rules? 13 PROFESSOR MCNAIR: Well, you're starting to see this 14 alignment. So, as you mentioned, in 2007 and this 15 language in this particular paragraph, I think is very 16 telling and really does move the situation forward from 17 a guidance point of view. The way that this is, 18 I think, applied within the neurosurgical context is 19 that the values and preferences that relate to 20 neurosurgery in particular, as Professor Huxtable has 21 already alluded to, the idea of a brain being part of 22 the self and these sorts of concepts are very typically 23 highly valued by patients in a way that would inform 24 practice. So if we take that first line, "We must take 25 time to get to know our patients as individuals". Page 7
1 brain, and the risks that might come with that. 2 So there's more I could say looking to the notes, 3 but hopefully that begins to give an answer. 4 Q. That's extremely helpful. We will, as we go through 5 aspects of your report, look at other particular 6 features of neurosurgery which have been identified as 7 having an impact on what its ethical standards need to 8 be. Two other aspects I just touched on in the passage 9 I read out. The first is one that probably falls within 10 questions that Professor McNair has answered more. Is 11 the introduction here to the possibility that it may be 12 particularly important, given the particular 13 characteristics of neurosurgery, that neurosurgeons in 14 particular must take time to get to know our patients as 15 individuals and share with them information and 16 perspectives suited to their personal needs, enabling 17 them to understand their own situation and knowledgeably 18 participate in decisions about their own care? 19 In an exchange yesterday, Professor McNair, about 20 the move away from paternalism. I quoted to you 21 a passage that we heard in evidence last week from 22 Mr Redfern, one of our consultant neurosurgeon experts, 23 who said that in the relevant period we were looking at, 24 we were in a period where patients were involved in 25 their care, neurosurgeons were expected to ask them Page 6	1 I would propose that any individual, if they were 2 thinking about their brain and selves, would have some 3 values attributed to it and some preferences about how 4 one would want to care for them if they had issues with 5 their brain that might require neurosurgery, for 6 example. 7 Q. You've touched on a concept which I intended to revisit 8 with you, which we haven't touched on yet. I think it 9 is a concept which is, like principlism, an approach to 10 ethics that might be relevant and you've mentioned the 11 word "values" there and I think there is something 12 called "value ethics". Could you tell us, as succinctly 13 as you can, what that is? 14 PROFESSOR MCNAIR: I'll refer to Professor Huxtable. 15 PROFESSOR HUXTABLE: I confess, I'm not entirely sure. So 16 values are sometimes seen as synonymous with ethics. 17 So, yeah, there's a degree of perplexity there. There 18 is certainly an approach known as "virtue ethics", 19 I wonder if that was coming before then. 20 MR DAWSON: Well, it's really trying to understand the 21 extent that values play a role in ethical 22 decision-making and I suppose why that's important? 23 PROFESSOR HUXTABLE: Oh, right. Okay, so I would certainly 24 say in that regard people might hold different values 25 and they may value different things to a different extent. Page 8

1 Such that what I value might qualitatively differ quite 2 significantly from what Professor McNair values. If 3 I'm the one potentially to be in the operating room then 4 I would hope that the surgeon would talk with me about 5 not only what they know and what's important to them in 6 terms of technique, consequences, side effects and the 7 like, but also explore with me how that fits with my own 8 personal values. 9 A quick example, the sort of example I might use 10 with undergrads would be if one is operating on the hand 11 of a patient that might well be relevant to any and all 12 patients but it might be particularly important to 13 explore the values of the concert pianist, for example. 14 Q. Okay, thank you. That's very helpful. A last comment 15 from the introduction to the statement of ethics. There 16 is an assertion here which I think is made by the 17 various bodies that are contributing to this document 18 that, "We must work to ensure our own ethical 19 independence and the independence of our scientific 20 conferences and publications". Does that tend to 21 suggest that these societies are asserting that it's 22 important, because of the particular features of our 23 field, that we have our own ethical guidance, we have 24 our own ethical thinking, we have our own ethical 25 literature? Is that what that's getting at? Page 9	1 in relation to the neurosurgical field. 2 We've been through the first box already. The last 3 thing we talked about there was the significance of 4 records. In relation to relationships with patients and 5 family members, one of the key principles and 6 obligations that you set out is the need to provide 7 access to records and second opinions. Why would that 8 be an important ethical principle in neurosurgery or 9 more broadly in medical care? 10 A. I think there were two aspects of this. The first would 11 be, if we go back to that four principled approach we 12 referred to yesterday, I think it will align with the 13 first of those principles on some accounts, the idea of 14 respect for autonomy, the idea of self-rule. So I can 15 make decisions about my current or future care if I have 16 the information made available to me, such as the 17 information included in my medical record. 18 With regard to second, third, fourth opinions, 19 I think that might have more a bearing on -- certainly 20 a bearing on respect for autonomy, but beyond that 21 I think there may be questions of benefit and harm that 22 are the second and third principles we referred to 23 yesterday. So it might be that we have a wider pool of 24 opinions on what is the best thing to do for me. So 25 I think that's how it would engage but I think probably Page 11
1 A. My reading of that -- there are several dimensions 2 potentially to this, but one reading of that statement 3 would be to ensure that we do not have our patient care 4 influenced by any alternative or other interests. And 5 they might be conflicts of interest. Our own interests 6 in our own commercial interest, for example, should not 7 compromise patient care. I think that's one reading of 8 that. Another might be if there are external pressures 9 for us to do things in such a way that might, again, 10 compromise patient care. So it's resistance to outside 11 forces as well as resistance to any internal forces such 12 as a conflict of interest. That's amongst the readings 13 I give to that statement. 14 Q. I understand. That's helpful, thank you. Could we 15 please go back to the table, table 5, which you 16 helpfully produced to us and we were working through 17 yesterday. It's the statement at page 72, please. 18 Again, just to remind us, you've extracted from the 19 different sections which you called "domains" on the 20 left-hand side of this document we were just looking at, 21 the statement of principles from 2007, some important 22 principles and obligations in the second column, and 23 quotations related to those in the third. Again, as 24 I said yesterday, I'd be interested in drawing out and 25 asking you if you can elaborate on these in particular Page 10	1 predominantly here is this idea for respect for autonomy. 2 Q. Thank you. On the access to records front, we touched 3 on this when looking at the quote relating to records in 4 the first box. But again, what you said in response to 5 the importance of that principle would tend to confirm 6 what I think was said yesterday, that access to records 7 should not be seen as something ancillary to ethics or 8 medical care but something which is fundamentally 9 an important part of it because access to records that 10 you've talked about is a means by which respect for 11 autonomy is shown and patients are able to exercise 12 autonomy; is that correct? 13 A. That's correct. 14 Q. And I suppose that would apply to medical records 15 relating to treatment at the time, at the time of the 16 treatment, to be able to make good decisions, so access 17 to test results or something to be able to make properly 18 informed decisions. But it might also apply to records 19 relating to what has happened to a patient because that, 20 too, is a part of autonomy; is that correct? 21 A. I think that's a fair interpretation, yes. 22 Q. Yes, thank you. And as far as second opinions are 23 concerned, you mentioned, again, a number of principles 24 that might be engaged in that regard. And the 25 importance of that, I think, in order to be able to Page 12

1 respect those principles, it would be necessary, as 2 I understand it, for a neurosurgeon to be open to the 3 possibility that someone else may be able to provide 4 better care, perhaps greater respect for autonomy or 5 more emphasis on beneficence, perhaps as a result of 6 having more skill or something like that. Is it 7 important therefore for neurosurgeons to be open to that 8 possibility? 9 A. I think so. 10 Q. Thank you. In the right-hand box, you've taken 11 a particular quote which I think touches on aspects that 12 I discussed with Professor McNair already. It says: 13 "Neurosurgeons should be willing to provide patients 14 with clear information, and discuss fully the benefits, 15 risks, and costs of appropriate treatment alternatives 16 using language that allows them to understand the issues 17 at hand." 18 Now, we've covered that already and we'll come back 19 to consent, but I'd like to focus on that last bit, 20 which is to do with language that allows them to 21 understand the issues at hand. How important is that as 22 an ethical principle, or indeed a tool towards good 23 ethical practice? 24 A. Well, I would see that as all tied to this notion of 25 respect for autonomy. It's all well and good me, for Page 13	1 "We should be honest with patients and their 2 families about the reasons for complications, and 3 express our sincere regret when the situation does not 4 go according to plan." 5 Which ethical principles are engaged there? 6 A. So there's different schools of thought, I think it's 7 fair to say, on this. If we looked at the theorists 8 some would say you could link these sorts of ideas to, 9 again, these principles of autonomy, benefit, avoidance 10 of harm, but there are also those who would say these 11 are simply freestanding ethical principles, such as the 12 idea of candour. So candour or truth telling and 13 similar notions, they sometimes are seen as freestanding 14 not necessarily tied to any of the principles we've 15 talked about so far. Fundamentally though, whether one 16 sees it as an implied version or an interpretation of 17 a given principle or its own principle, a great many 18 people would be in agreement this is important. 19 Q. We'll come back to candour in due course in more detail 20 but just as a trailer to it. Candour is a bit like the 21 way we discussed the way in which the need for proper 22 informed consent permeated ethics through academic 23 writings, then ethical guidance and then the law. Are 24 developments in relation to candour a similar process? 25 A. That's my understanding. Page 15
1 example, being bombarded with information that's in 2 jargon or indeed in a language I don't speak, but for me 3 truly to have choice and to be able to make decisions 4 I need to have the information made accessible to me as 5 an individual. 6 Q. And if we look over the page, I think that's linked to 7 another principle that you've set out there, it's the 8 requirement to communicate appropriately. So it's not 9 just to communicate, for example, in a language 10 a neurosurgeon might understand but to communicate in 11 that individualised way we were discussing with 12 Professor McNair earlier; is that correct? 13 A. That's right. 14 Q. Thank you. And that may, in the same way as people's 15 values or beliefs may differ widely from a patient you 16 see on Tuesday to a patient you see on Wednesday, how 17 you communicate with them might equally vary enormously; 18 is that right? 19 A. Yes. 20 Q. Another aspect as far as the principles are concerned, 21 it says here that neurosurgeons should: 22 "Provide clear, honest, and accurate information, 23 tailored to the individual ..." 24 And on the right-hand side there's a quote which 25 says: Page 14	1 Q. We'll come back to the details of that in due course. 2 In the next box what we see there is -- I'll just dwell 3 on that very briefly. One aspect that we've seen 4 a number of times is the need for honesty. We'll come, 5 again, to concepts to do with that and a particular 6 associated word which is "probity" that we've seen in 7 a number of the surgical guidance documents, but why is 8 honesty important? 9 A. A similar to answer to the previous one. Certainly from 10 my approach anyway, and my perspective, would be that 11 this is either a freestanding, important ethical 12 obligation or we can tie it to other things such as if 13 we're dishonest with a patient then they're not going to 14 be able to make the appropriate choices for them because 15 they'll be doing so on the basis of faulty information. 16 I think Professor McNair would like to add something on 17 this. 18 Q. Thank you. 19 PROFESSOR MCNAIR: I do because there's a word we've not 20 used yet and it relates to several of the points you've 21 made in the section which is maintaining "trust", and 22 trust is quite central to the GMC's position on ethics 23 and in particular around good medical practice and to go 24 back to your previous point, access to records, second 25 opinions, honest information, candour could be aligned Page 16

1 with the idea of maintaining trust within a very 2 sensitive and sort of vulnerable relationship. 3 Q. And is it correct to say that the greater the 4 sensitivity and vulnerability, the greater the need for 5 attention to be paid to the establishment and 6 maintenance of trust? 7 A. That's certainly the general tenor of all the documents 8 we've read so far, including the GMC documents. 9 Q. Thank you. What happens broadly if the trust of 10 a patient is lost? 11 A. That is a situation that has a number of, I guess 12 deleterious for want of a better word, or worsening 13 outcomes for the individual. The breakdown of trust 14 creates issues with ongoing care in a way that that 15 individual, I guess, wouldn't be optimally looked after. 16 So I'm going to have to think on that a little bit 17 unless Professor Huxtable wants to come in. 18 PROFESSOR HUXTABLE: Yes, briefly. I entirely endorse that 19 idea there would be potentially adverse consequences for 20 the individual because their failure to trust in their 21 professionals might mean that they refuse to engage with 22 professionals going forward, which could, of course, 23 have bad impacts on their own health and health status 24 but could, in turn, have impacts on the health of 25 others. And it might be those close to them, let's Page 17	1 impair competence" and one of the quotes you've 2 helpfully taken out is: 3 "The neurosurgeon's self-interest is subordinate to 4 patient care. Patient referrals, the choice of 5 procedure, and the use [of] devices or surgical aids 6 must never be affected by personal financial benefit." 7 So how important are those principles, in particular 8 in light of the fact that it can be difficult sometimes, 9 I suspect, for even an ethical, a very ethical 10 neurosurgeon to be able to achieve these goals? 11 PROFESSOR MCNAIR: Yes, and we're speaking here in some ways 12 around conflicts of interest and in particular financial 13 conflicts of interest. 14 Q. Yes. 15 A. And we've submitted several documents in and around 16 financial conflicts of interest and how the general 17 ethical approach is to be open and transparent, again 18 trying to maintain the trust of individuals, especially 19 when perhaps choice was also involved. Because all 20 things being equal, somebody having personal financial 21 gain from receiving a treatment when they could have, 22 for example, an alternative treatment where there wasn't 23 financial benefit but still the same potential outcome, 24 that's important for an individual, potentially 25 important for an individual to know. So yes, I think it Page 19
1 think they have a transmittable disease, for example, 2 but they refuse to engage. But beyond that, if there's 3 a public health dimension to it and they're refusing to 4 engage, then there could be societal consequences as 5 well. So certainly I think it's those reasonings -- I'm 6 hypothesising here but it's that sort of reasoning that 7 might underlie the GMC's central emphasis on this notion 8 of trusting individual doctors but also the profession 9 at large. 10 Q. Thank you. We've mentioned, on a couple of different 11 subjects this morning, the need for an individualised 12 approach, for example in relation to the sharing of 13 information. Would it be correct to say, especially in 14 sensitive and vulnerable situations, that there's 15 a requirement for an individualised approach to the 16 maintenance of trust as well, because different patients 17 might start to lose trust or lose trust in different 18 ways based on their own circumstances and attitudes; is 19 that correct? 20 PROFESSOR MCNAIR: I think that's a reasonable position, 21 yes. 22 Q. Thank you. To carry on into the next box which is 23 entitled "Standards of Personal and Professional Life", 24 two aspects which seem to be connected. It says that 25 a neurosurgeon should "avoid overwork or habits that Page 18	1 is important. 2 Q. And as far as the related subject of overwork is 3 concerned, that, I would imagine, perhaps poses a number 4 of difficult ethical questions because it could be the 5 case that overwork could be perceived by a neurosurgeon 6 or any other doctor as being something that's promoting 7 beneficence in the sense that it's seeking to try to 8 offer as much care as possible to as many people. But 9 what I think this is trying to make clear, in the 10 particular neurosurgical guidance, is care needs to be 11 taken that, in fact, doesn't engage one of the 12 other principles and in fact it starts to harm patients 13 because the general level of the care that's being 14 offered is undermined. Would that be a fair reflection 15 of what the rule is trying to convey? 16 PROFESSOR HUXTABLE: I will come in on this, if I may. 17 Q. Yes, please. 18 A. I think that is a fair assessment of what the rule is 19 trying to convey and I think what it helps us to add at 20 this juncture is, emphasising various pieces of the 21 professional ethical guidance we reviewed, the role or 22 judgment on the part of the individual surgeon or 23 sometimes the broader, multi-disciplinary team. So we 24 do have, on the one hand, these various guidance 25 documents and in the background theoretical ethical Page 20

1 obligations but certainly some of the General Medical 2 Council documents emphasise that there's a role for and 3 it's very important for you to exercise judgment. So if 4 we have a scenario where there is a risk of overwork or 5 indeed overwork is indicated in order to benefit the 6 patient, that surgeon must still be going through 7 a process of judging: well, is it the right thing to 8 press on with this relative to the risk I might pose 9 through the overwork, my skills might deteriorate over 10 time, any risk to other patients being bumped down the 11 list? So it's multi-factorial and indeed, balancing out 12 those multiple factors will require, on occasion, 13 judgment. 14 Q. And is that -- sorry, Professor, come in please? 15 PROFESSOR MCNAIR: So I was just going to add that I feel 16 like a key part of that sentence is avoid overwork or 17 habits "that impair competence". And I think that if we 18 are taking a position that these things, or these 19 ethical ideals should be individualised, the working 20 habits may vary between surgeons or professionals that 21 impair competence. And so I don't think we can say that 22 a particular, for example, rota or job plan or set of 23 activities may universally impair competence or there 24 may be some individuals who need more or less in that 25 respect and so I think it's reasonable to individualise Page 21	1 and the reasons why they may or may not be. And through 2 that process, there would be an opportunity to reshape 3 somebody's job plan and an obligation to do so. 4 If you're considering the more, I guess, acute 5 level, I think the example was around perhaps having 6 done five operations on a particular day and their level 7 of competence perhaps to achieve the sixth is that, 8 again, there should be structures in general in place to 9 either relieve or perhaps cancel a patient if the 10 individual surgeon felt they were impaired within that 11 moment because of events perhaps either within or 12 outwith their control. 13 I can think of examples operations perhaps earlier 14 in the day haven't gone as intended and therefore by the 15 end of the day perhaps you feel that your competence is 16 impaired and in that situation, for example, somebody 17 may wish to delay a patient, cancel a patient or have 18 another surgeon come and relieve them. 19 THE CHAIR: All right, thank you. Mr Dawson, I'm not sure 20 whether that took you off course. I'm happy to leave 21 a Post-it note, but there is an organisational aspect 22 that is of potential interest there. 23 MR DAWSON: Yes, I think one aspect that it might be fair to 24 point out is the question that the Chair posed was to do 25 with whether there was an ethical obligation on Page 23
1 this and this probably sits well with your ideas of 2 judgment, that there is an obligation on the surgeon to 3 exercise judgment as to whether their working pattern is 4 impairing their competence and doing something about it. 5 THE CHAIR: Is there an ethical obligation on the employer 6 of the surgeon to respect that exercise of judgment if, 7 for example, it was made to the effect that it would not 8 be safe for me to operate on this patient because I have 9 conducted five operations already and it would be too 10 risky? 11 PROFESSOR MCNAIR: So I believe there is an obligation on 12 organisations and structures. The way that this is 13 operationalised relates to sort of the broader ideas of 14 clinical governance. And so there would be systems and 15 structures in place, within organisations, to 16 support individuals who are reaching the limits of their 17 competence, for example due to workload considerations, 18 either at an individual moment in time or on a more 19 structural basis. 20 So, for example, on a more structural basis, as part 21 of the annual appraisal process, individual surgeons 22 will sit down with appraisers and go through their 23 complete scope of practice including their job plans and 24 activities and have an opportunity to reflect upon 25 whether they are achieving the higher standards of care Page 22	1 an organisation and the authors of the report have been 2 keen to point out that there is a limit to their 3 expertise with regard to organisational ethics. 4 Although, I think what Professor McNair has told us, as 5 we discussed yesterday, there's a sort of logical 6 connection between the need for there to be ethical 7 obligations that are imposed on organisations to enable 8 doctors to be able to exercise their clinical judgment 9 in an ethical way. Is that broadly what you've been 10 telling us? And would you like to acknowledge whether 11 that is an appropriate limit as to your expertise, 12 Professor McNair? 13 PROFESSOR MCNAIR: It is. This is an extension of our 14 understanding of the ethical obligations as we have 15 found them within the review and we have been applying 16 it to the slightly broader perspective. 17 MR DAWSON: Yes, thank you. Just on the subject of what 18 I'm assuming you're talking about when we're talking 19 about judgment, Professor Huxtable, is clinical 20 judgment; is that correct? 21 PROFESSOR HUXTABLE: Well, it would ultimately become 22 a clinical judgment because it would be a judgment as to 23 whether or not surgery proceeds or how it might proceed, 24 for example, but I think a component of that judgment 25 will be ethical, I would suggest. Perhaps not on every Page 24

1 occasion but certainly in the sorts of questions we're 2 exploring today. 3 Q. Well, in essence, what I'm keen on understanding is 4 whether your view is that it's important that ethics and 5 the striking of the equilibrium we talked about 6 yesterday forms a key part of clinical governance and 7 clinical decision-making? 8 A. I think it must and should. Both words, in fact. 9 Q. Yes, thank you. Just to finish off our assessment of 10 aspects of the 2007 guidance which helpfully summarises 11 some key principles for us. Again, on page 73. Another 12 aspect which comes in here is related to the way in 13 which one requires or should work with colleagues. In 14 particular, the general principle one should: 15 "Communicate with, and behave respectfully towards 16 colleagues." 17 But more particularly, that one requires to: 18 "Protect patients, including from colleagues' 19 harmful behaviour ..." 20 And you've helpfully extracted the quote: 21 "If there is reason to believe the actions of 22 a colleague are endangering patients, we have a duty to 23 make every effort to persuade that colleague to change 24 his or her practice. If this approach fails, we must 25 act to protect patients from risk when there is good Page 25	1 caveat that notions of what counts as a benefit and 2 harm, patients themselves will have views on that. So 3 the autonomy aspect is important. But still, if we 4 stick with the way the priority is set out by the GMC, 5 it's all about benefit and harm at the top. Hence, if 6 you have a colleague who is at risk of posing harm or is 7 actually posing harm to patients, then there is 8 an obligation on you, if you are aware of this, to have 9 it dealt with in some way and there's obviously further 10 guidance on what "have it dealt with" means. 11 Q. Is the suggestion or is the rule or standard that's 12 applied there in the quotation which suggests that the 13 process that one should follow is to make every effort 14 to persuade a colleague to change his or her practice 15 and then take things further if that's unsuccessful, is 16 that an attempt to balance what might be conflicting 17 obligations here? One is to communicate with and behave 18 respectfully towards colleagues and the other is, at the 19 end of the day, always to prioritise patient care. Is 20 that why that step is incorporated, do you think? 21 A. I think so. I will double-check with Professor McNair. 22 PROFESSOR MCNAIR: So I agree with that broadly. I think 23 that there are different ways that individuals can 24 exercise their duty to make sure that patient care and 25 patient standards are maintained. One of those Page 27
1 reason to believe the ability of a colleague to provide 2 a high standard of care is compromised." 3 Again, we've touched on this in a broad sense 4 already, but those particular obligations to the way in 5 which one interacts with colleagues and the way in which 6 one requires to put the interests of patients at the 7 forefront of decision-making with regard to colleagues' 8 clinical practice, are these important ethical rules or 9 standards that should be applied in neurosurgical 10 practice? 11 A. Yes, I believe they are. 12 Q. And I suppose I'll ask my favourite question for today 13 which is: why? 14 A. I would go back to the notions we've touched on already 15 a few times this morning of benefit and harm. So 16 certainly, if one looks to the regulator, first and 17 foremost, for all doctors essentially the General 18 Medical Council says, at the top of its duties as 19 a doctor, at the top of its central document Good 20 Medical Practice, that one should be making the care of 21 patients one's first concern. So that means we should 22 be minded to work towards the benefit of patients and 23 the avoidance of harm to patients and everything else is 24 subordinate. 25 But I would obviously add the rejoinder or the Page 26	1 mechanisms would be to raise it with the individual 2 because if somebody is subject to the same professional 3 standards and perhaps hadn't recognised that patient 4 care, for whatever reason, was below standard by, you 5 know, in the view of another person, that that may be 6 all the action that needs to be taken to rectify the 7 situation and then patient care would be at its highest 8 standard again. 9 We've seen in other documents, and I'm afraid 10 I can't remember exactly which ones, but the more 11 UK-centric documents also describe a kind of escalating 12 approach to these sorts of concerns, and so that 13 certainly alliance with other documents outwith this 14 one. 15 Q. Thank you. And just one other aspect from this document 16 which again, is a slight refinement on aspects we've 17 discussed, so over the page to 74, please. It's the 18 quote on the right-hand side, back to risks and benefits 19 but a particular aspect of that. It says: 20 "We may describe risks and benefits as cited in the 21 world literature, but we must also describe our own 22 experience and results with the patients we treat when 23 requested." 24 So again, there's another individualising component 25 to that, as I understand it, but in this sense, Page 28

7 (Pages 25 to 28)

1 individualising it to the position of the surgeon such 2 that it's not good enough simply to say: well, the risks 3 of this procedure, they're well-known, cited in the 4 textbooks as 4% or something like that. One needs to be 5 honest enough to convey your own experience of 6 a particular neurosurgery; is that what this is getting 7 at? 8 PROFESSOR MCNAIR: I think so. And I would extend it 9 perhaps to individualising information based on patient 10 factors as well because their own experience, you're 11 bringing one part to this conversation, this is my 12 practice, and potentially my results but similarly, 13 patients have factors that may influence the outcomes of 14 treatment and individualising that information to 15 a patient's particular circumstance would, again, fall 16 in line with the other ethical obligations. 17 Q. So there are various factors at play here which need to 18 be balanced up against each other in order that the 19 clinical decision-making and performance is optimised. 20 In particular, if there were information available that 21 a surgeon's ability to carry out a particular surgery 22 and his experience of it, his ability was impaired or 23 his experience was less perhaps than others, combined 24 with the fact that the patient had a particularly high 25 concern about things, those things might gravitate to Page 29	1 We talked yesterday about academic sources, and in 2 part of the conversation, Professor Huxtable made it 3 clear that academic sources would need to be approached 4 with a certain degree of caution on the basis that they 5 rank lowest, if you like, in terms of the three main 6 types of authoritative standard setting sources. But 7 also that dependent on a particular time, dependent on 8 a particular nature of the academic source, dependent on 9 how accepted or controversial its content might be, that 10 might either heighten or lower the extent to which it 11 would inform the answer to our fundamental question. 12 Now, one aspect of this which may be actually more 13 of a practical question in relation to the use of 14 literature, would be trying to understand, in relation 15 to surgical ethics in particular, what sorts of 16 literature, let's say a consultant neurosurgeon would be 17 expected to have regard to and a broad understanding of 18 informing him or herself to be able to make good 19 ethical decisions? 20 PROFESSOR HUXTABLE: So my way of approaching this question 21 would be to turn some of what I said yesterday on its 22 head and I engaged with concepts of authority, influence 23 and what you might say mere interest yesterday. 24 One could convey the same essential ideas but 25 basically ask: what would be the consequences for me if Page 31
1 conspire or combine to leading to a very different 2 outcome than might be the case in what one might 3 describe as a standard case. Is that correct? 4 PROFESSOR MCNAIR: Yes. 5 Q. Thank you, that's helpful. You've provided, in your 6 report, a very helpful analysis of both general ethical 7 approaches to surgery and then, in a more particularised 8 sense, aspects of standards relating to neurosurgery. 9 And we've seen some of those in the materials we've 10 looked at already but I'd like to look at some of the 11 things you've told us and explore some of the concepts, 12 in particular, looking here and there at some of the 13 literature you've cited. I wonder before I do that if 14 I could ask a general question. 15 We discussed yesterday the multiplicity of different 16 sources that one could look to, to try to answer the 17 fundamental question that we've asked again and again, 18 which is what are the ethical rules, the ethical 19 standards relating to a particular practice or 20 situation. And we discussed yesterday that there would 21 be a sort of a hierarchy of different standards and that 22 one would need to take care in a particular area to work 23 out where one should be looking, but also how 24 authoritative certain standards might be in helping 25 answering that question. Page 30	1 I failed to read and heed the information in front of 2 me, the document let's say, rather than a podcast or 3 similar? So let's say I have got an academic text in 4 front of me, what are the consequences if I fail to 5 engage with it, fail to follow it? Well, possibly none. 6 Perhaps at most, if all one's peers have read said 7 document and think it's right and follow it, perhaps 8 there might be a degree of negative judgment in the 9 community but strictly speaking, no major consequences 10 expected to flow from not reading an academic tome. 11 And then, as one proceeds through the professional 12 ethical literature, so the guidance from various 13 organisations, I find myself looking through what are 14 the consequences of failing to heed a given document 15 from a given organisation. So some, as I suggested 16 yesterday, although held in high regard, I would 17 suggest, the BMA's guidance perhaps has less teeth if 18 one fails to follow it. But then once one gets into, 19 arguably the World Federation of Neurosurgical Societies 20 but certainly once one is into the Royal College and the 21 General Medical Council, then failure to heed such 22 guidance will, in all likelihood, lead to deleterious 23 consequences again. So potentially the loss of one's 24 licence to practice, for example. 25 So does that begin to answer the question? Page 32

1 Q. It does, yes. I suppose what you mentioned there was if 2 one has an academic tome in front of one, that would 3 tend to imply that there's probably a first hurdle as to 4 the accessibility of some journals. So, for example, 5 there may be, in a particular field, journals that 6 effectively consultant neurosurgeons might subscribe to 7 or be available to the hospital they worked in, there 8 would be standard reading, but there would be others 9 that would be more niche interest or perhaps more 10 controversial or that sort of thing. 11 In general terms, is that a concept which you would 12 recognise in terms of working out the exercise you're 13 carrying out which is trying to work out what is the 14 authority I should attach to this document? 15 PROFESSOR HUXTABLE: Yes, that's my understanding. 16 PROFESSOR MCNAIR: I think it's reasonable. Just to come 17 in, I was minded to refer to GMC's Good Medical Practice 18 through this initial discussion because domain one, 19 knowledge skills and development I think are relevant 20 here, and what's interesting about this document is that 21 it leads on being competent, the idea of being competent 22 and it lists five different things about being competent 23 and they include things such as keeping up to date with 24 guidelines in developments. You must follow the law, 25 our guidance on professional standards and other Page 33	1 aspects of medical practice, to what extent would it be 2 important for say a consultant, doctor of any kind, to 3 have regard not only to the main publications in his or 4 her field, but also have regard to publications which 5 are to do with ethics primarily, which I think exist 6 from the documents you've provided. And to what extent, 7 in practice, do you think that that actually happens? 8 PROFESSOR MCNAIR: Well, I don't think that the professional 9 guidelines particularly set this out, aside from these 10 statements, as you say, about keeping your professional 11 knowledge and skills up to date which I would believe is 12 a judgment-related issue. Is some of the more academic 13 debates about the nature of particular theoretical 14 ethics broadly applicable to the day-to-day working of 15 a neurosurgeon? I would probably say not necessarily 16 because we have structures like the regulators, or 17 professional bodies, who have taken on a role of, in 18 some ways, synthesising those opinions and providing 19 guidelines so that they can be operationalised. 20 I think on a practical basis, detailed engagement 21 with theoretical, ethical literature would not be 22 a common part of somebody's, for example, maintaining 23 their professional knowledge, unless there had been some 24 sort of step change, I guess, in the general approach to 25 those topics that would require the surgeon to revisit Page 35
1 regulations relevant to your work and these sorts of 2 statements. But you have to go a little further along, 3 all the way down to item 11, where you start getting to 4 "maintaining, developing and improving your 5 performance". And in this section it describes "you 6 must keep your professional knowledge and skills up to 7 date", but doesn't mandate how you would go about doing 8 that. 9 Q. Yes. 10 PROFESSOR MCNAIR: And so I think that that again, really 11 describes this hierarchy you've been setting out through 12 yesterday and today that the GMC is saying: well, if 13 there's law, guidance, guidelines, professional 14 standards, then they seem to be taking primacy. You 15 know, the keeping your professional knowledge and skills 16 up to date is probably something that is more a judgment 17 based on the particular scope of practice that you have. 18 Q. Thank you. In relation to that very question, 19 Professor McNair, the particular scope of practice that 20 you have, I noticed that a number of the authorities you 21 cited, at least to my untrained eye, look like they come 22 from what one might describe as more ethical journals 23 than say neurosurgical journals or surgical journals. 24 Because of the importance that we've discussed so far 25 and our developing understanding of ethics in all Page 34	1 them. 2 Q. Thank you. So with those reasonable limits in mind, the 3 requirement to maintain knowledge, that would go beyond 4 technical knowledge of neurosurgery or something, but 5 would have an ethical component to some extent. Would 6 you think that would be a reasonable interpretation of 7 that role? 8 PROFESSOR MCNAIR: That's definitely the case and is 9 explicit within good medical practice. 10 Q. Thank you. I'd like to look at various aspects of the 11 statement in order to try to understand the various 12 components, first of all of surgery in general that 13 you've helpfully set out in your report as being perhaps 14 distinctive and informative as regards what good ethical 15 practice within surgery is. 16 Now, I'm going to jump around the statement a little 17 bit and read out various passages which I think 18 helpfully bring together a number of concepts and then 19 we can discuss the importance of those in due course. 20 So if we go to the statement, please, at 21 paragraph 5.2. This is in a section where you are 22 telling us about academic positions on clinical freedom 23 and its limits. You tell us there: 24 "Various academic sources recognise that surgeons 25 have considerable power and freedom, but also that their Page 36

1 activities are constrained by obligations to others. 2 "Surgeons have power and freedom: 3 "Little's analysis, which others cite with 4 approval ... recognises that surgeons have power: 5 'Surgery conveys power, the power to enter the body of 6 another by cutting into it. That power is socially 7 endorsed, and may be reinforced by the surgeon's 8 individual charisma ..." 9 If I could just pause with that concept. A couple 10 of questions first of all. 11 The Little article which you pointed out, you tell 12 us later, the author is an Australian surgical 13 oncologist, I think. And first of all, could we take 14 that article as being kind of representative of the 15 question that we were talking about and try to work out 16 whether an article like that is the sort of thing that 17 one would expect a consultant surgeon of the time to be 18 familiar with? You mentioned that, for example, it's 19 cited later by others with approval. 20 PROFESSOR HUXTABLE: So I'll briefly mention something and 21 then perhaps Professor McNair would like to come in as 22 well. So the Little article, if I recall correctly, was 23 published in the journal Bioethics, so very much 24 a journal aimed, first and foremost, at I would suggest 25 academics working in the broad field of bioethics that Page 37	1 people interested in the study of ethics being surgeons 2 and otherwise. It would not be your sort of general 3 practising surgeon. If you wanted that message to get 4 to those individuals, you would probably choose 5 a different journal. I think in the UK, certainly 6 something like the British Journal of Surgeons is 7 something surgeons would commonly be aware of and read. 8 But then this creates an interesting kind of issue, 9 which is the journals and the journal editors will 10 choose which papers they publish based on what they 11 think their audience wants to read and the impact that 12 may have on the community or clinical practice. And so 13 we might find that some of these more 14 theoretically-leaning ethical pieces may well be 15 rejected from general surgical journals because they 16 think perhaps either it won't have the impact that the 17 authors expect, or that the surgeons won't read it and 18 incorporate it into their practice. So there is 19 an interesting relationship there between choice of 20 journal and impact. 21 Q. Thank you. As regards the particular passage that 22 you've taken from the Little article in Bioethics, just 23 a couple of questions about that. Is it correct to say 24 that what Little -- we'll go to look a bit more at the 25 Little article here, but what Little is saying is Page 39
1 we discussed yesterday. So certainly, from my 2 perspective, I would wouldn't personally expect, 3 routinely, surgeons and clinicians to be engaging with 4 that journal. But I do know certainly from 5 conversations -- this is very much anecdotal -- that 6 there are professional clinician colleagues who do 7 engage with that and similar journals in the medical 8 ethics field as well. 9 In terms of insofar as it might be helpful, my own 10 publication strategy on occasion is I know that there 11 are some journals where I will essentially be publishing 12 something to my peers, so people working academically in 13 medical ethics and law. And then sometimes I might take 14 the particular publication to a journal that reaches 15 either general doctors or specific subsets of doctors or 16 other health professionals because -- and I'm now 17 inferring from my own behaviour -- I recognise that 18 those are the places they're most likely to look. They 19 won't only look there, but most likely to look. 20 Professor McNair, do you want to come in? 21 PROFESSOR MCNAIR: Yes. I think choosing a journal for your 22 particular topic and publication does involve the 23 understanding of their audience and a journal such as 24 Bioethics, without going into a lot of detail on it, 25 I would expect its main audience would be ethicists and Page 38	1 a starting point in relation to ethics in relation to 2 surgery is that surgery involves a power dynamic, if you 3 like, which is imbalanced between the patient and the 4 surgeon. Is that correct? 5 PROFESSOR HUXTABLE: Yes, that's correct. 6 Q. And we'll get into the detail in due course, but as far 7 as that imbalance is concerned, how does that imbalance 8 manifest itself in an ethical context? 9 A. Well, I suppose I could just amplify the words from the 10 extract from Little, there is a sense that surgery and 11 therefore surgeons are special and distinctive in that 12 they may not be alone in doing so but they are amongst 13 those members of society empowered to invade another 14 person's body in ways that, certainly if we looked at 15 the law, ordinarily the criminal law would have a view 16 on it, it would have a negative view on. 17 So there's something special about the nature of 18 surgery. There is something -- and I think I am 19 beginning to tap into Little's analysis -- there's 20 something innately invasive and, by definition, harmful 21 about surgery and, in fact, one of the points advanced 22 by Little and indeed other academics in this field is 23 this surgery, in essence, it harms before it does 24 anything else because we are cutting into or otherwise 25 invading the body. Page 40

1 So it harms first but, of course, behind that is 2 a motivation to heal, to help, to benefit in some way. 3 Q. So I think you're right that this is a concept that 4 manifests itself in a number of the papers as a kind of 5 starting point. If we try to translate that into the 6 language of the equilibrium, does that mean that surgery 7 starts off with a maleficent act and therefore there 8 needs to be greater effort in the other areas to 9 counterbalance that, or is that too simplistic? 10 PROFESSOR MCNAIR: So I'd like to come in at this point 11 because I feel that this line of argument is extremely 12 helpful within the context of, for example, this Inquiry 13 and the lens within reviewing surgical practice. But 14 I don't feel like it's unique and I'm sure my oncology 15 colleagues would agree with me that delivering 16 chemotherapy agents to somebody with cancer also causes 17 harm in the short-term with the potential for long-term 18 benefit. And so I agree with the proposition but would 19 just be mindful that we don't think that this is wholly 20 unique to surgery but it is extremely useful to try and 21 frame our discussions from here on in. 22 Q. Understood, that's very helpful indeed. One phrase that 23 I must admit I have struggled with is the one to do with 24 "the power socially endorsed and may be reinforced by 25 the surgeon's individual charisma". Do you have any Page 41	1 manner and approach is how they process or express the 2 power that they hold. 3 Q. Thank you. We'll come back to the context in a moment, 4 we won't go past that. But I think it's easier to bring 5 it in, in a slightly different point in the analysis, if 6 that's okay. 7 Can we go to paragraph 3.8, please, where you very 8 helpfully flesh out Little's position in relation to the 9 particular characteristics of surgery and refer to some 10 other more recent authors that are reflected on the same 11 subject. Just bringing that up. This is in the context 12 of pointing out that there are various different 13 approaches to the question as to whether surgical ethics 14 give rise to particular different rules or whether they 15 are, in fact, just a sort of refinement if one likes, to 16 put it like that, of general rules. And you've set out 17 already in the statement above this, two positions and 18 you've now come to a third position which is supported 19 by a certain body of literature. If we could zoom in, 20 please. 21 It says: 22 "The third position holds that surgical ethics does 23 give rise to different considerations from the field of 24 medical ethics more generally, as it has distinctive 25 features, which require the specification of particular Page 43
1 insight into what Little maybe getting in that regard? 2 PROFESSOR HUXTABLE: So, I certainly have a reflection on 3 the first clause, the idea that the power is socially 4 endorsed, so it's that idea I mentioned a moment ago, 5 that the law empowers surgeons to do things that the 6 rest of us, generally speaking, can't do. So I can't, 7 as a private citizen, be cutting into other bodies, for 8 example. With regard to a surgeon's individual charisma 9 I'm going to, perhaps unfairly, defer to my colleague. 10 PROFESSOR MCNAIR: I found this statement interesting. 11 I must admit, if we're going to have an extensive 12 discussion about it I would like to see it within its 13 full context. Because the power dynamic I think is 14 created by having an individual who is the conduit for 15 a patient having benefits, so the idea of beneficence, 16 or avoiding harm together with maintaining the autonomy. 17 And this is particularly amplified because that 18 individual is in a vulnerable position, they have 19 a healthcare condition which makes them vulnerable. So 20 it is that process that creates the power dynamic. 21 And power, it influences an individual's behaviour 22 in a number of different ways, and we can see that both 23 within a healthcare context and outside of a healthcare 24 context, and I guess one of those kind of, I guess, 25 influencing factors on somebody's personality and their Page 42	1 approaches, which attend to the particularities of 2 surgery. This position implies that surgical ethics 3 gives rise to given considerations from the field of 4 medical ethics more generally. 5 "Little, who was an Australian surgical oncologist, 6 felt 'there is clearly something distinctive about 7 surgery' ... Various other authors similarly refer to 8 the 'distinctive' ..., 'unique .., or 'special' 9 characteristics of surgery. Authors like Ferreres, 10 a surgeon based in Buenos Aires and Washington, suggest 11 that these different features 'necessitate a specialized 12 ethical framework' such that surgical ethics 13 'differentiates itself from the field of medical 14 ethics'. 15 "The manual dexterity required of surgeons, along 16 with their use of devices potentially generate 17 distinctive ethical obligations. However, scholars like 18 Ferreres tend to highlight six features of surgery, 19 which they consider to be distinctive and ethically 20 salient: 21 "Surgery harms before healing and curing the 22 patient ... 23 "The operating room concentrates risk and error ... 24 "Surgical decision-making occurs under radical 25 uncertainty ... Page 44

1 "Surgery carries unique accountability ... 2 "The surgical relationship embodies extraordinary 3 intimacy and vulnerability ... 4 "Surgery evolves rapidly ..." 5 And then, at paragraph 3.15, please, further down. 6 It says there, just reading halfway through the first 7 paragraph: 8 "Little suggests that these distinctive features are 9 captured by five categories of surgical ethics. The 10 first four of these describe the patient's experiences, 11 while the fifth is more normative, in requiring the 12 surgeon to address the patient's needs. The five 13 categories described by Little are: 14 "Rescue: In order to be 'rescued', the patient 15 submits to the skill -- and power -- of the surgeon ... 16 "Proximity: The patient-surgeon relationship tends 17 to be intense intimate, and time-limited ... 18 "Ordeal: The patient will undergo an extreme, 19 disruptive experience ... 20 "Aftermath: The patient will live with the -- 21 [possibly] negative -- experience and impact of 22 surgery ..." 23 And finally: 24 "Presence: The surgeon should recognise that their 25 presence is both a virtue and a duty, which requires Page 45	1 of the surgical relationship and suggests that there are 2 various components, I think, which are characteristic to 3 the surgical relationship with a patient which mean that 4 perhaps it needs to be looked at in a different way with 5 regard to ethical considerations. Is that, broadly 6 speaking, what we're looking at here; a particular 7 academic approach, looking at surgery in particular, 8 which leads us perhaps to considering that surgery has 9 different or heightened ethical considerations compared 10 to other medical ethics? 11 PROFESSOR HUXTABLE: That's right. 12 PROFESSOR MCNAIR: Although again I would just come in here 13 because I feel -- and when we wrote this I thought quite 14 carefully about these different sections because one can 15 argue the counterfactual and we won't now, but I could 16 go through examples potentially of other disciplines 17 where perhaps these different concepts that Little 18 describes also apply. The reason why I think this is 19 helpful for this Inquiry is because this approach to 20 ethics and this approach to viewing surgical practice is 21 potentially a lens through which we can gain insights 22 that meet this Inquiry's objectives. So it is very much 23 not the only approved approach, and I would be very 24 cautious to say that the ethical obligations, for 25 example of a surgeon, in some way are heightened above Page 47
1 them to attend to such needs of the patient as might 2 arise in any or all of the previous four categories. 3 Little suggests that patients 'want the surgeon's 4 presence', both throughout the process of surgery and in 5 its aftermath; 'That presence is at best a real, 6 physical, cognitive and engaged presence; at least 7 a delegated presence in which junior doctors and nursing 8 staff express the surgeon's engagement and concern'." 9 And then back to paragraph 5.4.1. You say there 10 that: 11 "Little goes on to note that, 'as with all power', 12 the power enjoyed by surgeons 'must be constantly 13 renewed and re-validated. In surgery, that renewal and 14 re-validation is derived from surgery's techne (its 15 technical capabilities), its episteme (its knowledge 16 base), and its phronesis (practical wisdom or 17 judgement)' ... Little suggests that this power is in 18 service to -- and therefore constrained by -- the 19 obligation to 'rescue' the patient, which he sees as one 20 of the distinctive aspects of surgical ethics ... As 21 Little puts it, 'there is always an element of surrender 22 in the surgical relationship', but this 'is a surrender 23 that presupposes rescue'." 24 So a lot of different concepts there, but this 25 appears to embody a particular assessment of the nature Page 46	1 any other doctor or in any other situation but this is 2 a very useful way for us to gain insights to help 3 understand this particular situation. 4 Q. Thank you, that's understood and that obviously links 5 into your previous comments about, by way of example, 6 oncology as being a field where one does harm in order 7 to try to improve the overall condition of the patient. 8 What I'm seeking to elicit here, professor, is not in 9 any way some league table or competition between the 10 various different fields of medical practice, but in 11 particular to contextualise surgery -- and oncology or 12 other fields may also be in the same category -- as 13 being one where there are heightened obligations because 14 of the particular nature of the relationship, in 15 particular when one considers it in the context of 16 general medical ethical rules. 17 The reason why that's important is it may not be the 18 most difficult, but it's higher up, therefore if we are 19 looking at generalised medical ethical guidance, is it 20 the case that your opinion, as you've expressed it, is 21 to the effect that surgery, along with possibly other 22 medical fields, requires a particular ethical approach 23 because of its particular characteristics and so simply 24 looking at general medical ethical guidance would not 25 give one the full story? Page 48

1 PROFESSOR HUXTABLE: Well, I would say broadly, yes, but 2 with the note of caution that, of course, we have 3 focused here on Little and others who see surgery as 4 either distinctive or "heightened" in your words but we 5 should remember there are at least two other schools of 6 thought, support all of them. One would say it is 7 not that special, in fact, it's just a general 8 application and others would say perhaps it's a slightly 9 more general, slightly more specific application. So it 10 becomes a little theoretical, a little abstract and 11 a little technical but certainly the view you advance is 12 one of the views that's out there and that's certainly 13 Little's view. 14 Q. Thank you. I won't go into the various different 15 components of the rescue, proximity, aftermath or 16 presence but there's one aspect I did want to focus in 17 on which may be of relevance to us and that's presence. 18 It said, to remind us: 19 "The surgeon should recognise that their presence is 20 both a virtue and a duty, which requires them to attend 21 to such needs of the patient as might arise in any or 22 all of the previous four categories [rescue, proximity, 23 ordeal or aftermath]. Little suggests that patients 24 'want the surgeon's presence', both throughout the 25 process of surgery and in its aftermath; 'That presence Page 49	1 then realises or achieves the benefit that was proposed 2 at the beginning. 3 Q. So again, does that lead to a greater ethical 4 requirement to have regard to the individualised needs 5 of a patient in a surgical situation than perhaps in 6 a situation where, in oncology, albeit extremely risky 7 and initially harmful, anyone could administer the drug? 8 PROFESSOR MCNAIR: That would follow. 9 Q. Thank you, I appreciate that. Just to go to the passage 10 you mention because I think it is helpful if we can try 11 and look at this in its full context. If we could look 12 at ELJ0002-00110. This is the Little paper. And if we 13 can just focus in. As you said earlier, 14 Professor Huxtable, or perhaps Professor McNair, I can't 15 remember, this is from the journal Bioethics and one can 16 see, if we scroll up to the top, this is from 2002, so 17 a publication which you had selected, I think, of being 18 of particular relevance to the period we are looking at 19 in terms of academic thinking at least on ethics in 20 surgery, is that right? 21 PROFESSOR MCNAIR: Yes. 22 Q. If we could go to page 3, please. This is where the 23 author is telling us about the five categories that we 24 just looked at and their significance and the first of 25 those was "rescue" and this is where this charisma idea Page 51
1 is at best a real, physical, cognitive and engaged 2 presence; at least a delegated presence in which junior 3 doctors and nursing staff express the surgeon's 4 engagement and concern'." 5 So I think what Little is doing here is highlighting 6 this is a particular important feature of surgery, given 7 its particular risks and characteristics and that it is 8 important therefore, in an ethical sense, to understand 9 that it would be perfectly reasonable for patients in 10 those circumstances to be highly reliant upon a surgeon 11 being present, not just physically present although that 12 is a component, but present in a wider sense in their 13 care. Is that what Little is getting at here? 14 PROFESSOR HUXTABLE: Yes. 15 PROFESSOR MCNAIR: I think so and for me the key idea is 16 that the mechanism through which surgery achieves its 17 benefit, as an ethical principle, involves some of these 18 ideas of skill or dexterity that perhaps are different 19 to my other example of delivering oncology medicines, 20 for example, because the process of benefit, of 21 receiving chemotherapy, of course happens through the 22 way that the drug works and its pharmacology and tumour 23 biology, for example, whereas in surgery the mechanism 24 through which benefit is gained is through a typically 25 surgeon's hands, skills or dexterity where the patient Page 50	1 appears. The author says: 2 "Rescue. 3 "Surgery conveys power, the power to enter the body 4 of another by cutting into it. That power is socially 5 endorsed, and may be reinforced by the surgeon's 6 individual charisma, but as with all power it must be 7 constantly renewed and re-validated. In surgery, that 8 renewal and re-validation is derived from ..." 9 Various other things that I have already set out. 10 And it says: 11 "Power must be analysed as something ..." 12 This is Foucault, saying that: 13 "Power must be analysed as something that 14 circulates, or rather as something which only functions 15 in the form of a chain. It is never localised here or 16 there, never in anybody's hands, never appropriated as 17 a commodity or piece of wealth. Power is employed and 18 exercised through a net-like organisation. And not only 19 do individuals circulate between its threads; they are 20 always in the position of simultaneously undergoing and 21 exercising this power. They are not only its inert or 22 consenting target; they are always also the elements of 23 its articulation. In other words, individuals are the 24 vehicles of power, not its points of application. 25 "This formulation of power enables us to distinguish Page 52

1 at least four different types of power that the surgeon 2 may have." 3 So the context, if it's helpful, Professor McNair, 4 it may more or may not be, is in that first aspect of 5 the surgical relationship, the need for rescue and the 6 importance of power. Does that help us at all in 7 understanding the reference to charisma? There is 8 a reference at the bottom to another text but I don't 9 think that helps us because it just tells us the title? 10 PROFESSOR MCNAIR: Yes, I think that this does provide the 11 sort of broader context that Little is arguing. 12 Q. Does it help us with defining what he means by the fact 13 that the power, which although, as Professor Huxtable 14 said is socially endorsed, may be reinforced by the 15 surgeon's individual charisma? If I could propose what 16 that might mean, I wondered whether, in that power 17 relationship, it is important to understand that because 18 the patient is seeking rescue and because, as you said 19 a moment ago, there's an individualised requirement to 20 rely on the surgeon's dexterity and individual skill, 21 the possibility that a charismatic surgeon may suggested 22 something may make it all the more attractive to the 23 individual. And that's something which an ethically 24 minded surgeon should bear in mind when deciding how to 25 approach, for example, consenting a patient for surgery. Page 53	1 through to the present day, that there were very 2 considerably more academic pieces of literature on what 3 one might describe as palliative care ethics than 4 surgery. The score came in 1,566 to palliative care 5 only 52 to surgery. 6 Was there a point associated with that in terms of 7 whether surgical ethics was something that -- were you 8 trying to make the point that it didn't feature very 9 much in the literature compared to other areas? 10 PROFESSOR HUXTABLE: Broadly, yes. And I would attach, 11 again, a note of caution to the search. It was a search 12 undertaken by me, it was a very quick search. Obviously 13 in the academic sector we're used to running much more 14 robust, systemic searches with very many more steps to 15 them. But this was to give a sense of my growing 16 impression and I was essentially seeking to validate, so 17 far as I could within limited time, that impression. 18 And the impression was that I was not encountering 19 a wealth of literature from the ethics perspective on 20 surgery and those sources I was identifying tended, not 21 entirely, but tended to come from outside the UK. I was 22 mindful we were being asked to look at surgical ethics 23 particularly, first and foremost, from the UK. And so 24 I was hoping to find much more of that, but I did not 25 find too much. Perhaps with more time and different Page 55
1 Is that fair? 2 PROFESSOR MCNAIR: That's a fair argument. 3 Q. I'm not dwelling on this simply for academic interest, 4 there is an important component in this in relation to 5 the matters that we are looking at in terms of 6 Mr Eljamel's presentation to patients, the extent which 7 he was looked at as a figure of considerable wisdom, 8 experience, charisma, if I could put it like that, 9 certainly by colleagues, and no doubt by patients. So 10 that important characteristic is one which is of interest 11 to us. Do you think that that explanation is what 12 Little is talking about? 13 A. Without knowing the details of -- within that context, 14 then yes, I think that the relationship here between 15 power and charisma is described as that sort of broad 16 web in that Foucault quote there, so yes. 17 Q. Thank you, that's very helpful. One thing I just wanted 18 to ask you quickly about, I don't necessarily need to go 19 to the report for this, but you very helpfully, when 20 doing your extensive search for articles that might be 21 of assistance to us, undertook a relative search looking 22 for articles related to surgical ethics in various 23 different time periods and you did a comparator, 24 I think, with palliative care ethics. And the result of 25 that was that you found, back from 1995 all the way Page 54	1 methods we would find more, but I chose the comparator 2 of palliative care because it's another field in which 3 I have done a great deal of work over recent decades 4 because I knew it was extensive there. 5 Q. Thank you very much. So yes, you've deliberately chosen 6 that as being one that would score highly but the 7 exercise is to try to convey the impression that you had 8 in your researches, that surgical ethics may not be 9 a subject which features in the literature; it features 10 low in the league table, if I can put it that way? 11 A. That's my sense, yes. 12 Q. That's very helpful. We'll come on to a text in due 13 course that you also talk about which may give us some 14 further insight into that question. But that would be 15 an appropriate moment, sir, for a break? 16 THE CHAIR: Yes, indeed. Gentlemen, we'll take a 15-minute 17 break now and aim to start again at 11.35. Thank you. 18 (11.20 am) 19 (A short break) 20 (11.42 am) 21 THE CHAIR: Right, can we have the witnesses back, please. 22 Mr Dawson. 23 MR DAWSON: Thank you. Can you see and hear me okay, 24 gentlemen? 25 PROFESSOR HUXTABLE: Yes. Page 56

1 Q. Great, thank you. I just wondered if -- we were talking 2 there about surgical ethical articles and ones that 3 related to palliative care and going through aspects of 4 the report which tell us something about themes that 5 arise, particularly in the field of surgical ethics 6 generally. Could we look at the report at 7 paragraph 3.4, please. 8 In this paragraph we're talking about one of the two 9 previous approaches, I think. We talked about the third 10 option. This is one where we're talking about surgical 11 ethics as the application of general medical ethics in 12 a slightly different interpretation of the way in which 13 surgical ethics should be viewed. It says, just over 14 halfway through: 15 "Other authors instead (or also) emphasise that 16 surgeons need good characters, so they should exhibit 17 particular virtues ..." 18 And you cite various sources there: 19 "... Such as perseverance, punctuality, fairness, 20 honesty, kindness and teamwork. 21 "Sources on surgical ethics also often refer to 22 areas of applied ethics, particularly the four 23 principles approach in medical ethics [which we've gone 24 through already] and the specific obligations that these 25 generate, such as the obligation to ensure that patients Page 57	1 but a couple that we perhaps haven't touched on which 2 certain authors identify as important virtues are 3 perseverance, punctuality and fairness. Now, are these 4 characteristics which either the literature or you 5 consider to be important in surgeons and, if so, why? 6 PROFESSOR HUXTABLE: Yes, I think certainly the literature 7 cited would suggest they're important. I can see, at 8 first blush, the reason for their importance. One might 9 need to persevere with, for example, a complex or 10 difficult procedure. One needs to be punctual not least 11 with regards to the individual patient on whom you are 12 about to operate, they have certain expectations about 13 when that will occur, but of course your colleagues and 14 other patients later down the list will also have 15 expectations. So punctuality I can see as a virtue. 16 And then the third one you referred to, fairness. In 17 that regard I would say this aligns with that principle 18 of justice generally. So one, for example, should be 19 treating patients fairly, equitably in the sense of not 20 favouring patients for any particular characteristic or 21 the like, but basically treating all patients equally, 22 essentially. 23 Q. Thank you. One of the sources that you refer to there 24 and indeed you attribute this general view to this text 25 or this individual author is the McCullough text. Could Page 59
1 provide informed consent. 2 "Some sources on surgical ethics therefore see the 3 scope of surgical ethics as 'the way in which the 4 procedural nature of surgery and its capacity for bodily 5 and psychic damage modify general ethical considerations 6 such as virtues consequences, rights, justice, and 7 equality'. This view, which has been attributed to 8 McCullough et al ... essentially holds 'that the ethics 9 of surgery is a special case of the general ethics of 10 medicine'." 11 So first of all, I think that identifies that that 12 particular approach, which one might see in the 13 McCullough text, is a slightly different interpretation 14 of the way that surgical ethics should be viewed, not as 15 a separate discipline but of one that has different 16 characteristics but should be viewed as a special case 17 or modification of those to apply to the particular 18 ethical issues that arise in surgery; is that right? 19 PROFESSOR HUXTABLE: That's right. 20 Q. I just wondered if we could dwell on something that 21 I think we'll come back to later and we've mentioned 22 already is the surgeon's requirement to have good 23 character and exhibit particular virtues, such as 24 perseverance, punctuality, fairness, honesty, kindness 25 and teamwork, we've touched on some of these already, Page 58	1 we have up, please, on the screen -- there's a couple of 2 things I want to get to with this. Have up on the 3 screen, please, ELJ0002-00115. Just zoom in, please, 4 on that. This is I think from a book called "Surgical 5 Ethics" is that right? 6 A. That's correct, yes. 7 Q. So this is the first chapter, I think. I actually have 8 the book in front of me and there was a couple just 9 quite general aspects I wanted to put to you. You have 10 produced, in order to extract some important commentary 11 which we'll get to in a moment, the first chapter, 12 I think, as an exhibit to your statement. But it says, 13 in this book, which was published by Oxford University 14 Press, I think, in 1998, it says that: 15 "This the first textbook on the subject of surgical 16 ethics. This is a practical, clinically comprehensive 17 guide to ethical issues and surgical practice, research 18 and education written by some of the most prominent 19 figures in the fields of surgery and bioethics. 20 Discussions of informed consent, confidentiality and 21 advanced directives, core concepts integral to every 22 surgeon-patient relationship open the volume. Seven 23 chapters tackle the ethical issues in surgical practice, 24 covering the full range of surgical patients, including 25 emergency, acute, high-risk, elective, poor surgical Page 60

1 risk and dying patients. The book even considers the 2 special relationship between the surgeon and patients 3 who are family members or friends." (As read) 4 So, in 1998 the authors -- I should say there are 5 three authors. There is Professor McCullough who is 6 described as the professor of medicine, community 7 medicine and medical ethics at Baylor College in 8 Houston. Professor James Jones, who is a professor of 9 surgery, cell biology and medical ethics at Baylor 10 University as well, and Professor Brody, who is the 11 professor of biomedical ethics and director of centre 12 for medical ethics at Baylor as well. So these 13 experienced authors, who I think are put together as 14 "the McCullough approach" in your statement, have 15 written what is claimed to be the first textbook on the 16 subject of surgical ethics. Now, I won't go into 17 whether that's the case or not but would it be correct 18 to take this as being one of the first or a major tome 19 in relation to the advancement or development of 20 surgical ethics as a field? 21 PROFESSOR HUXTABLE: That's my impression, it's a major tome 22 and it probably is amongst the first. I would add some 23 caution yet again, in fact, we could go once again all 24 the way back to the Hippocratic Corpus and suggest that 25 the principles there, there's reference to surgical Page 61	1 Q. It's a very important caveat for one particular reason 2 I'm going to ask you about in a moment, but for the 3 moment what I'd just like to focus on is what it is that 4 you have taken from this book as being particularly 5 important. And I think one of the things that you tell 6 us that you have taken from this book, in the statement, 7 is there are concepts of the patient in authority and 8 the surgeon as fiduciary from the text that you've 9 looked at. Could you tell us a little bit what that 10 approach to surgical ethics is trying to emphasise? 11 A. So I will offer a view, but it may also be helpful to be 12 directed to the relevant passage of the report? 13 Q. Yes, well, if you go to the text which is on the screen, 14 if we could just scroll down a little bit. Sorry, 15 I'm working from multiple different copies here. If we 16 go down to the bottom of page 4. You see "Basic 17 Concepts" and "The Basic Rights of Patients". There's 18 a passage there which I think is what you're referring 19 to, which says: 20 "Surgical ethics is based on a recognition of the 21 rights of patients who require the care of surgeons. 22 Although it is understood that the surgeon is 23 'an authority' in the practice and outcomes of surgery, 24 it is the patient who is 'in authority' -- that is, the 25 individual in the transaction between caregiver and Page 63
1 ethics. So it's not going to be the first, full stop, 2 but it could be, in contemporary terms, amongst the 3 first. 4 The major caveat I would add is that all three 5 authors are based in one institution in the US and 6 I think therefore the remainder of the book has a very 7 much US focus. 8 Q. I was going to ask a question about that because you 9 counselled us, I think, helpfully yesterday when looking 10 at sources one should be careful about looking at their 11 timing but also as to what their reach is in terms of 12 their geographical area because I don't know but it 13 might be that in America, approach to surgical ethics 14 because of the different healthcare system, for example, 15 might be different than some of the considerations that 16 pertain within the NHS, for example, in the UK. 17 It is a book that's published by Oxford University 18 Press though. So it is one that appears to have been 19 published in the UK at least. 20 PROFESSOR HUXTABLE: Presumably so. I may not be entirely 21 correct on this, but I believe that OUP and similar 22 publishers have offices globally. So it may well be 23 a British publisher but it might actually have been 24 published in the US, but I wouldn't want to press that 25 too far. Page 62	1 care-seeker on whom the salient rights devolve." 2 Then it goes on to explain that the patient has 3 a number of different rights. So that was the concept 4 that I think you introduce in your analysis in the 5 statement of the patient being in authority. Now, 6 what's the importance of that concept? 7 PROFESSOR HUXTABLE: So I think what's being referred to 8 there, we can cast in terms of our familiar principle in 9 respect for autonomy. So the patient is the one who 10 gets to make the relevant choice or choices, the 11 decision about for example whether or not to proceed 12 with surgery. The surgeon then is the authority in 13 relation to conducting that surgery, its pros, cons, 14 side effects and the like. And where there was that 15 reference you made a moment ago to the fiduciary 16 relationship, I think what's being referred to there is 17 the sense that the patient trusts in the doctor. So 18 it's notions of trust that are coming to the fore there. 19 That's my interpretation, at least what we've just heard 20 from those passages. 21 Q. Yes, I'll take you down to the bit that refers to 22 fiduciary. If you scroll to the final paragraph, 23 starting "the concept of acting": 24 "The concept of acting as moral fiduciary of the 25 patient is central to virtually all of surgical ethics. Page 64

1 The moral character of the conscientious surgeon is 2 therefore one of the central themes addressed in this 3 book. The law provides a useful departure point for 4 understanding this ethical concept. Being a fiduciary 5 is legally understood to be 'a person holding the 6 character of trustee, in respect of the trust and 7 confidence involved in it and scrupulous good faith and 8 candour which it requires', and also to be 'a person 9 having duty, created by his undertaking, to act 10 primarily for another's benefit in matters connected 11 with such undertaking'. The key concept here is that 12 a fiduciary should put aside self-interest, focus 13 primarily on the interest for the person for whom he or 14 she serves as fiduciary, act to protect and promote 15 that's individual's interest, and so earn the trust and 16 confidence of that individual. The concept of the 17 surgeon as the patient's moral fiduciary captures these 18 ideas in the following way. The surgeon should make the 19 protection and promotion of the patient's interests the 20 primary consideration in the surgeon-patient 21 relationship and in surgical research and education. 22 This primary commitment holds self-interest in check and 23 makes it a systematically secondary consideration. 24 Self-interest is thus blunted and not permitted to 25 generate the vice of selfishness in the surgeon's Page 65	1 I have a copy of the book in front of me and 2 I'm just going to read you a passage because it's very 3 important, I think, to observe in reading this passage 4 that we recall what Professor Huxtable said about the 5 fact that this is effectively an American text. 6 However, there are some concepts here which will lead 7 into our later discussion in relation to consent that 8 I wanted to ask you about. The chapter is called: 9 "Informed consent: Autonomous decision-making of the 10 surgical patient." 11 And the first page and a half of this is as follows: 12 "The clinical skills required in the informed 13 consent process tend not to be taught to fellows, 14 residents and medical students within the formal 15 curriculum. Furthermore, surgical residents are seldom 16 supervised during their communication with patients. As 17 a result, faculty and trainees alike forego 18 an opportunity to identify, evaluate and address 19 weaknesses in the resident's interpersonal skills with 20 patients generally and during the informed consent 21 dialogue in particular. Surgical practice is 22 distinctive in that the surgical patient plays a more 23 passive role than patients of other medical specialties 24 once anaesthesia is induced. The patient then becomes 25 incapable of participatory interoperative Page 67
1 professional character. This makes the fiduciary's role 2 morally demanding. 3 "When the surgeon's ethical, fiduciary-based 4 obligations come into conflict with self-interest, the 5 surgeon confronts the ethical issue of conflict of 6 interest." 7 So I think this bears out what you've said 8 there about -- it's drawing on a legal concept almost to 9 describe it, but it's an important aspect of the 10 relationship which I think gives rise to a number of 11 subsidiary obligations involving the need to develop 12 trust, the duty of candour and the need to put 13 self-interest to one side; is that a fair summary? 14 PROFESSOR HUXTABLE: Yes, it is. 15 Q. Now, there's one aspect of this book which I wanted to 16 bring to your attention. Unfortunately, if we scroll 17 all the way down to the bottom of this extract, I wasn't 18 quite aware until I checked it in the early hours of 19 this morning, but this is a limitation of -- if we go 20 right to the end of this chapter, the bottom page, if 21 you look at the left-hand page, you can see there that 22 this is the end of chapter 1. And scroll across to the 23 right, that's the beginning of chapter 2. 24 Unfortunately, it's that page that I wanted to read 25 from. Page 66	1 decision-making. The surgeon has full control of the 2 decision-making process at this point. As a result 3 surgeons may have a less fully developed sense of 4 an active physician-patient partnership in the work of 5 healing than colleagues in other specialties and this 6 can affect their approach to the informed consent 7 process. The surgeon may also assume that the referring 8 physician has already made the necessary intellectual 9 and emotional preparations and effectively has obtained 10 the patient's consent for surgical resolution of the 11 clinical problem. In combination, these factors can 12 lead the unwitting surgeon to underestimate the capacity 13 and willingness of the patient to participate in the 14 informed consent process that should proceed induction 15 of anaesthesia. As a consequence, the surgeon can lose 16 the opportunity to form an effective therapeutic 17 alliance with the patient. Our approach to informed 18 consent in this chapter responds to these ethical 19 challenges and opportunities. We consider informed 20 consent a morally essential course of action that the 21 surgeon should utilise to form a strong therapeutic 22 alliance with the patient. Our evaluation of the 23 informed consent process in surgical practice will 24 include assessment of how the process should occur under 25 both uncomplicated and adverse conditions to ensure the Page 68

1 mutual rights and responsibilities of all involved 2 parties. We first provide an ethical analysis of the 3 concept of informed consent. We then discuss its 4 implementation in typical and atypical circumstances." 5 (As read) 6 So of course with the caveat that this is talking 7 about obviously the American system and particular 8 issues that Professor McCullough et al have experienced 9 there, I just wanted to try and draw out whether there 10 are issues there relating to the practice of surgeons 11 generally. So what it's saying -- obviously and this 12 was in an American context -- is that there are dangers, 13 I think, in the way in which patients come to be in 14 front of a surgeon, if I can put it that way, which mean 15 that there is a possibility at least that a surgeon may 16 underestimate the importance of the informed consent 17 process and, as Professor McNair told us yesterday, that 18 has a kind of domino effect potentially in the sense 19 that if people are studying to be surgeons, if they see 20 from their mentors that there's an underdeveloped sense 21 of informed consent in the process, then that can have 22 an effect more widely. 23 I wonder, before we go into our later detailed 24 analysis of informed consent, whether these features are 25 purely factors of a different system, or they are Page 69	1 move on to this later so I won't dwell on that, but that 2 evolving concept in the mid to late 1990s and its 3 relationship with the concept of informed consent and 4 alignment behind patient-centred care, I think was 5 a very known topic in 1998. And so they were making 6 an important point but I would hope, even by 1998, that 7 that underestimation was starting to fade, and something 8 that would be less of an issue -- I mean, certainly 9 an issue, but I would hope even in 1998 people weren't 10 underestimating the importance of autonomy. And we'll 11 come to that based on the professional guidance and 12 informed consent. 13 I completely agree with the therapeutic alliance and 14 I completely agree that once somebody is under 15 anaesthesia, they can't be consulted on interoperative 16 decision-making. Sometimes that interoperative 17 decision-making will have a bearing on patients' 18 preferences and other times it may not. What I mean by 19 that is that, for example, there are many different ways 20 to perform operations typically and a surgeon's approach 21 to them may vary and, say, for example, intraoperatively 22 somebody may decide to perform a dissection over here, 23 or over there, then that perhaps may not impact on 24 somebody's preferences or choices around an on 25 operation. But, for example, if they encounter Page 71
1 dangers which one can recognise as the starting point 2 for a need for particular care to be taken in informed 3 consent in surgical and particularly neurosurgical 4 processes? 5 PROFESSOR MCNAIR: I can start and please just guide me if 6 I am straying from where you want to take this 7 discussion. My first thoughts of the passage relate to 8 the time rather than the location, with the publication 9 in 1998, and the passage starts with a description of 10 training that I think is relatively contemporaneous to 11 the time. So describing things not being taught and the 12 role models who perhaps are not communicating or 13 performing informed consent to a standard expected in, 14 for example, 1998. And my reflection on that is that 15 the role models that existed in 1998 were probably 16 training in medicine maybe 20 years earlier so are 17 possibly reliant upon kind of ethical standards that 18 were even less developed than where they were in 1998. 19 The extension of that around surgeons 20 underestimating the role of patients within informed 21 consent kind of practice, I think was a very important 22 point to make in 1998 but perhaps, in my understanding 23 in the historical context, things were already very much 24 moving on, especially when we consider the allied 25 concept of shared decision-making. And I know you'll Page 70	1 a difficulty and if they need to remove a different part 2 of the brain, for example, or a different organ of the 3 body then that absolutely would. 4 So there is some complexity there, but I completely 5 fully support the idea that once somebody is under 6 anaesthesia then they are not capable of making or 7 contributing to those decisions. 8 Q. Well, there are two things I draw out of that. That's 9 very helpful, thank you, Professor McNair. The first 10 thing is that your description of looking back to the 11 past and seeing 1998 as a period where we're moving into 12 a different culture is precisely the way in which the 13 McCullough text has been viewed by the Inquiry so far, 14 on the basis that this is precisely what the authors are 15 trying to do. They are trying to say: this is the way 16 things have worked and there's a danger this may still 17 be going on. Let us try to help you with the way it 18 should work going forward, in particular on consent but 19 on a number of other areas as well; is that broadly the 20 right interpretation? 21 PROFESSOR MCNAIR: I think so and I think that's a very 22 useful way of thinking about it, in that a lot of this 23 knowledge was out and available within these various 24 different sources but as with the permeation of any sort 25 of practice, there will be people at the vanguard and Page 72

1 there will be laggards who haven't changed, so yes. 2 Q. Thank you, and on the other specific point that you 3 raised which is of particular significance, you've 4 helpfully put it in a neurosurgical context for us. 5 You, I think, are trying to create a difference, 6 a distinction, based on this important concept that in 7 a surgical process involving a general anaesthetic, like 8 neurosurgical interventions tend to be, one requires to 9 approach consent in a particular way because there will 10 be a point at which the patient will not be able to 11 participate in that therapeutic alliance. So you, 12 I think, are trying to distinguish between two separate 13 scenarios, one which has ethical implications or 14 consent-based implications and one which does not. And 15 I'd be interested in exploring that as you brought it 16 up. 17 One, I think you said, is a situation where you 18 might be doing something slightly different from what it 19 was that you agreed with the patient but not materially 20 different, such that the patient would be unlikely to 21 have made any different consent choices if they were 22 aware you were going to do it. 23 And then the alternative situation, which I think 24 was an extreme situation, was one where you were saying 25 you did a craniotomy, you opened up the brain and you Page 73	1 a particular piece of equipment within the surgery 2 because clearly for them, as an engineer with 3 a background, that is important for them to understand. 4 However, other patients, that might not make any 5 difference to their reasoning and therefore, by getting 6 to know my patient ahead of time, I can tailor that 7 information in an appropriate way. And so I think for 8 me, it really hinges on this idea of getting to know the 9 patient in front of you in order to tailor that 10 information. 11 Q. So I think there's two components there, just again to 12 draw that out. If you are trying to educate yourself as 13 a surgeon to a sufficient level, to do your job 14 ethically, I think what you need to do is think of two 15 particular components. One is what are the individual 16 preference, values, priorities of this patient, is that 17 right? 18 PROFESSOR MCNAIR: Yes. 19 Q. And the other is what are the various predictable, or 20 reasonably predictable, complexities or difficulties 21 that might be faced, such that I can canvas those within 22 the context of the individual's choices at a stage when 23 they can participate in that discussion, so that I can 24 inform myself as best I can as to what they would want 25 me to do if they could participate in it during the Page 75
1 resected a different part of the brain or something like 2 that. Now, just without looking at those particular 3 scenarios, they I think represent two different ends of 4 the scale, why are those two things, from an ethical 5 perspective, different, those two scenarios? 6 PROFESSOR MCNAIR: I think I'm going to refer to the idea 7 that we covered before around patient-centred care of 8 understanding what is important to the individual. And 9 within this context, you can see these conversations 10 going in different directions and these are things 11 I think all surgeons as well have had experience of, 12 that if you understand an individual in front of you, 13 and understand how they are reasoning, so what sort of 14 factors are contributing to their preferences in the 15 decision-making process, then that guides you to the 16 sorts of information one would communicate beforehand 17 around what events might take place within an operation 18 when you would no longer contribute to decision-making 19 processes. 20 So, I'll try and think of some examples. I meet 21 some patients -- and this is a broad generalisation -- 22 is when I meet an engineer, by professional background, 23 they often are incredibly interested in my use of 24 devices, maybe energy, different sorts of techniques and 25 I might describe to somebody the use of, for example, Page 74	1 surgery. Is that a fair assessment of what an ethical 2 approach would be? 3 A. Yes, I think that sounds fair. 4 Q. That's extremely helpful, thank you. Did you have 5 something to add, Professor Huxtable? 6 PROFESSOR HUXTABLE: Yes, thank you very much. So I would 7 take it all the way back, as Professor McNair has 8 implicitly done, to the idea of respect for patient 9 autonomy, patient choice, self-rule and the like. 10 I have just written a note to myself to clarify my 11 thinking. If I step all the way back, what I would be 12 thinking is if I'm in the moment, I should be thinking: 13 what, in my good faith judgment, is within the bounds of 14 the permission I have been granted? 15 Q. That's a very helpful way to put it, thank you. 16 I'd like to move on from McCullough and into some of the 17 other concepts, trying to take them at a bit higher 18 level because you've given us a lot of detail around 19 these things. But you've told us there are a number of 20 other -- we've looked at some of them -- but a number of 21 other important features of surgery that have an ethical 22 consequence or lead to certain ethical consequences. If 23 we could look, please, at paragraph 3.14. I think it's 24 extracted from one of the texts, the Ferreres text that 25 we've talked about, but this is a characteristic of Page 76

1 surgery that you've highlighted in particular as being 2 of importance. It's that "surgery carries unique 3 accountability". I wonder if you could tell us what you 4 meant by that? 5 PROFESSOR HUXTABLE: This is, if I recall correctly -- yes, 6 looking at the references I think I'm correct in 7 recalling that this was a point made by Ferreres who is 8 an author who has published various chapters, and indeed 9 books, on surgical ethics in relatively recent years. 10 And so, as you see from the paragraph, Ferreres is 11 suggesting there's something specific, unique in his 12 words, about surgery in terms of where ultimately the 13 buck stops if something, certainly something 14 problematic, occurs in relation to surgery and he 15 attempts, in some of his writing, to distinguish surgery 16 from, for example, the pharmaceutical products which 17 might be more predictable whereas there's a degree of 18 uncertainty in surgery. I think that's broadly what 19 Ferreres was referring to. 20 Q. Thank you. I think also there was an element of that 21 which resonated with something that Professor McNair 22 said earlier about the skill and dexterity of the 23 particular surgeon being an important component of 24 an ethical patient-doctor relationship and indeed, in 25 that passage a few lines from the bottom, it's referring Page 77	1 acquire knowledge and skills, and 'embody the attitude 2 and behaviors expected of them such as forming 3 relationships with and having a devotion to their 4 patients'." 5 And if we read further down in paragraph 5.10.2, it 6 refers to the GMC guidance about five lines up from the 7 bottom: 8 "GMC guidance on raising a concern further conveys 9 how the commitment to patient safety overrides other 10 obligations, including to an employer: 'You must not 11 enter into contracts or agreements with your employing 12 or contracting body that seek to prevent you from or 13 restrict you in raising concerns about patient safety. 14 Contracts or agreements are void if they intend to stop 15 an employee from making a protected disclosure'." 16 So I'm interested in this idea that the surgeon 17 requires to form relationships with and have devotion to 18 their patients. In particular that first element, which 19 may again resonate with what Professor McNair was 20 telling us about the need to develop an individualised 21 understanding of what a patient might want us to do in 22 certain foreseeable or indeed unforeseeable situations 23 during the course of a surgery. Is that what that 24 passage -- it's slightly flowery language, but it's 25 getting at the need to develop that relationship on Page 79
1 to literature but focusing in on the responsibility 2 tending to lie with an individual surgeon. And I think 3 from earlier text, that should be understood within the 4 context of that doesn't necessarily mean one surgeon has 5 to do everything because one can have juniors, but the 6 juniors are still under the ambit of the individual 7 surgeon's responsibility and that is a very important 8 component of the relationship. Is that what this body 9 of thought is directed towards? 10 PROFESSOR HUXTABLE: Yes, it certainly does seem to be, yes. 11 Q. Thank you. Another aspect, which I think we've touched 12 on already at paragraph 3.15, relating, I think, to the 13 fiduciary relationship, is that the surgical 14 relationship embodies extraordinary intimacy and 15 vulnerability. That might be said in particular of 16 neurosurgery; is that correct? 17 A. Yes, I think so. 18 Q. Thank you. And if we could have a look, please, at 19 paragraph 5.10. Again, you're talking here about 20 obligation surgeons owe to their patients. An aspect 21 I just wanted to draw out with you is you're referring 22 here to the Castlen et al text, where it's said they: 23 "... note how, in return for autonomy and power, 24 doctors owe obligations to 'provide professional and 25 ethical care', which (inter alia) requires them to Page 78	1 an individual level? 2 PROFESSOR HUXTABLE: I think so. So, I would, first and 3 foremost, tether it to a familiar concept that recurs 4 throughout our report because it recurs throughout the 5 GMC's position, that's of working to the benefit of 6 patients and having patient care at the centre of what 7 one does, that's your first obligation. So all of this 8 is supposed to be in service to that, the idea of that 9 ethical obligation. So if what is to benefit patients 10 then one should form a relationship with a patient. 11 The further point I'd make because it relates to 12 some observations we've made in recent minutes is the 13 idea that consent, for example, is not one and done. It 14 is not get a signature on a form and that's the end. 15 There is the phrase we heard from McCullough et al 16 earlier of "consent is a process". And once you're into 17 a process of course, to my mind, that implies 18 a relationship, an ongoing relationship through time. 19 Q. You've not seen the notes I have in front of me but that 20 was precisely what I was about to ask you about, 21 professor. The particular question I was going to ask 22 was, to put what you've just said and also what 23 Professor McNair told us earlier about the need to 24 develop those relationships into a more practical 25 context. Does it not follow that in order to do what is Page 80

1 necessary and ethical, time needs to be taken by 2 a surgeon to be able to develop the requisite 3 understanding to be able to carry out a surgery 4 ethically? 5 PROFESSOR HUXTABLE: In a word, yes. 6 Q. Anything to add to that from a practical perspective, 7 Professor McNair? 8 PROFESSOR MCNAIR: Yes, time is very important. Time, as is 9 a resource, is something that we can talk about perhaps 10 at a later stage but the ethical guidance is all very 11 clear that we have an obligation to get to know our 12 patients for the reasons that we've described up until 13 now. I'll just add that in addition to decision-making 14 being a process, over time with deliberations, so 15 considering of all the different facts and information 16 and revisiting the information and building on the 17 relationships, decision-making is also what we call 18 distributed because it isn't just between, for example, 19 a surgeon and a patient. 20 We will find that other people contribute to the 21 reasoning of everyone involved in a shared decision. 22 So, for example, family members or loved ones may 23 contribute in their own way. We might find different 24 members of the multi-disciplinary team providing 25 different perspectives. So if you were to consider Page 81	1 don't know what the outcome is going to be and it is 2 typically irreversible so you are not able to return to 3 your original state once it has been completed, and that 4 has uncertainty. 5 Q. Thank you. I wonder whether I might be able to put the 6 conversation we've been having over the last 10, 7 15 minutes into the context of the equilibrium and the 8 four principles approach, because I wonder if you would 9 agree with this. 10 In a surgical relationship, we've discussed already 11 the fact that there is automatic harm being done and 12 that being a feature of some of the ethical analyses as 13 being an important component of ethical decision-making. 14 But because of the uncertainty involved in 15 a neurosurgery, the possibility for further harm to be 16 done is also heightened perhaps beyond other types of 17 procedure. 18 As a result of that, in terms of the equilibrium, is 19 that one of the reasons why it is important to go 20 through the process that we've discussed of taking 21 particular care in relation to understanding and 22 respecting the autonomy of the individual, to reset the 23 equilibrium in a principlism-type approach? 24 PROFESSOR HUXTABLE: I would succinctly say, yes, and 25 a quick addition to that "yes" would be every individual Page 83
1 a patient's journey over time where they may meet 2 a surgeon, for example, maybe two or three times but 3 they will have conversations relevant to the 4 decision-making process amongst other people at 5 different times, then we start to build up a picture of 6 how we start to understand our patient and their context 7 better. 8 Q. Thank you. And one aspect I wonder, in that process, 9 which might apply to neurosurgery as a characteristic is 10 the significant degree of uncertainty that's involved in 11 it. Is that a factor which complicates that process and 12 therefore requires more diligence on the part of the 13 ethical surgeon? 14 PROFESSOR MCNAIR: Yes, and I will perhaps draw a line 15 between this idea and one characteristic of surgery 16 which is that usually surgical care is delivered, as 17 we've said, with a patient unconscious at a particular 18 moment in time. And so the outcomes of surgery, be them 19 benefits or harms, are not known beforehand in a way 20 that somebody can alter their decision-making. And 21 I raise this because, for example, if you start taking 22 a pill, you will know its potential side effects or 23 benefits and you could potentially stop that pill 24 partway through your treatment as a result. Whereas 25 usually surgery is perceived as different in that you Page 82	1 I would hypothesise has a different attitude to risk. 2 So it's certainly important to think not only from the 3 surgeon's perspective about what counts as a risk, what 4 counts as a harm, what counts indeed as a benefit, but 5 look into the patient's account. Because some patients 6 will be more willing to run some risks than other 7 patients. 8 Q. Thank you. One concept, I think I mentioned earlier but 9 has certainly come up in evidence from other places in 10 various places, Royal College, GMC etc, is a concept 11 which one witness told us he had only ever seen this 12 word used in professional guidance for doctors and 13 surgeons, which is the word "probity". It features in, 14 I think, all of the editions of Good Surgical Practice 15 that you have sent us and I wonder if you could tell us 16 first of all is it something with which you are familiar 17 in particular in the surgical field, and, if so, can you 18 tell us why it is, from your perspective, that probity 19 is an important ethical component of good surgical 20 practice? 21 PROFESSOR HUXTABLE: Well, I'll offer, if you like, the 22 academic perspective on this but then I will quickly 23 defer to my colleague. 24 So in terms of the academic perspective, so this 25 idea of probity for me instantly kind of gives notions Page 84

1 of honesty and the two words I used earlier on, that of 2 good faith. So one of the examples, if you'll indulge 3 me, that I occasionally use with my undergraduate 4 medical students when teaching about notions of honesty 5 and the like would be if one is deciding whether or not 6 to proceed with a procedure, whatever that procedure 7 might be, on let's say a Friday afternoon, one shouldn't 8 be making a decision based on whether one can get to the 9 golf course quickly. That would be a decision in 10 so-called bad faith, there wouldn't seem to be the 11 relevant integrity or probity to that decision. It 12 should be led by, as in all things, considerations of 13 benefit or harm to that patient. 14 So I certainly think, from a general academic 15 ethical perspective, notions of probity, honesty, 16 integrity and the like are entangled and ethically 17 important. Much as I said earlier, they might be 18 freestanding obligations or they may be linked to other 19 things such as respect for autonomy or indeed benefit or 20 harm. 21 But Professor McNair will have more of a view of how 22 probity features in clinical practice. 23 Q. Thank you. 24 PROFESSOR MCNAIR: As you say, it does form a particular 25 part of clinical practice and I'm sifting through Page 85	1 a conflict of interest ... 2 "Avoid denigrating others ... 3 "Ensure that the literature provided by the 4 institution where they work and any interview they give 5 to the media does not make unreasonable claims; and ... 6 "Demonstrate honesty and objectivity when providing 7 references for colleagues and team members." 8 So this is a "must" obligation but I think there's 9 a general concept here of probity and these are some 10 particular examples, as I understand it. And I think as 11 time goes on, as one tends to see in the guidance, the 12 number of examples increases as people realise: yes, 13 this is a big area we need to include in the next 14 version. But is that consistent with your general 15 positions on that matter? 16 PROFESSOR HUXTABLE: Yes, and I also can see some of the 17 words I used, or synonyms for the word I used. The word 18 "honesty" features there, the idea of good faith I think 19 is written through these examples given and you have the 20 idea that I concluded with of attending to the interests 21 of the patient not other interests. So I think that's 22 embedded in the idea of conflict of interest. 23 PROFESSOR MCNAIR: And I guess if we think of a more common 24 word, I think a lot of these things align with integrity 25 which you did mention before. So if we take that Page 87
1 various guidelines because I don't have a definition of 2 "probity" at my fingertips I'm afraid. I was going to 3 describe it in a similar way to Professor Huxtable here. 4 But to add to it, it's this sort of central concept of 5 maintaining trust that the GMC is so keen to point out 6 and I think the word embodies this sort of, I guess, 7 attitude or actions in a way that support the broad 8 range of ethical obligations upon a doctor. 9 Q. If it's helpful, certainly I think the definition of 10 particular aspects of probity does change in the 11 different guidelines. But if one looks at 12 ELJ0002-00180. Page 32, please. 13 PROFESSOR MCNAIR: That's what I was looking through. Thank 14 you, you found it for me. 15 Q. Not at all, that's what I'm here for. This is the 2002 16 version, the original Good Surgical Practice one. And 17 it says: 18 "Probity in professional practice. 19 "Surgeons should adhere to all the principles set 20 out in Good Medical Practice. In particular, when 21 providing information surgeons must: 22 "Avoid any material that could be interpreted as 23 designed to promote their own expertise, either in 24 general or in a particular procedure ... 25 "Declare any commercial involvement that might cause Page 86	1 example of earlier evidence that people don't see the 2 word "probity" outside of professional guidance, I think 3 "integrity" probably would be a reasonable synonym 4 notwithstanding probably academic differences in the 5 definition. 6 Q. In light of that general definition and some of the 7 specifics here, would it be unethical for a consultant 8 neurosurgeon to misrepresent his qualifications on 9 a professional CV? 10 PROFESSOR MCNAIR: Yes. 11 PROFESSOR HUXTABLE: Yes. 12 Q. Why? 13 PROFESSOR MCNAIR: Because -- so, if we take that first 14 line: 15 "[Avoiding] material that could be interpreted as 16 designed to promote their own expertise, either in 17 [a] general or ... particular procedure." 18 I believe that would fit your example because it 19 would be promoting their expertise on their CV 20 inappropriately. 21 PROFESSOR HUXTABLE: And I would add it would be dishonest, 22 deceptive, misleading. So it would link to either 23 freestanding ethical obligations to be honest, open, etc 24 and/or those other obligations about benefit, harm and 25 respect for individual choices. Page 88

1 Q. It might also, in a practical sense, lead to someone 2 being appointed to a position for which they were not 3 actually properly qualified? 4 PROFESSOR MCNAIR: Correct. 5 PROFESSOR HUXTABLE: Yes. 6 Q. Which could have patient care implications? 7 PROFESSOR MCNAIR: Very much so. 8 Q. Thank you. I'm just going to break off our discussion 9 of the various ethical rules related to surgery and 10 neurosurgery simply to follow the way the statement is 11 set out. You were asked some questions which you've 12 helpfully engaged with us on relating to professional 13 training. We've heard quite a lot of evidence already 14 about professional training, in particular in the field 15 of surgery and neurosurgery. You've given us some 16 helpful general information about that, as I say which 17 we've covered with other witnesses, but also the 18 specific aspect that you were asked about which you 19 helped us with was the question as to whether ethics and 20 ethical concepts and surgical ethics were included 21 within teaching of people who will eventually be in 22 a position where they have to make good ethical 23 decisions. And you told us that, I think, there were 24 what one might consider -- and indeed we have seen in 25 other context to be -- both formal and informal methods Page 89	1 ethics education of future doctors, in order to equip 2 them with the relevant tools they needed to make said 3 judgments in their professional practice. 4 So, those have grown over time. Do I think this is 5 sufficient? I, as one might expect of an ethics 6 educator, would always say there should be more room 7 given in the undergraduate curriculum and particularly, 8 to my mind, nowadays the postgraduate curriculum to 9 ethics education. I would say I think ethics education 10 at the undergraduate level is reasonably well advanced 11 at this stage, from two sources. So the General Medical 12 Council itself has recognised the importance and done so 13 by the early 1990s of ethics education for 14 undergraduate, so medical students. And that nowadays, 15 the "Outcomes for Graduates" is the modern document. 16 That starts with ethical obligations to really signal 17 the importance of this education. But that is all 18 supplemented, complemented and expanded upon by 19 a document from the charity of the Institute of Medical 20 Ethics which sets out more flesh on the bones of 21 a medical ethics curriculum for all five, usually, years 22 of the undergraduate curriculum. 23 So, in short, I think there's been growing 24 recognition over the last three or four decades of the 25 need for more formal equipping of medical students and Page 91
1 of such education being given. And if we can go to the 2 statement again please at page 27. You tell us there in 3 relation to formal methods, again, you're going to the 4 text by Ferreres, he says that: 5 "... surgical education must address not just what 6 Bosk called the 'ethics of technique' but the 'technique 7 of ethics' -- the practical skills needed to navigate 8 moral complexity in real time'. " 9 That seemed to be quite a pithy quote to be able to 10 encapsulate a number of the concepts you discuss here, 11 but could you tell us why there is an importance that 12 training involve training on the technique of ethics, 13 and whether, in your view, there has been and is 14 sufficient emphasis on that training? 15 PROFESSOR HUXTABLE: Yes, thank you. So there has been 16 recognition that, if I go back to the concept 17 I introduced much earlier today of judgment. But if 18 a surgeon in this instance is to exercise their judgment 19 then they almost certainly need a toolkit to help them 20 exercise said judgment. So they will learn from 21 different sources, both informal and formal. And it was 22 increasingly recognised over time -- and I can tell you 23 more about the timeline if that would be of interest -- 24 but it was increasingly recognised in the late 1980s 25 that there needed to be more overt, indeed formal, Page 90	1 doctors of the toolkit of ethics. I personally would 2 always make a plea for there being more but there is 3 certainly, I suspect, more now than there was 30, 4 40 years ago. 5 Q. Okay. Thank you. Professor McNair, any perspectives on 6 that aspect? 7 PROFESSOR MCNAIR: Yes, probably an elaboration. We 8 internally debated this phrase "hidden curriculum" which 9 you referred to in 4.1.2 and it's a direct quote so we 10 include it. But I have a little bit of concern about 11 the idea of a hidden curriculum. In that sense, 12 a curriculum sort of defining what people need to be 13 educated on for example and I think a document such as 14 Good Medical Practice actually do set out, in quite 15 broad and deep terms, the curriculum of what makes 16 a good doctor especially around ideas of ethics and, as 17 you say, the centrality of ethics and the primacy of 18 certain concepts and much of good medical practice is 19 aligned with good ethical judgment. 20 So the bit that I feel is hidden is the delivery of 21 that education rather than the curriculum itself. And 22 so what the postgraduate curriculum typically consists 23 of is a sort of apprenticeship-type model, where 24 surgeons in training are observing and participating in 25 educational activities alongside senior and fully Page 92

1 trained members of staff. And so the bit that's 2 difficult to get under the bonnet of is how that 3 education is being delivered in a way that supports the 4 curriculum which I think is, at least explicit within 5 the extent of, you know the words on the page are 6 perhaps not as comprehensive as Professor Huxtable would 7 like. 8 Q. Thank you. The hidden curriculum, I think, comes again 9 from Ferreres, or does it? Yes, it does. 10 PROFESSOR MCNAIR: It does. 11 Q. And at page 28, the sort of upside and the downside of 12 the informal training appear to be laid out, where it 13 suggests that, sorry, on the previous page at 4.1.2: 14 "... 'When residents observe attending surgeons 15 obtaining truly informed consent, acknowledging 16 uncertainty, or admitting error, they learn ethical 17 practice more powerfully than through any lecture'." 18 But it also suggests that there's a possibility, at 19 the end of that paragraph, that in the negative 20 situation "students might learn the wrong lessons from 21 poor role models." 22 One aspect of that that is interesting in this 23 context, I think, is the suggestion that it's not just 24 a question, when obtaining truly informed consent, of 25 seeing people doing that, but also seeing people who Page 93	1 people will be better or worse at different things. 2 I would certainly expect that everyone would meet 3 a particular standard, but there may be some educators 4 who are particularly good at this, and some educators 5 who are merely acceptable at this. And so the exposure 6 to a best practice or good practice may well be variable 7 within somebody's training experience. 8 Q. Thank you. If we could look, please, at page 45 of the 9 statement. Up at the top, please, 7.10.1. This is 10 actually a passage in which you're talking about the 11 particular features of neurosurgery and their ethical 12 implications if you like, but I wondered whether in fact 13 this may tie in with the discussion we were having been 14 training and its significance in ethics. I think you 15 referred to this earlier, the Shroeder article from 16 2018, Professor Huxtable, when you talked about 17 an important component of neurosurgery being the fact 18 that it involves operating on the brain and therefore 19 having implications for the self. I think that's 20 a Shroeder-related concept. But here, he also talks 21 about some of the distinctive features of neurosurgery 22 which in turn imply some ethical obligations. First: 23 "Caring beyond technical expertise. Shroeder 24 observes how the development of the technical aspects of 25 neurosurgery has meant that 'the human side of Page 95
1 acknowledge uncertainty or admit error as being 2 an important part of training. Do you have any 3 reflections on that aspect of things because it sort of 4 recognises the reality of human fallibility which, of 5 course, all surgeons possess? 6 PROFESSOR MCNAIR: Yes and possess -- I would say and again, 7 this is an anecdote from my perspective, is I think 8 surgeons have a very heightened sense of this. Mainly 9 because the weight of what we do has such profound 10 consequences that even if it isn't expressed perhaps 11 outwardly, the surgeons that I know are incredibly 12 introspective and reflective individuals and so it does 13 weigh heavily on them. Again, just in terms of 14 reflection, I take a slight issue with the word 15 "informal education" and I don't know how my educational 16 colleagues would have taken that last week, for example. 17 I think that my postgraduate surgical training is 18 very formal and structured and, generally speaking, 19 transparent and well supervised. But I think there's 20 an important point to raise here, that the educators, 21 the senior team, need to be -- well, are subject, and 22 need to be practising medicine at a level that fully 23 supports the whole range of concepts that we've talk 24 about over the last day, day and a half. And as is the 25 nature of, I guess, performance is that some of those Page 94	1 neurosurgery has often been lost or ignored'. Shroeder 2 implies that neurosurgeons should be better prepared 'to 3 deal with the nonmedical, or at least less medical parts 4 of caring for their patients'." 5 Now, what that seeks to set out is the possibility 6 that the way that training and thinking and the 7 attractiveness of the particular field to certain people 8 tends to attract people who perhaps are more interested 9 in the technical side of the neurosurgery and less 10 interested in what he describes as the human side of 11 neurosurgery. 12 This again, has some resonance in the materials that 13 we are looking at and the specific matters we are 14 discussing and therefore it's of interest to us to 15 understand this. Is it possible that neurosurgery may 16 have, as a detriment, the fact that it attracts people 17 who are particularly interested in the technical perhaps 18 to the detriment of the human? 19 PROFESSOR HUXTABLE: Well, I suspect it's possible but 20 I mean, both the passage and the question make several 21 empirical claims or even predictions which -- certainly 22 I have never tested them empirically. So I am slightly 23 hesitant to answer that one but that seems consistent 24 with Schroeder's view. 25 PROFESSOR MCNAIR: I would second that. I don't have any Page 96

1 data to support that position and so I would sit that 2 within Schroeder's interpretation in the absence of us 3 searching and looking for evidence in one way or 4 another. 5 Q. Yes. Perhaps if we can address that on a more 6 theoretical level. If, on the hypothesis that this is 7 the case, that people are more interested in the 8 technical and attracted to the field because they're 9 more technical and less interested in the human. First 10 of all, just on a practical level I think as a result 11 of what Professor McNair has told us possibly more 12 than once, that wouldn't just be related to 13 an individual. Because of the way people were trained, 14 if that were true, it would have the effect of 15 promulgating that amongst future generations. Because 16 of what we've been talking about in the training field. 17 Because if you're learning from someone who is very 18 technically skilled and interested but doesn't 19 concentrate so much on the human side, that will tend to 20 be the way that you go because it's what you see; is 21 that correct? 22 PROFESSOR MCNAIR: I think that's a reasonable -- yes, 23 a reasonable proposition. 24 Q. And again, within that hypothesis, if it were to be the 25 case that that process were something that existed Page 97	1 practice, 'where much is unknown or at least unclear to 2 the general public' ... and even other clinicians. This 3 implies that more should be done to inform people about 4 neurosurgery, and -- by extension -- make the field more 5 transparent, accessible, comprehensible, and presumably 6 accountable." 7 So what Shroeder is getting at here is that what he 8 describes as a "mystical" area of practice is one that 9 is not only poorly understood, for perfectly 10 understandable reasons, by the general public which of 11 course includes potential patients, but also by other 12 clinicians. First of all, is that, Professor McNair, 13 that second part -- I can take the first part as read, 14 but does the second part, is that an accurate 15 representation of neurosurgery as far as other 16 clinicians are concerned? 17 PROFESSOR MCNAIR: I would very much like to hear from 18 a neurosurgeon about that, so I don't know if that 19 question was put to one of my neurosurgical colleagues. 20 The obligations around scope of practice are clear that 21 we should keep ourselves up to date within a particular 22 scope and practice, so the intersection of, say, my 23 practice with neurosurgical practice is relatively 24 narrow. Sometimes neurosurgeons do procedures that 25 connect the brain to the abdomen, for example, and so Page 99
1 within the field of neurosurgery, would it therefore be 2 all the more important, when people are being trained, 3 that emphasis be put on the importance of the human side 4 in ethical decision-making? 5 PROFESSOR MCNAIR: I agree with that position. I think in 6 some ways you're talking about culture change, I guess, 7 on some level, and if the thought experiment is that 8 there is a culture within neurosurgery that propagates 9 the technical over the human side of things, then the 10 extension would be efforts need to be made from within 11 and without to change the culture, to align with Good 12 Medical Practice, which not only really has a single 13 domain around skills but has three other domains which 14 you could interpret as being around the human side of 15 surgery. 16 Q. Thank you. While we're at this passage it might be 17 worth you looking at some of the other things. We've 18 covered, with Professor Huxtable, the concept of 19 thinking about brains and cells. This is where we're 20 looking at some of Schroeder's concepts as to why 21 neurosurgery might be ethically different from other 22 fields. One aspect that he focuses on in accordance 23 with your narrative, is what is called "dispelling the 24 mystery": 25 "Shroeder sees neurosurgery as a 'mystical' area of Page 98	1 I have some familiarity with those and then broader into 2 my general medical training as an undergraduate. So 3 because I'm not a specialist within the field of 4 neuroscience I wouldn't attribute that necessarily to 5 being mystical. It's complicated but there are many 6 other aspects of medicine that are outside of my scope 7 of practice that I recognise to be complicated. 8 So I think probably the Inquiry would benefit from 9 a neurosurgical opinion on that as well. 10 Q. Okay, thank you. One aspect of the commentary that 11 you've helpfully provided to us, we've covered a number 12 of different areas of surgery and particularised that to 13 neurosurgery as we've gone through the analysis. But 14 one particular area which you've drawn our attention to 15 which, again, is of some particular interest to us is 16 the fact that there is some literature related to the 17 ethical position with regard to functional neurosurgery 18 which is something we are interested in, in this 19 Inquiry. In particular, if we look at the statement at 20 paragraph 7.7 you refer us to a paper from 2004 by Ford 21 and Henderson, which you say there: 22 "... suggest that 'neurosurgical ethics does not 23 constitute an ethic separate from general medical 24 ethics, surgical ethics, or neuroethics' ... However, 25 they recognise how neurosurgical ethics -- and Page 100

1 functional neurosurgery specifically -- presents 2 'significant unique textures' ... which 'add further 3 detail to some of the issues raised in general surgical 4 ethics'." 5 So again, within this more specific context, this is 6 that phenomenon we saw earlier, I think, of trying to 7 work out whether this is a separate body of ethical 8 rules or it's a refinement of a more general body or 9 a refinement of a more specific body. Is that broadly 10 the territory we're in here? 11 PROFESSOR HUXTABLE: That is, yes. 12 Q. Thank you. If we could look, please, at ELJ0002-00092. 13 This is the Ford and Henderson paper that you've 14 helpfully referred us to. It's from 2004, called 15 "Functional neurosurgical intervention: neuroethics in 16 the operating room". If we can just go over to page 2, 17 please, it tells us that: 18 "Evaluating ethics in neurosurgical practice 19 requires a re-evaluation and recalibration of the 20 analysis found in other areas of neuroethics. 21 Neurosurgical practice adds complexities to the 22 neuroethics [dimensions] because of the structure of 23 surgical teams, popular perceptions of surgery and 24 surgeons, and the relatively transitory nature of 25 patient-surgeon [relationship]. Although neurosurgical Page 101	1 This is in the third full paragraph. And reading 2 about six lines from the bottom on the right-hand side, 3 scroll down a bit, please, the word "Generally": 4 "Generally, the small window of interface prior to 5 surgery does not give the surgeon ample time to make 6 a full evaluation of complex relations and how they 7 interface with a patient's decision-making or health. 8 Although surgical teams rely a great deal on referring 9 physicians to identify these conflicts, it is important 10 to watch for warning signs that ethical problems may be 11 present. [It] is particularly true when dealing with 12 'functional' surgeries that have a potential to 13 alleviate the caregiver's burden at the expense of other 14 aspects of a patient's health." 15 So I think this is something that we talked about 16 earlier, that there's a need to take time to understand 17 these things, both in relation to neurosurgery and -- 18 this is particularised here -- in relation to what are 19 called functional surgeries, given what the authors 20 appear to think is a particular ethical risk in that 21 situation. Is that right? Is that what this is talking 22 about, the sort of concept that we talked about earlier? 23 PROFESSOR HUXTABLE: I think so, to which I'd add an element 24 of what this passage states that I think is worth noting 25 is there is a suggestion, perhaps more implicit than Page 103
1 ethics does not constitute an ethic separate from 2 general medical ethics, [the opinion you reflected in 3 the report] surgical ethics, or neuroethics, significant 4 unique textures must be taken into account. 5 Neuroethical issues discussed in other chapters of this 6 book have relevance and must be recognized when 7 evaluating ethically appropriate neurosurgical 8 practices. For instance, the ethical implications of 9 emerging neuroimaging cannot be ignored if neurosurgeons 10 rely upon these images for guidance in surgery. 11 Similarly, the issues of cognitive capacity must be 12 understood in order to evaluate informed consent 13 processes ... The interesting challenges come in 14 integrating these concerns into the events of 15 neurosurgery." 16 Then it goes on to have a look at functional 17 neurosurgery in particular in this article. And if we 18 go over to page 3, please. We probably want to put that 19 the right way around if we can. (Pause). If I could 20 maybe just read you out the passage. These passages 21 reflect on something we've already discussed but at 22 page 3, there's a passage in it where they're talking 23 about considering a patient's best interest and desires 24 and the need for a surgeon to recognise the competing 25 interests of patients and their social supports. Page 102	1 explicit, that one shouldn't expect every member of 2 a team to do everything. So there will be different 3 parts of the process over time that might be handled by 4 different members of the team or different teams 5 altogether, but I think what's important that's being 6 said here is although it might be right to rely on other 7 people for certain elements of the process, for example 8 earlier on there might be a more robust explanation of 9 the patient's values, what matters to them, the 10 neurosurgeon should still be alert to any signs that 11 further discussions are needed. 12 Q. Yes and I think what it's saying there is that the short 13 window of time that one has on the day of the surgery is 14 unlikely to be sufficient for that complex exercise to 15 be undertaken; is that correct? 16 PROFESSOR HUXTABLE: That's right. 17 Q. Yes, thank you. This article contains a lot of very 18 interesting reflections on neurosurgical ethics 19 generally but also particularised into the functional 20 area. I think what it's saying in relation to the 21 functional is that that is -- we've heard a bit about 22 what functional neurosurgery is from other people and it 23 seems to involve a situation which is more elective than 24 many other neurosurgical procedures and that's a matter 25 that's drawn out in the article. Page 104

1 To what extent does that aspect change the ethical 2 dimension of the decision-making? So if someone for 3 example is presenting, as we heard last week, with some 4 sort of tumour in the brain, it's, in many 5 circumstances, highly likely that the surgeon is going 6 to need to do something about that at some stage either 7 straight away or in relatively short order. The 8 functional neurosurgery side appeared to be one where, 9 as I understood it, the neurosurgeon would be offering 10 various procedures, often involving devices that would 11 involve trying to manipulate the nerves in some way as 12 to minimise the effects of a separate condition such as 13 pain or tremor or something like that. So in that sense 14 the procedure, and I think the article tells us this, is 15 more elective. 16 How does that change the ethical dilemma that's 17 faced by the surgeon? 18 PROFESSOR HUXTABLE: So I'll begin and then Professor McNair 19 may wish to come in. My understanding of the literature 20 I've seen broadly around the distinction between, if 21 I put it very loosely, necessarily versus elective 22 procedures, the ethical obligation bar is essentially 23 raised in relation to elective procedures precisely 24 because the individual is electing to undergo this, 25 there's less of a necessity to do so, such that, for Page 105	1 streamlines a process where professional opinion and 2 patient preferences are really closely aligned. 3 You're right that there is an added time dimension 4 there and time we can talk about, perhaps, shortly. 5 From a functional perspective, there is a greater need 6 to understand the functional impact on somebody's 7 quality of life which may be more subtle or nuanced or 8 communicated in ways that perhaps aren't as 9 straightforward as: I want to live longer than if I had 10 this cancer. And trying to unpick those quality of life 11 aspects, so as a secondary consideration -- forgive me, 12 say, for example you have a tremor in your hand, the 13 tremor in the hand is important but that might mean that 14 you can't hold a coffee cup or you can't drive, or these 15 are the sort of knock-on quality of life impacts. You 16 can't play golf. These things are important to 17 patients. 18 And therefore the reasoning involved in how much 19 benefit would this procedure potentially give you in 20 terms of tremor, and therefore how much quality of life 21 improvement might we see, are relatively more 22 complicated in that respect. And I agree with 23 Professor Huxtable in that context that the time of 24 that, the necessity or the urgency is typically less, 25 but it might not be. Page 107
1 example, we might raise the information bar, they might 2 be entitled to know about more what lies ahead. The 3 parallel might be drawn with research as opposed to 4 clinical treatment and care. 5 So in research, my impression is the information and 6 other ethical bars are raised to recognise that people 7 are volunteering their time, bodies and interests for 8 the good of others, in that instance. So that's my 9 sense, that the ethical bar is somehow raised if we're 10 talking elective. 11 PROFESSOR MCNAIR: I'm going to come in. In the interests 12 of a healthy academic debate, I'm going to challenge 13 that a little bit because in my thinking in one of these 14 contexts, and let's stick with a cancer context for 15 a minute, so neuro-oncology, my understanding would be 16 that in cancer care, patients often have very clear 17 preferences and that preference usually relates to 18 extending life. So certainly within my practice it's 19 very common for patients to want to extend their life 20 through cancer surgery. And that benefit is quite easy 21 to articulate and clear because if there is a surgical 22 procedure that might form part of your care then the 23 benefits of that procedure will very clearly align with 24 the most important preference that you have at the time 25 of making a decision and so that, in some ways, Page 106	1 Q. Thank you very much. 2 MR DAWSON: Sir, that would be a convenient moment to break 3 for lunch. 4 THE CHAIR: All right, thank you. Gentlemen, thank you. 5 We'll break now for an hour for lunch and hope to see 6 you back here at 1.55. Thank you. 7 (12.55 pm) 8 (The short adjournment) 9 (1.57 pm) 10 THE CHAIR: Can we have the witnesses, please. Good 11 afternoon, Mr Dawson. 12 MR DAWSON: Good afternoon, gentlemen. Can you see and hear 13 me okay? 14 PROFESSOR MCNAIR: Yes. 15 PROFESSOR HUXTABLE: Yes. 16 Q. Thank you. We were talking about functional surgery, 17 and moving onto a slightly different area, you've 18 helpfully provided us with some information under 19 reference to professional guidance, relating to what 20 happens when neurosurgery goes wrong and when patients 21 have been harmed. If we can go to paragraph 7.21, 22 please, of the statement. 23 You tell us here about a number of sources in 24 professional guidance, so that middle layer of the types 25 of sources you were looking at, and start in familiar Page 108

1 territory with the 2007 statement of ethics that we were 2 looking at earlier. So this is entitled "Professional 3 guidance that applies when neurosurgery patients have 4 been harmed": 5 "The WFNS statement offers some specific guidance, 6 which applies when patients are wronged or harmed in 7 their neurosurgery: 8 "Recognition and correction: The WFNS suggests that 9 neurosurgeons should be trained in, and capable of, 10 recognising and managing complications. This point is 11 made explicit in the section addressing innovation: 12 'Introduction of new practices into clinical practice 13 requires appropriate education and training of surgeons, 14 as well as evaluation of their use of the new 15 technology. The qualifications of those who propose to 16 use the new technology must be carefully assessed. 17 These individuals must have had comprehensive education 18 and experience in the management of the disease process 19 for which the technology is applied, and must acquire 20 the necessary technical skills and competence to 21 recognize and manage any complications resulting from 22 the new technology' ... 23 "Honesty. If wrongs or harms occur, the WFNS 24 recommends openness: 25 "we should be honest with patients and their Page 109	1 likely short-term and long-term effects' ... 2 "Apologise: A doctor should 'apologise (apologising 3 does not, of itself mean that you are admitting legal 4 liability for what's happened)' ... 5 "Correction: A doctor should 'put matters right, if 6 possible' ... 7 "Reporting and governance: A doctor should report 8 the incident and cooperate with complaints processes ... 9 "In Good Surgical Practice, the RCS provides its own 10 specific guidance on 'Being open when things go wrong'. 11 This draws on the GMC's Good Medical Practice. As with 12 the GMC, some passages of the RCS guidance state what 13 'must' happen, while others state what 'should' happen. 14 Key points and related principles include: 15 "Openness and honesty: 'Surgeons must be open and 16 honest with patients if things go wrong'. In line with 17 the GMC guidance, surgeons should 'explain what has 18 happened and the likely short-term and long-term 19 effects' ... 20 "Apologise: In line with the GMC guidance, surgeons 21 'should offer an apology'. '[W]here harm is linked to 22 an error, then an apology should [...] include an 23 acknowledgement and acceptance of responsibility -- this 24 is not an admission of legal liability' ... 25 "Correction: In line with the GMC guidance, surgeons Page 111
1 families about the reasons for complications, and 2 express our sincere regret when the situation does not 3 go according to plan' ... 4 "Redress. If wrongs or harms lead to legal 5 proceedings, then the WFNS recommends co-operation when 6 serving as an expert witness: 'We should cooperate with 7 lawyers to provide justice to those who may have 8 suffered through medical accidents' ... 9 "Neurosurgeons will also be subject to guidance that 10 applies to surgeons and doctors more generally whenever 11 patients are wronged or harmed. Some of this wider 12 guidance specifically concerns candour, which is dealt 13 with in detail elsewhere in this report ... Other 14 relevant guidance has been issued by: 15 "The General Medical Council ... 16 "Royal College of Surgeons of England ... and ... 17 "Healthcare Improvement Scotland ... 18 "The GMC's Good Medical Practice includes guidance 19 on 'Being open when things go wrong' ... Some passages 20 of the GMC guidance state what 'must' happen, while 21 others state what 'should' happen. The key points and 22 related principles are: 23 "Openness and honesty: 'You must be open and honest 24 with patients if things go wrong'. A doctor should 25 'explain fully and promptly what has happened and the Page 110	1 'should put matters right (if that is possible)...' ... 2 "Reporting and governance: Surgeons should 'Report 3 all incidents where significant harm has occurred 4 through the relevant governance processes of your 5 organisation'. They should co-operate with local 6 complaints procedures and '[p]articipate fully in any 7 investigations relating to significant harm, following 8 local guidelines'." 9 Now, the first aspect I just wanted to tease out 10 with you here is the 2007 document that we've looked at 11 contains a number of principles. You then refer, in 12 paragraph 7.23 and 7.24, to guidance within GMC and RCS 13 documents that we've looked at before. Is there any 14 particular difference between the sorts of important 15 ethical steps that appear in the later documents and the 16 former and is there any reason to think that what's 17 being suggested in the later one, 7.23 and 7.24, are 18 innovations on what happens in this situation? Because 19 my proposition to you is they're all consistent with 20 general principles that already existed. 21 PROFESSOR HUXTABLE: Yes, that's my sense as well. 22 PROFESSOR MCNAIR: I agree. 23 Q. Yes, that's very helpful because, of course, we are 24 trying to orientate ourselves in time and we have seen, 25 I think, some areas where the guidance has significantly Page 112

1 developed over time but here it appears that these 2 rules, which you framed helpfully under the most recent 3 guidance from the RCS and the GMC, are ones that would 4 have applied, I think, even during the relevant period 5 that we're looking at; is that fair? 6 PROFESSOR HUXTABLE: It is fair. If I may, I'll briefly add 7 that later passages paragraph 31.2, all the way through 8 to point 6 does give something of a timeline of the 9 General Medical Council's evolution but I still think 10 the general proposition stands, so the key principles 11 have been consistent since at least the 1990s, possibly 12 even before. Around about 1995 the GMC wasn't saying 13 a huge amount about this but it certainly was saying: 14 maintain good standards of care, be honest and 15 trustworthy, keep accurate records. And around about 16 1998 the GMC starts to say in the terms that the World 17 Federation then later says ten years later: notions of 18 dealing with complaints, to put things right, explain what 19 happens, offer apology. So, in short, yes, broad 20 principles. Although early on it was not as cashed out 21 as it became, but the principles I think were there. 22 THE CHAIR: I don't want to take you too far from your 23 script. I would certainly find it helpful, if there 24 were relevant passages in, for example, the 1998 25 guidance, to have some sight of that and indeed whatever Page 113	1 familiar evolution of ethical principles through the 2 literature, into professional guidance then ultimately 3 into law; is that right? 4 A. Yes, I think so. 5 Q. And I think you identify, as far as the legal position 6 is concerned, that I think it was in 2018 that the duty 7 of candour became part of Scots law, I think it was 8 earlier in English law. We may get to that specifically 9 in due course, but let's go through this. So it says 10 that: 11 "The 1995 edition of Good Medical Practice did not 12 state an explicit duty to disclose adverse events or 13 surgical errors to patients. However, that guidance did 14 contain obligations to provide 'good standards of 15 practice and care' ... 'be honest and trustworthy' ... 16 and 'keep clear, accurate, and contemporaneous patient 17 records which report the relevant clinical findings, the 18 decisions made, information given to patients and any 19 drugs or other treatment prescribed'." 20 So, as you were telling us, we start off with 21 general principles which are consistent with the sorts 22 of obligations that we've been looking at in this area, 23 but they are perhaps particularised over time, is that 24 right? 25 A. Yes, that's right. Page 115
1 predecessor to the 2025 Royal College, Good Surgical 2 Practice. I quite take the point, Professor Huxtable, 3 that the principles may not be replicated in those 4 precise terms but just to give substance to your sense, 5 as you put it, that they might cover the same ground, it 6 might be quite helpful to see what they say. 7 PROFESSOR HUXTABLE: So I would direct counsel to 8 paragraph 31, point 2, through to point 9 I think, in 9 the report we're in currently. 10 MR DAWSON: Yes, so this is -- I was going to deal with this 11 in a slightly different way. We can certainly deal with 12 it now. 13 THE CHAIR: Well, I mean, if -- 14 MR DAWSON: It's okay, sir. This is the development in 15 relation to candour. It's a sort of broader category 16 than simply the narrower category of being honest with 17 patients and trying to take certain steps if things have 18 gone wrong, but the principles are interlinked; I think 19 is that fair to say, professor? 20 PROFESSOR HUXTABLE: That's it, yes. 21 Q. Which is why you've drawn our attention to this 22 particular aspect. Again, to talk in the context of 23 candour, we identified, I think in our canter through 24 other areas earlier, that this was within of the 25 examples of a situation in which there had been that Page 114	1 Q. So: 2 "The 1998 edition of Good Medical Practice directly 3 tackled the issues in a section entitled 'If things go 4 wrong'. This conveyed such obligations as the need 'to 5 deal with complaints constructively and honestly' ... 6 co-operate with inquiries or investigations, and obtain 7 insurance or indemnity cover ... It also stated: 'If 8 a patient under your care has suffered serious harm 9 through misadventure or for any other reason, you should 10 act immediately to put matters right, if that is 11 possible. You should explain fully to the patient what 12 has happened and the likely long- and short-term 13 effects. When appropriate you should offer an 14 apology'." 15 Then we see the 2001 edition of Good Medical 16 Practice and then over the page, the 2013 edition. You 17 tell us, under sections "Maintaining trust" and "show 18 respect for patients": 19 "This conveyed the obligation in clear terms: 'You 20 must be open and honest with patients if things go 21 wrong. If a patient under your care has suffered harm 22 or distress, you should: put matters right (if that is 23 possible); offer an apology; explain fully and promptly 24 what has happened and the likely short-term and 25 long-term effects'." Page 116

1 So, you also tell us, at the bottom of the page 2 there, 31.7, that in the now familiar 2002 first edition 3 of Good Surgical Practice, there were explicit 4 obligations set out down in relation to adverse events: 5 "... not only should surgeons 'inform patients of 6 any adverse events that occur during their care', they 7 should also notify people within and without the 8 organisation as necessary (for example, a local audit 9 meeting or the Medical Devices Agency) ... Elsewhere, 10 the section on maintaining trust states that surgeons 11 should 'fully inform patients and their supporters 12 of ... any untoward developments as they occur, or as 13 soon as possible afterwards' ... while the section on 14 communication states that surgeons should 'act 15 immediately when patients have suffered harm and 16 apologise when appropriate'." 17 So as far as the development of the literature is 18 concerned, we see a relatively early particularisation 19 of this matter, I think, from the 1998 edition of Good 20 Medical Practice and certain relevant obligations from 21 the 2002 edition of Good Surgical Practice. Is that 22 a fair summary, Professor Huxtable? 23 PROFESSOR HUXTABLE: Yes. Yes, it is. 24 Q. Thank you, sir. Just one aspect of that which I might 25 pick up with you. It's connected with two concepts that Page 117	1 would suggest you wouldn't be also open and honest and 2 report accordingly. 3 Q. Yes. So I think we discussed earlier, Professor McNair, 4 in connection with -- you highlighted two different 5 situations in surgery where things might need to be 6 dealt with that may not entirely have been predicted at 7 the beginning, one where, if you've gone through the 8 proper consenting procedures, you would be confident 9 it's covered. I think you used the phrase, 10 Professor Huxtable, "by the permission you had been 11 given" but in others where what you were contemplating 12 doing was outwith that permission, such that effectively 13 you would need to seek that permission from the patient. 14 And I think what we're seeing here is the requirement to 15 correct things also has to take account of the 16 requirement to be open and honest with the patient as to 17 what's happened; is that right? 18 PROFESSOR MCNAIR: Yes. 19 Q. Thank you. And as far as the details are concerned, 20 I'd be interested to know, because it is of relevance to 21 us, whether it would have been unethical in the relevant 22 period for a consultant neurosurgeon not to have 23 reported to a patient who conducted his or her surgery? 24 A. Is that in the context of something going wrong? 25 Q. Not necessarily. In any surgery? Page 119
1 come up there that might be confused, just to 2 understand. There are general and specific concepts 3 relating to openness and honesty with patients but there 4 is also an obligation to put things right, I think, as 5 soon as possible, correction is a concept that comes up 6 here. Would it be unethical and would it have been 7 unethical over the relevant period for a surgeon to have 8 sought to correct a surgical mistake but without telling 9 the patient or his or her employer what had gone wrong 10 in the primary surgery? 11 A. It feels like it would be unethical. These don't seem 12 to be a series of obligations from which you can pick 13 and choose, I think that all the obligations obtain --so 14 one needs a degree of judgment to work out when to 15 rectify, how to rectify, whether there is time to bring 16 the patient background, rouse them and obtain their 17 informed consent to do so. But my sense is one still 18 needs to be open, even if one had to do it, in the 19 moment when the patient was under general anaesthetic. 20 That's my sense. Professor McNair? 21 PROFESSOR MCNAIR: I agree in the case of somebody who is 22 not under anaesthesia, something going wrong in real 23 terms and I think this has been highlighted in other 24 areas this idea of emergency care needing to react but 25 apart from that, no, I can't see anything in here that Page 118	1 A. In any surgery. So, we're going to have to make 2 reference to another part and I'm just going to offer my 3 thoughts at the minute while I try and organise where 4 I think this comes up. 5 Q. Thank you. 6 A. Because it is, I believe in Good Surgical Practice and 7 Good Medical Practice that doctors need to make patients 8 aware of the "people involved in their care", I believe 9 is the turn of phrase used. 10 Q. Yes. 11 A. And therefore in that context of somebody who is going 12 to be involved in their care, who are doing 13 an operation, and that I think would fall under that 14 general umbrella. You then have the training-related 15 issues that we've discussed partly and so sometimes 16 trainees may do whole or part of the operation, 17 typically that's under the direct supervision of the 18 trainer, so in the context of a fully registered 19 consultant surgeon, then in that way, the surgeon would 20 be overseeing and responsible for the care, even when 21 that task is delegated to an appropriately qualified 22 trainee. 23 So, in terms of the ethical standpoint, given the 24 GMC's position on involving people in the care and we've 25 previously asserted that there's a close personal Page 120

1 relationship, I think that what this is telling us is 2 that the patient should generally be aware of who is 3 doing the operating. 4 Q. Yes, so I think you're looking at it, professor, from 5 a perspective point of view, ie you're entitled to know 6 before the surgery who is going to be doing the surgery. 7 Also can we look at it from a retrospective point of 8 view, that you'd be entitled to know who actually did 9 it? 10 A. Yes, as in that context. I guess in that way -- 11 I'm trying to think of the circumstances where that 12 might happen but, yes, if we take that as a given that 13 for whatever reason the person who the patient was 14 expecting to operate on them didn't actually operate on 15 them, then that might be a very reasonable thing to be 16 open and honest about, I think in this context. 17 Q. Yes, I wonder. Sorry, professor, did you have something 18 to add there? 19 PROFESSOR HUXTABLE: Yes, the observation I was going to add 20 is a degree of hesitation you can hear and I would share 21 that hesitation. The one bit that we don't have at our 22 fingertips is the precise point in time at which the 23 GMC, or for that matter the Royal College, set down the 24 obligation that patients should know whether 25 prospectively or retrospectively who was involved. Page 121	1 assistant ..." 2 And as we read further down: 3 "The operative diagnosis ... 4 "The operative findings ... 5 "Any problems/complications ... 6 "Any extra procedure performed and the reason why it 7 was performed ... 8 "Details of tissue removed, added or altered ..." 9 So these, I think, cover both of those areas. So, 10 therefore, if you have to write it down, one assumes 11 there would be an ethical obligation to inform the 12 patient? 13 PROFESSOR MCNAIR: Yes, as in, we are open and honest about 14 all the events and in that respect access to the notes 15 we've already established, there's an ethical obligation 16 for. So, yes, your logic follows. 17 Q. Thank you. Just on the subject of things going wrong in 18 surgery and the obligation to be open about it, could we 19 go to paragraph 32.2. (Pause). You set out in this 20 section a number of important obligations relating to 21 communication: 22 "Surgical ethics is built ..." 23 It says: 24 "... not only on principles, but on actions, chief 25 among them, effective communication'." Page 123
1 Presumably there was a point in time the GMC set this to 2 paper but we don't have it at our fingertips. 3 Q. Yes, okay. I'm certainly familiar with the passages 4 that Professor McNair is referring to about information 5 about people involved in their care. That's referred to 6 actually, I think, several times in the report. I can't 7 put my finger on it. I also wondered whether the 8 following entry in Good Surgical Practice might be of 9 assistance. ELJ0002-00180, please. Page 14. So we've 10 been talking there about first, being open and honest 11 with the patient about what's happened including what's 12 gone wrong in the surgery and who carried out the 13 surgery. Here, we see it's one of the "must" 14 obligations relating to record-keeping. If we go down 15 a little further, it says that: 16 "Surgeons must: 17 "Ensure that there are legible operative notes 18 (typed if possible) for every operative procedure. The 19 notes should accompany the patient into recovery and to 20 the ward and should be in sufficient detail to enable 21 continuity of care by another doctor. The notes should 22 include: 23 "Date and time ... 24 "Elective/emergency procedure ... 25 "The names of the operating surgeon and Page 122	1 And then you set out a number of, again, sources 2 which tell us the various important aspects in this 3 regard. And at paragraph 32.3.1, at the bottom: 4 "Singh nevertheless suggests that surgeons are under 5 an 'ethical duty to disclose medical errors'. 6 Kana et al. concur but they also go further, in 7 suggesting that a surgeon can be under an 'ethical 8 obligation to disclose the errors of others'. Steinberg 9 and Warshaw note that this too can be challenging: 10 'Doctors are often hesitant to report or confront 11 colleagues [when there are] failings and errors. The 12 tenet of self-regulation of a profession requires 13 corrective action when there is recognition of a failure 14 or deficiency in the practice of surgery. To meet 15 professional responsibility proper actions include 16 communication with the relevant erring colleague, 17 patient, family, and, when appropriate, the colleague's 18 supervisor, institution, or even [authority]'." 19 And so in circumstances where things have gone 20 wrong, there's an obligation on the treating, 21 supervising, responsible consultant to tell patients 22 that that's happened but also there is an obligation on 23 other doctors who are aware that that's happened, is 24 that right? 25 MR DAWSON: I think we may have frozen, sir. Page 124

1 THE CHAIR: Now, this happened at almost exactly the same 2 time yesterday. I wonder if whatever button or switch 3 was deployed can be done again? 4 PROFESSOR MCNAIR: I'm sorry, I don't know what happened. 5 MR DAWSON: Can you see and hear me? 6 PROFESSOR MCNAIR: Yes. Yes, we can see and hear you. 7 Q. We can now see and hear you, I think, as well. We can 8 at this second in time, but you were back a moment ago 9 and then disappeared. Shall we try and carry on. I was 10 reading out paragraph 32.3.1 in relation to not only 11 there being an ethical duty to disclose medical errors 12 on the part of the responsible surgeon but also those 13 who are aware of it may have obligations of disclosure 14 when they were one of the other doctors to have 15 witnessed it. Is that correct? 16 PROFESSOR HUXTABLE: Correct. 17 Q. And you do tell us in the statement, for the sake of 18 completeness if we go to paragraph 33.4. 19 THE CHAIR: Sorry, before you do that Mr Dawson, I may have 20 missed that answer before or the full answer, but did 21 I understand you to agree with the proposition that the 22 person who was not conducting the surgery who observes 23 an error is under an ethical obligation to report that 24 or did I understand you to agree with the fact that 25 Kana et al reached that view as a development of Page 125	1 ethical for a clinician to withhold the fact or 2 information about something having gone wrong with 3 a surgery from a person with capacity. And you set out, 4 from 33.4 onwards, that there are such situations but 5 that they are limited; is that correct? 6 PROFESSOR HUXTABLE: Correct. 7 Q. So, for example you tell us in more detail: 8 "Exceptionally, when disclosure would cause the 9 patient serious harm ... 10 "When disclosure would reveal confidential 11 information ... 12 "When the patient does not want to know ... 13 "[Or where] no harm resulted ('near miss') 14 [situation]." 15 These are all situations which it's possible that it 16 would be ethical not to inform the patient but even 17 within these situations, as I understand the report, 18 that they're quite circumscribed to make sure that 19 effectively, the ethical situations are a subset of 20 a subset, if you like. They would be very exceptional; 21 would that be fair? 22 PROFESSOR HUXTABLE: Yes. 23 Q. Thank you, it's helpful to have the clarification. This 24 relates to the matter that I discussed with 25 Professor McNair earlier as regards the extent to which Page 127
1 a previous view; which was it, sorry? 2 PROFESSOR MCNAIR: So if we elaborate on that, sir. I can 3 confirm that was Kana's view. In terms of the 4 obligation to disclose the errors of others, I think 5 we've seen that from other perspectives, as in there are 6 obligations to do it. The operationalisation of that, 7 again, might be more subtle than such things. So for 8 example, an individual observing an error may not 9 immediately, for example, tell the patient themselves 10 but rather have a conversation with the responsible 11 surgeon to disclose it to the patient because they have 12 an existing relationship with them and that would confer 13 the greatest trust and maintaining trust to do that. 14 But if, for example, the surgeon were to refuse or to 15 deny it, yes, the obligation stands. 16 THE CHAIR: That clarifies it. It was just to confirm 17 whatever the operational aspects to it, that you don't 18 disagree with the existence of such an ethical 19 obligation and principle? 20 PROFESSOR MCNAIR: We do not. 21 THE CHAIR: Thank you. 22 MR DAWSON: Thank you. I was taking you to a passage 23 there's a slight refinement to these situations where, 24 at paragraph 33.4, please, you're addressing here that 25 there may be some circumstances in which it would be Page 126	1 one has authority or permission to be able to carry out 2 a procedure that is slightly different though still 3 connected to the permission that's been given. Would it 4 have been unethical in the relevant period for 5 a consultant neurosurgeon to have kept from his or her 6 patient that he or she had not carried out the surgery 7 as had been agreed? 8 PROFESSOR MCNAIR: So, no, I'm sorry. I couldn't remember 9 the framing of the question, but I agree that it would 10 be unethical to not disclose that you didn't perform the 11 procedure as agreed. 12 Q. Just to tap into the discussion that we talked about 13 earlier, there would be situations in which it would be 14 ethical to perform a variation of the surgery that had 15 been agreed, if one could ethically justify that it was 16 included within the permission; is that right? 17 A. Correct. 18 Q. But not if it exceeded the permission, correct? 19 A. Except under these very specific circumstances that we 20 mentioned, the emergency care and such like. 21 Q. Yes, but the question I asked you a moment ago, I think 22 Professor McNair, that you agreed with was whether in 23 either of those circumstances it would be necessary, to 24 be ethical, for the patient to be told that there had 25 been this variation in what had been agreed and it be Page 128

1 justified as being within the permission, effectively? 2 A. I believe it is ethically necessary to talk to the 3 patient about the procedure they actually had, 4 especially if it's a variation or perhaps different to 5 what you spoke about beforehand. 6 Q. Thank you. Would it have been unethical in the relevant 7 period for a consultant neurosurgeon not to have 8 reported to his or her patient that he or she had not 9 undertaken the surgery which had been agreed upon at 10 all? 11 A. Yes, it would be unethical to not communicate that the 12 procedure did not go ahead. 13 Q. Would it have been unethical in the relevant period -- 14 the answer to this question I suspect will follow from 15 the last one, or would there have been an ethical 16 requirement to explain to the patient why certain 17 courses had been taken that deviated from the strictly 18 agreed course? 19 A. Yes, with the caveat that, under some limited 20 circumstances, the patient may not want to know but it 21 should be framed in the context of potentially a full 22 description based on the preferences of the individual. 23 Q. Thank you. To widen this out from the discussion with 24 the patient into other obligations we've discussed. 25 Would it have been unethical in the relevant period for Page 129	1 obligation to report that to the organisation and that 2 may well include the responsible officer, as might be 3 escalated through the various layers of clinical 4 governance. 5 Q. Yes, so those layers of clinical governance might 6 include something like an adverse incident policy or 7 something like that, is that what you're talking about? 8 A. That's correct, and this side of things, specifically 9 historically, I don't have great understanding of, but 10 typically things would escalate up from an incident 11 report, to an investigation, to various other sort of, 12 I guess, more institutionally sort of serious 13 escalations, depending on the nature of the incident. 14 Q. Yes. 15 A. But the ethical obligations remain clear that even for 16 both minimal harm or even near miss situations, then 17 there are ways that the institution and the healthcare 18 profession can learn from those to prevent incidents 19 from happening in the future. So there is an obligation 20 to report them regardless of the scale. 21 Q. And the precise mechanism would be defined in a local 22 policy as to whether it was to go through an adverse 23 incident or a serious clinical review or something like 24 that and that's what you mean by the "local policy", is 25 that right? Page 131
1 a consultant neurosurgeon to have kept things which had 2 gone wrong in surgeries from his or her professional 3 colleagues? 4 A. That would be unethical. 5 Q. Why would that be the case, professor? 6 A. It would be unethical because of the sort of the 7 principles of being both open and honest and 8 contributing to working well with colleagues which we 9 have covered previously especially around, I guess, in 10 some respects the shared responsibility of caring for 11 patients, the benefits and the harms that might be from 12 continuity of care. If somebody didn't have 13 an operation and then, for example, they needed 14 emergency treatment through another colleague then they 15 would be unaware that that procedure didn't happen and 16 that might result in harm. That would be my initial 17 response. 18 Q. Thank you. And does it follow from that, because the 19 definition of "professional colleagues" might be wide 20 enough to bear this, that it would be unethical in those 21 circumstances for a consultant neurosurgeon not to have 22 reported something which had gone wrong to his or her 23 responsible officer? 24 A. Yes, so within the context of local governance 25 procedures and processes, then there is an ethical Page 130	1 A. Yes and I'm sure that there's an interception between 2 local and national policy on this, again, it's not my 3 area of expertise, but off the top of my head there are, 4 for example, national reporting standards on so-called 5 "never" events, which are particularly serious events 6 across both medicine and surgery, for example, and they 7 have particular reporting processes. But it'll be 8 a combination of local and regional and national 9 reporting processes. 10 Q. And so, to put all that together, if we use your phrase 11 a "never" event, would it have been unethical for 12 a surgeon who had been responsible for an operation in 13 which a "never" event occurred, for it not to have 14 been reported in accordance with the reporting 15 mechanisms? 16 A. That would be unethical. 17 Q. Following on from the passage we looked at earlier about 18 other doctors' obligations, would it be unethical for 19 another doctor not to have made a similar report about 20 a "never" event over which another surgeon had presided, 21 if I can put it that way? 22 A. That would be unethical, with the same caveat from 23 earlier. 24 Q. Thank you very much. You were asked some questions 25 about quite a specific aspect of clinical governance Page 132

1 that I wanted just to touch on and that was the question 2 of supervision. You help us with the concept in the 3 report, paragraph 23.7, please. So you helpfully set 4 out here for us the concept of supervision and different 5 types of levels of supervision that might be imposed 6 upon a doctor in connection with various things that 7 might have happened. But the fundamental question which 8 I'm interested in is whether it would have been 9 unethical in the relevant period for a consultant 10 neurosurgeon not to have informed his patients that he 11 or she was under clinical supervision? 12 A. We debated this section quite extensively when we 13 created the report. Again, this is not areas we are 14 particularly fluent in all the different elements and so 15 it's probably worth briefly touching on our ideas around 16 this. You mentioned, first of all, "in the relevant 17 period". I think 23.7 speaks to that, in that the 18 guidance from what we could tell, from 2004 was probably 19 the earliest description but it doesn't really describe 20 these three different levels that you get over the page 21 on page 221. 22 So, we could not find any professional obligations 23 related to that error and then, when you consider the 24 modern levels of supervision that we've abridged on 25 page 211 with the "supervised", "closely supervised" and Page 133	1 "GMC Decision making and consent guidance provides 2 'examples of information that may be relevant to and, if 3 so, should be shared with patients'. It states that 4 this may include 'the names and roles of key people who 5 will be involved in their care, and who they can contact 6 (and how) if they have questions or concerns'. The 7 application of this statement in the context of clinical 8 supervision is open to interpretation. It is mandatory 9 for surgeons under direct supervision to have 10 a supervisor present for all patient contact, suggesting 11 the greatest obligation is to inform patients about who 12 will be involved in their care." 13 So therefore because of the fact that if someone is 14 under X supervision, there will be somebody else 15 involved and I think you told us who will ultimately be 16 responsible for the care, is it only in that 17 circumstance these obligations will arise, or is it only 18 in that circumstance that these specific obligations 19 arise, with there still being general patient, respect 20 for autonomy-type obligations that would sit underneath 21 this? 22 PROFESSOR MCNAIR: So I think this is a good example of 23 where we're at the interface between these theoretical 24 ethical obligations and professional medical obligations 25 because the language that we see within -- and bearing Page 135
1 "directly supervised", the guidance themselves, as far 2 as our reading goes, does not specify that patients 3 should be informed of that supervision, but by 4 an extension of that, we considered our previous 5 position that the names and roles of key people who will 6 be involved in the care who they can contact if they 7 have questions or concerns, is relevant because 8 especially at the highest level of supervision where 9 somebody is directly supervised, in that context my 10 reading of that section is that it best aligns to being 11 a doctor in training because all of their clinical work 12 is subjected to oversight which is how it's defined. 13 So that, in my reading of this, linking those two 14 statements together would suggest there's an obligation 15 to say that there is a different individual who is 16 taking final responsibility for your care, given that 17 that's such an important element of the relationship. 18 Q. I can see how the complexity arose in your discussion of 19 this, because of the various different levels of 20 supervision and the greater degree of specification that 21 appears to have been added to that over the years, if 22 you like. So you have framed this in terms of that 23 general obligation. If we look at 23.9, this is the 24 obligation that you've mentioned several times before. 25 It says: Page 134	1 in mind this is a recent version of "Decision making and 2 consent" so it's reasonably contemporaneous, is examples 3 of information that may be relevant. And so it does not 4 carry the same statement of "you must" which is clear 5 within other GMC guidance. So almost by virtue that we 6 are having this debate suggests to me that the 7 professional ethical obligations or what we're 8 considering to be that higher level are unclear enough 9 that we can be uncertain that that's the obligation. So 10 we would fall back on theoretical ethical obligations 11 which we're happy to debate and we can go through the 12 four principles approach, especially in the context of 13 shared decision-making, where some of these issues may 14 be particularly or highly relevant and important to 15 individuals to talk about, but that's how I would 16 approach this particular problem. It's probably from 17 a theoretical ethical perspective. 18 Q. Because from a patient perspective if one thinks about 19 it simply, so if a surgeon is under any level of 20 supervision, and if a patient is deemed to be entitled 21 to have access to relevant information to make a fully, 22 personalised, informed decision about whether they wish 23 to proceed with the surgery for by that surgeon, it 24 would seem to be necessary that that patient would have 25 all that information available to them in order to be Page 136

1 able to make a fully informed decision, as a matter of 2 general principle, if I can put it that way? 3 A. Yes, so the way that we would frame this is -- and is 4 within both the "consent" and "shared decision-making" 5 sections, so it's the information that's important to 6 the patient. And you can completely understand in 7 circumstances where this information will be important 8 for that individual to make a decision. 9 Q. It would be difficult, I would imagine, to conceive 10 a situation in which a patient contemplating having 11 surgery would themselves raise the issue of whether 12 someone is under clinical supervision. Most patients, 13 I would imagine, would have no idea what clinical 14 supervision is. So therefore is it not incumbent on the 15 surgeon and/or the healthcare provider to raise that 16 issue because they should be aware of that fact and the 17 patient will almost certainly not? 18 A. I agree and I think that this probably highlights 19 a discussion worth having with the GMC about whether 20 this is a "must" statement or not because, as I said 21 before, I think that the current professional ethical 22 obligations are a bit ambiguous in this area and there 23 are challenges, as we've already established, about 24 mandating theoretical ethical obligations within this 25 context. But I agree with your point. Page 137	1 and important and explore that with patients, even if 2 they choose not to explore it further, for example. 3 Q. Thank you. I'd like to move on to an area we have 4 touched on but there is probably a little bit more to 5 cover, that's the duty of candour and candour in 6 professional medical ethics. Again, as we said earlier, 7 this is something where a legal duty has arisen. If we 8 could look back, please, at paragraph 46.4. If we just 9 leave it at the top of the page, actually you can see 10 there the matter I referred to earlier, that were 11 slightly different start dates, if you like, for the 12 legal duty of candour: England, 2014, Scotland, 2018. 13 And in 46.4, I think there's a section of yours, 14 Professor Huxtable, it says: 15 "The statutory duty of candour is essentially 16 an organisational duty, so the focus is on 17 organisations. However, individual professionals -- 18 including surgeons -- must discharge the duty on behalf 19 of their organisations, so they are required to have 20 a clear understanding of the difference between the 21 professional and statutory duty." 22 So first of all, I just wondered if you could help 23 us with, broadly speaking, what the difference between 24 the professional and statutory duty is. From the 25 statement it seems to relate to where there is Page 139
1 Q. Thank you. I suppose that is perhaps -- you may have 2 made this point already, Professor McNair, but it may be 3 quite a useful illustration of the fact that you 4 can't have one set of rules to determine what sort of 5 information an individual patient will need to make 6 a fully, individualised, personal decision because, as 7 you say, for one patient it may be completely irrelevant 8 that someone is under clinical supervision, for another 9 it may be the pivotal factor upon which their decision 10 is based on whether they go ahead with the surgery or 11 not? 12 A. That's correct. As an extension by that though, there 13 are ways that we can establish a starting point. 14 Because it is difficult to explore patients' preferences 15 for information and tailoring that information without 16 having a starting point. Some of these, or many of 17 these procedures that we're talking about here are 18 highly complex and so starting with a position of: well, 19 what do you want to know about this, can be unhelpful 20 because if somebody doesn't know anything about brain 21 surgery, then they wouldn't know where to start. And so 22 there is absolutely a balance to this that it is 23 an ethical obligation to understand what's important to 24 the patient, but that also comes with an obligation, as 25 a professional, to explain what you think is relevant Page 138	1 an obligation to report things based on the level of 2 risk or the level of harm that might be associated with 3 a particular fact? 4 PROFESSOR HUXTABLE: Yes, that's broadly my understanding. 5 So I will probably skirt over differences that may be 6 present between the legislation in England and Scotland, 7 but if I start with the law, my understanding of the 8 legal position, so the statutory duty, is that if 9 there's harm on a particular level then it's 10 an obligation on the part of the organisation to be open 11 with patients, investigate, apologise and make sure that 12 support is provided to such a patient. 13 The professional duty meanwhile applies then to 14 professionals including an individual professional and 15 this involves, again, a duty to the patient, to inform, 16 apologise, support, explain the consequences whether 17 long or short-term for that patient but also a duty to 18 colleagues, including to be open and honest with 19 colleagues, to participate in any review or 20 investigation that might ensue, to tell the regulator if 21 appropriate and indeed to support other colleagues so 22 that they can be open when the need arises. 23 And so those are general points looking across, very 24 briefly, the legal, the statutory duty first of all and 25 then the professional duty, as found in guidance from Page 140

1 the GMC dating from 2013 and onwards, but there are 2 similar points made by Royal College of Surgeons' 3 guidance, including the guidance on candour. 4 Q. Thank you. I think in the passage we've looked at, 5 46.4, we've come across this before but this is 6 a situation where we find again that interface between 7 what might be an organisational duty in law but the 8 reality that the obligations of a body, like a health 9 board for example, are in reality discharged through its 10 agents such as a number of different people but those 11 could include doctors; is that right? 12 A. That's right. 13 Q. So therefore, even although a doctor may have a lower 14 threshold to apply to these sorts of matters where one 15 requires to be candid in professional guidance, in 16 reality it would be important that doctors also 17 understand that because they are the agents of a body 18 with a higher duty, they will require to respect that 19 duty in the way in which they conduct themselves. Is 20 that correct? 21 A. I think that's right. 22 Q. And as we said before, there requires, I think, to be 23 a complementary nature between the way in which doctors 24 conduct themselves and the facilities and conduct of 25 health boards to make sure that there is a mutual Page 141	1 that right? 2 A. That's right. 3 Q. And at 32.9 you start to tell us particular features of 4 the way in which the duties relating to candour require 5 to be carried out. First of all, that it requires to be 6 respectful. You tell us: 7 "Professional guidance conveys that communication -- 8 with patients, those close to them, and/or colleagues -- 9 should be respectful, sensitive, and compassionate." 10 Is that correct? 11 A. That is correct. 12 Q. And then as we go through the pages, one finds at 32.13, 13 there's professional guidance telling us that it should 14 be -- another word we've heard a lot, "individualised"; 15 is that right? 16 A. That's right. 17 Q. Over the page to 32.17, that it should be timely. And 18 32.18, the one I particularly wanted to ask you about, 19 that it should be secure. It says there, and this is 20 under reference to more recent General Medical Council, 21 Good Medical Practice from 2024: 22 "The GMC also refers to obligations to ensure that 23 patients' confidences are respected, with Good Medical 24 Practice stating that a doctor 'must [...] maintain 25 patient confidentiality in all your professional Page 143
1 respect for each other's obligations in this regard? 2 A. Yes, I think so. 3 Q. Thank you. We've been through the passages at 32 4 related to candour, but there are some specific aspects 5 I'd like to ask you about in that regard. We've looked 6 at the guidance as it emerged. In particular 32.18, 7 please. Actually, from 32.8, if we could just have 8 a look at that. Sorry about that. You helpfully 9 produce again our favourite WFNS 2007 statement on 10 ethics, where you show some information patient 11 communication in 2007: 12 "'We should be careful about discussing outcomes 13 that our proposed treatment or surgery may be unlikely 14 to provide, and should never guarantee that a particular 15 treatment will be effective. 16 "'We must ensure that information we provide is 17 accurate and up to date, and can be verified if 18 challenged ... 19 "'We should be honest with patients and their 20 families about the reasons for complications, and 21 express our sincere regret when the situation does not 22 go according to plan'." 23 So, there's some guidance there relating to the 24 particular features and situations in which 25 communication and candour is important from 2007, is Page 142	1 written, verbal and digital communications'. In its 2 specific guidance on confidentiality, the GMC notes that 3 'Most communication methods pose some risk of 4 interception -- for example, messages left on answering 5 machines can be heard by others and emails can be 6 insecure. You should take reasonable steps to make sure 7 the communication methods you use are secure'." 8 Now, why is it important, in considering the ethical 9 responsibilities of a doctor, that information relating 10 to a patient should be kept secure? 11 A. So if I go back to theoretical ethical obligations and 12 the like, I would myself tie this to notions like 13 privacy and confidentiality which some would connect 14 very closely with the idea, again, of respectful patient 15 autonomy. So it's my information, it's information 16 about me. I want it to be stored securely and only 17 shared with those I permit it to be shared with. 18 Q. And that is an ethical concept, is that right? 19 A. Yes. Yes, an ethical concept. 20 Q. Because again, somewhat connected to the questions 21 I asked earlier about documents and the need to fill 22 documents, it might be thought that this sort of thing 23 is perhaps ancillary to ethical medical practice and one 24 should focus on the main things, but this is something 25 less important. But you're telling me there are ethical Page 144

1 obligations to make sure that patient information is 2 secure related to those general principles you just told 3 us about? 4 A. Yes, and I would say, in fact, if we go once again all 5 the way back to the Hippocratic Oath, so ancient Greece, 6 even in the Hippocratic Oath you can see clear 7 statements to the effect that doctors should keep their 8 patients' confidences. And I think this is the sort of 9 obligation that's in line there, this idea of keeping 10 things secure. 11 Q. So, the Hippocratic Oath would look unfavourably on data 12 breaches? 13 A. I think so, I suspect. They weren't dealing with answer 14 phones and emails at that point in time but I think the 15 general principle would be supportive of what I just 16 suggested. 17 Q. Thank you very much. I have a very specific question to 18 ask you in relation to ethical issues relating to 19 candour and as I understand it in relation to the way in 20 which obligations related to candour can be enforced. 21 We've talked quite a bit about obligations which exist 22 on other doctors to have regard to issues occurring in 23 practices of colleagues and we've talked about 24 situations in which obligations can arise not just on 25 the principle responsible surgeon, for example, but on Page 145	1 team members are job-planned to be present and require 2 to be present for the meeting to take place. Often, for 3 example, that could be in the context of cancer care, 4 and in those meetings patients' results, their 5 treatments and outcomes are discussed with a view to 6 providing high quality care. 7 I can imagine situations where things have gone 8 wrong which would need to be discussed within that forum 9 because one would need to make ongoing management plans 10 for that patient and so if those events weren't known 11 then the multi-disciplinary team would not be 12 functioning well and therefore, if those events were 13 disclosed then those professionals have the same ethical 14 obligations that we've discussed up until this point. 15 So it would potentially be a forum by which events 16 were discussed and therefore fall within the obligations 17 of the group. 18 Q. So, you say that could potentially be a forum in which 19 that could be raised. Given that that appears to be one 20 of its purposes, again, are we at the interface between 21 the organisational requirement to provide such fora in 22 order that doctors can provide a certain ethical level 23 of support and interaction with their colleagues to make 24 sure that they are complying with their ethical duties? 25 A. I say it might be because the purpose of the meeting is Page 147
1 colleagues of that surgeon. 2 There are mechanisms which we discussed which are 3 practical mechanisms and fora that we're aware of in 4 which such obligations are given space to be able to 5 thrive. For example, the concepts of multi-disciplinary 6 meetings or other team meetings in which issues or 7 concerns can be shared with others and thereby perhaps 8 giving rise to the sorts of obligations we've been 9 talking about. 10 I have been asked to ask you a specific question 11 about the extent to which such fora can exist 12 specifically as a means of colleagues of a particular 13 professional being able to become aware of breaches of 14 obligations of candour and the extent to which those 15 meetings and those fora are mechanisms by which such 16 failures can be reported or enforced? 17 A. If I may, I'll turn to Professor McNair on this point. 18 Q. Thank you. 19 PROFESSOR MCNAIR: Appreciating I think you have something 20 specific in mind, and I wonder if I answer in the 21 context of my understanding of formal multi-disciplinary 22 team meetings. 23 Q. Yes. 24 PROFESSOR MCNAIR: So, typically within certain areas of 25 practice there are more formal meetings where different Page 146	1 not necessarily to – those multi-disciplinary meetings 2 might not be to air, for example, things that have gone 3 wrong or the ethical obligations relating to that. And 4 so I gave an example of a situation where it would 5 become evident but is that then completely comprehensive 6 of all the errors that could happen and the broadest 7 extent of things that you might wish to be candid about? 8 I can't be certain. There are other elements of 9 clinical governance where adverse outcomes are collected 10 and reported and there are, typically, local policy 11 notwithstanding, specific forums where complications or 12 adverse events are discussed to facilitate team learning 13 and those are multi-disciplinary meetings as well. 14 So I guess what I'm trying to say is there is 15 a landscape of meetings here involving different 16 professionals which would be an opportunity for these 17 events to become known, but I'm not certain if any one 18 of them would be wholly comprehensive of all the sorts 19 of things one might want to be candid about. 20 Q. Thank you. I'd like to turn now to an area that we've 21 discussed in a number of different contexts already, but 22 just to bring aspects of it together, namely consent. 23 I identified what seems like quite a long time ago, at 24 the beginning of this evidence with Professor McNair, 25 that this is an area where I think Dr McMillan answered Page 148

1 the questions in the statement but as you are an expert 2 in consent, I think I'll ask you first but please feel 3 free, Professor Huxtable, to input as you see fit 4 because I also know that you contributed significant 5 aspects of this section. 6 Professor McNair, is it correct to say that medical 7 treatment can only be given to a person with their 8 consent? 9 PROFESSOR MCNAIR: Largely, yes. So that is the position. 10 Q. Would it be fair -- 11 PROFESSOR HUXTABLE: I was going to add, one, potentially in 12 some circumstances, important caveat. Consent or some 13 substitute for consent that's recognised. I'm alluding 14 essentially to situations where a person might lack the 15 capacity to provide consent themselves, some proxy might 16 do so. But otherwise, I would entirely agree, consent 17 is the gold standard. 18 Q. You're one step ahead of me again, professor. I was 19 going to ask: save in certain well-recognised 20 circumstances, such as with an unconscious patient 21 requiring emergency treatment or the treatment of 22 a patient lacking mental capacity to consent to it; is 23 that fair? 24 PROFESSOR HUXTABLE: Correct. 25 Q. And that consent must be informed, is that right? Page 149	1 ethical principles approach, that the requirement for 2 consent I think is founded in ethical norms; is that 3 correct? 4 A. That's correct. 5 Q. In particular the first of the ethical norms, respect 6 for autonomy? 7 A. That's correct. 8 Q. Is that because by knowingly considering and then 9 accepting rather than rejecting a proposed course of 10 action, based on adequate information, a patient 11 expresses their autonomy and their responsibility for 12 the decision whilst also accepting the expertise of the 13 doctor providing the care? 14 A. Yes. 15 Q. There is also, I think maybe for Professor Huxtable, 16 a legal imperative here. Even relatively historically 17 because treatment of a patient without consent might be 18 an assault; isn't that right? 19 PROFESSOR HUXTABLE: That's right. 20 Q. And where a patient suffers adverse consequences from 21 treatment about which they are not sufficiently 22 informed, they may have a claim in negligence against 23 a doctor or a hospital, is that right? 24 A. That's right. 25 Q. I'm interested in understanding -- to tap in a little Page 151
1 PROFESSOR MCNAIR: Yes. 2 Q. What does that mean? 3 PROFESSOR MCNAIR: It means that -- well, in modern 4 standards or historic standards, I guess, would be my 5 first question back? 6 Q. Insofar as there's a distinction please feel free to 7 point that out, but I suppose if we're looking at modern 8 standards as a baseline definition, that would be very 9 helpful? 10 A. Yes. So for a person to adequately consent they need to 11 be informed of the nature of the procedure, typically 12 the risks and the benefits and I like to add 13 consequences here because I think consequences are 14 slightly different to risks and benefits, as well as 15 certain other features that are listed in detail in the 16 GMC document. And I can pull that up for you if you 17 want, I have it here. The section starting 33.34, will 18 be the most recent, I believe. 19 Q. Well, we'll come to that in a moment but just to deal 20 with some general concepts first of all. Is it the case 21 that if a patient is not informed, that fundamentally 22 undermines his or her autonomy because the patient is 23 denied the opportunity of real choice? 24 A. Correct. 25 Q. And, as I think we've discovered so far in our four Page 150	1 bit more to Professor McNair's helpful question about 2 the historic definition or position and you've provided 3 to us a very helpful analysis of this spanning across 4 a number of different documents, the way in which this 5 ethical background developed. Because, as we said at 6 the beginning of the evidence, it might be tempting 7 based on contemporary materials that would tend in this 8 direction to think that consent started with the case of 9 Montgomery that we discussed yesterday. It would be 10 wrong to think that consent and the requirement for 11 informed consent started with the case of Montgomery, 12 wouldn't it? 13 PROFESSOR MCNAIR: Yes. 14 Q. What the case of Montgomery decided was that where 15 someone has suffered harm, as a result of a legally 16 inadequate consenting process, they may be entitled to 17 recover compensation for that harm; isn't that right? 18 PROFESSOR MCNAIR: Yes. 19 Q. But in fact, as I think we touched on yesterday by way 20 of recap if anything, that important legal decision by 21 the Supreme Court was informed, in large part, by 22 a significant body of ethical evidence suggesting that 23 that had been the position in ethics for some time? 24 A. Correct. 25 Q. If we could look then at, at least some of the Page 152

1 highlights. You've very, very helpfully gone through 2 a large body of material relating to this subject, some 3 of which was sent to you by the Inquiry and some of 4 which was not, I think, that sets out where we were 5 historically and the importance of these concepts. And 6 at paragraph 13.3, please -- actually, if we look at 7 13.1 which shows us where we're going as our 8 destination, it's a sort of summary of what comes next, 9 which says: 10 "Although guidance from professional organisations 11 has long conveyed the importance of obtaining consent 12 from the patient, the clearest and most authoritative 13 statements of the relevant principles appear to have 14 emerged in the 1990s ..." 15 Is it correct to say that's a summary of what comes 16 next? 17 A. Yes. 18 Q. It's a very helpful one. Paragraph 13.3, you tell us: 19 "In 1962, the MDU issued Consent to Operative 20 Treatment. This explained the legal background to 21 consent, and specifically the risk that a procedure 22 performed without valid consent might amount to assault. 23 The guidance addressed the form of consent: consent 24 could be express or implied, and oral or written. In 25 this regard, the guidance stated a preference for Page 153	1 universal, I find this choice of word interesting 2 because in my mind it doesn't really satisfy the ethical 3 obligation of autonomous action because the implication 4 of the word "universal" is the surgeon would be given, 5 in a sense, a carte blanche to do what they want and 6 completely kind of delegating autonomy to the individual 7 surgeon. So within that framing, it's quite a long way 8 from my understanding of the ethical obligation of 9 autonomy. 10 If we then think about specific and -- 11 Q. Explicit and written. 12 A. Explicit and written, then this starts to define for us, 13 I guess, sort of parameters. And if I take you back to 14 that idea that surgeons have power but within that, 15 there are obligations and constraints within that, 16 I think that sentence then starts to provide the 17 guard-rails about what is permissible and what the 18 patient is giving permission for. 19 Q. And it goes on to say an important concept was the 20 consent must be "fully and freely given"? 21 A. Yes, this idea of voluntariness, which I find difficult 22 to say, but patients should not be under undue influence 23 of others, so coercion or otherwise. 24 Q. We touched, earlier on -- I proposed an explanation of 25 the word "charisma" that appeared in one of the Page 155
1 consent to be explicit, written and specific (as opposed 2 to 'universal'), to which end it included example 3 consent forms. The guidance further conveyed how 4 consent 'must be fully and freely given'. The patient 5 should be informed, by an appropriately informed person, 6 about the nature and effect of the operation, and any 7 'special risks' should be explained -- although 8 a therapeutic exception was noted, according to which 9 information might sometimes be withheld in the interests 10 of the patient. The document went on to note some 11 exceptions to the need for consent, such as in 12 emergencies or when dealing with an unconscious 13 patient." 14 So the last sentence, I think, deals with the 15 exceptions that we pointed out at the beginning but if 16 we can approach this on the basis of the fact that we're 17 dealing with the normal case, if I can put it that way. 18 There are a few important concepts here which I'd just 19 like to address with you. First of all, even in this 20 1962 guidance, it stated a preference for a consent to 21 be "explicit, written and specific as opposed to 22 universal". Could you help us with, first of all, what 23 those concepts mean and why it is that that would be 24 preferred from an ethical perspective? 25 PROFESSOR MCNAIR: Well, so if we start with the idea of Page 154	1 documents that we looked at. Is there a potential that 2 over reliance on the charisma, in the context in which 3 I described it earlier of a surgeon, might in fact mean 4 that a consent was not freely given? 5 A. I'm pausing here for a moment because I want to say that 6 I believe in a more recent version of consent -- 7 professional obligations, it states something that their 8 persuading or pressurising -- I'm looking at my 9 colleague because I cannot quite remember the exact 10 reference. But in so much as charisma may be applied to 11 a situation whereby a pressure to agree to a particular 12 procedure could be applied, I could see that logic. 13 Charisma in itself or being charismatic I wouldn't say 14 would necessarily result in that but if it was applied 15 in a way that it was persuading somebody, perhaps 16 against their will or otherwise to consent for something 17 then yes, I can see how that will contribute. 18 Q. Thank you. A couple of other concepts. The nature and 19 effect of the operation and any "special risks" should 20 also be explained. Do you have a definition as to what 21 those special risks might be? 22 A. I do not. I think from 1962, I'm not entirely sure what 23 they had in mind. 24 Q. Yes, I struggled with that as well but I wondered 25 whether it might be trying to introduce a concept which Page 156

1 obviously is an important part of the later guidance 2 that it should be individualised, so particular risks 3 for that particular patient? 4 A. I think that's fair, except if I were to put myself in 5 the mid-1960s where perhaps patient-centred care wasn't 6 as entirely established as it is today, they might mean 7 special risks not about a patient but about a procedure 8 because there is this typical focus on the doctor and 9 the procedural elements to it. So it might be less 10 about what is special about the patient and more about 11 what's special about the procedure, historically. 12 Q. But if risks are required to be explained anyway, would 13 that not include special risks? 14 A. One would assume so and so, the fact that they have 15 noted these special risks I think says something about 16 what they were thinking at the time. If I was to apply 17 a different lens to this, then perhaps they were 18 thinking that there are general risks that are 19 applicable to every operation. So, for example, the 20 risks of having a general anaesthetic or having a deep 21 venous thrombosis or having bleeding, which are 22 typically applicable to every procedure, rather than 23 special risks that perhaps might relate to having 24 a neurosurgical procedure, for example, but I really 25 can't say what was in their mind when they wrote that. Page 157	1 Absolutely not currently. But perhaps in the 1970s they 2 were more authoritative, but we have no frame of 3 reference for that. 4 Q. Yes, understood, but would it be possible, as we go 5 through it -- these passages refer to the 1962 MDU 6 guidance, they refer to a 1966 guidance from the MDU, 7 1968, 1971, then the BMA in 1970 and then various other, 8 '74, 1980 etc. Is there something to be taken in trying 9 to work out whether these documents tell us about 10 ethical norms and ethical standards that there is 11 an accumulation of sources from more than one body and 12 that the position is adhered to over a long period; is 13 that important? 14 PROFESSOR HUXTABLE: Oh, yes. I think absolutely and 15 I think it's not only an accumulation but it's 16 an expansion. The references increase in number and in 17 nature over time. 18 Q. So what that means, in terms of that process that we 19 talked about before, of the particularisation of the 20 advice that's given in the guidance, is that what 21 they're seeing is more and more situations in which 22 consent needs to play a part as they think about consent 23 more and more and more and they incorporate it into 24 a greater number of sections; is that broadly what's 25 happening? Page 159
1 Q. Okay. The therapeutic exception is, I think, even 2 something which features in the current law where there 3 can be circumstances in which the doctor would be 4 absolved of requiring to seek informed consent based on 5 a limited advantage that there would be or disadvantage 6 there would be the possibility that the patient might be 7 harmed by doing so. I think we saw similar limited 8 exceptions earlier; is that the same sort of territory? 9 A. That's my understanding. 10 Q. Thank you. And you've provided us, as I say, with 11 a number of important pieces of similar guidance. The 12 document where we're looking at was one that was issued 13 by MDU and you refer to another one which comes in 1970, 14 referred to at paragraph 13.5, by the BMA. To go back 15 to a topic discussed a long time in terms of the 16 hierarchy of authority, I think the position was that 17 these were sort of middle-ranking authorities, was that 18 right, Professor Huxtable? They weren't GMC or Royal 19 College but they were the next rung down, if I can put 20 it that way? 21 PROFESSOR HUXTABLE: I think that's fair. 22 PROFESSOR MCNAIR: Although I would just add to that that 23 I certainly am unaware of the influence of the BMA in 24 the 70s and 80s and so, contemporaneously -- and we 25 mentioned yesterday, are all doctors members of the BMA? Page 158	1 PROFESSOR HUXTABLE: Yes, I think so. 2 Q. And we get to 1988. I think it's the case that this 3 1988 guidance is a potentially important one but the 4 document which I think that you referred to yesterday 5 when we were discussing Montgomery is the 1998 GMC 6 guidance; is that right, Professor McNair, as being 7 particularly important? 8 PROFESSOR MCNAIR: Yes, in the context of authoritative 9 organisations because again the BMA not having authority 10 in the same way as the GMC as the regulator. 11 Q. Thank you. We'll get to that in a moment but before we 12 do, there was another document that we had access to, 13 I think we provided to you, which you address very 14 helpfully at paragraph 13.13, if we could go there. 15 Where you say: 16 "In 1992, NHS in Scotland issued a guide to consent 17 to examination, investigation, treatment or operation, 18 which complemented guidance from the Department of 19 Health, and was intended to ensure consistency across 20 the UK. In addition to again providing some model 21 consent forms, this guidance echoed and expanded upon 22 many points that had been made in the preceding 23 documents, including about: the legal background; the 24 distinction between express and implied consent ... the 25 fact that a consent form provides only evidence of Page 160

1 consent ... the obligation to inform the patient ... the 2 obligation to advise patients about one's 3 recommendations, and clearly convey information that is 4 itself clear ... the need to take particular care with 5 some patients (... those who are distressed or who have 6 potential barriers to communication) ... and the 7 obligation to inform patients about substantial or 8 unusual risks." 9 Then over the page: 10 "Like the BMA in 1993, the NHS in Scotland guidance 11 also addressed the prospect of exceeding consent: 12 'Consent given for one procedure does not give any 13 automatic right to undertake any other procedure. 14 A health professional may, however, carry out further 15 procedures if the circumstances are such that 16 a patient's consent cannot reasonably be requested and 17 provided the farther procedure is immediately necessary 18 and the patient has not previously indicated that the 19 farther procedure would be unacceptable'." 20 That's the concept of the permission, I think, that 21 we discussed earlier, Professor Huxtable; is that right? 22 A. That's right. 23 Q. You go on to say: 24 "Around this time, the GMC also began to issue more 25 detailed guidance on consent. Aspects of the principles Page 161	1 its treatment and prognosis'. 2 "Providing information about the risks associated 3 with the treatment or procedure is a core feature of 4 'providing sufficient information' in the 1998 GMC on 5 consent ... including 'an explanation of any risks to 6 which they [the patient] may attach particular 7 significance'. It notes, for example, that a clinician 8 may need to give the patient more information for a 9 procedure with a 'high risk of failure or adverse side 10 effects'. Likewise, it includes likely benefits and the 11 probabilities of success as information patients may 12 want to know ... It refers several times to letting 13 patients know about the treatment options available to 14 them (including the option not to treat)." 15 And then at paragraph 13.32, in response to the 16 question: what are the categories of information 17 a person would need to know and understand in order to 18 give consent to surgical treatment? At paragraph 13.32, 19 you say: 20 "In the 1998 GMC guidance on consent, the 21 information that a patient 'may want or ought to know' 22 included: 23 "Details of the diagnosis, and prognosis, and the 24 likely prognosis if the condition is left untreated ... 25 "Uncertainties about the diagnosis including options Page 163
1 we have today appeared in the first edition of the GMC 2 guidance in 1995 (ie giving patients the information 3 they request or need to know, in a way that they can 4 understand, which was then framed as 'maintaining 5 trust') ... Consent (with regards to treatment) was 6 first mentioned explicitly in the 1998 guidance, where 7 it was noted that doctors should 'give patients the 8 information they ask for or need about their condition, 9 its treatment and prognosis ... [and should] be 10 satisfied that, wherever possible, the patient has 11 understood what is proposed, and consents to it, before 12 you provide treatment or investigate a patient's 13 condition)'." 14 And then you talk about detailed guidance on the 15 principles of consent in a document called "Seeking 16 patients' consent" from 1988. 17 And in paragraph 13.26, if we just go to that, in 18 response to the particular question about risks, 19 benefits or alternatives, you identify that: 20 "The earliest iteration of [the] GMC guidance ..." 21 Which we just referred to in 1995: 22 "... does not explicitly mention the disclosure of 23 risks or benefits, but this may reasonably be read into 24 the requirement that clinicians must 'give patients the 25 information they ask for or need about their condition, Page 162	1 for further investigation prior to treatment ..." 2 Over the page there's a long list of other things. 3 Number four, for example, in the list is: 4 "How the patient should prepare for the procedure; 5 and details of what the patient might experience during 6 or after the procedure including common and serious side 7 effects ..." 8 Missing one out: 9 "Advice about whether a proposed treatment is 10 experimental ..." 11 Missing one out: 12 "The name of the doctor who will have overall 13 responsibility for the treatment and, where appropriate, 14 names of the senior members of his or her team ... 15 "Whether doctors in training will be involved, and 16 the extent to which students may be involved in 17 an investigation or treatment ... 18 "A reminder that patients can change their minds 19 about a decision at any time ... 20 "A reminder that patients have a right to seek 21 a second opinion ... 22 "[And] where applicable, details of costs or 23 charges ..." 24 So you very much helpfully set out for us all of the 25 various components and I think it's fair to say that Page 164

1 you've identified this 1998 GMC guidance as being one 2 that includes a significant emphasis on and 3 specification of the requirements for informed consent. 4 And I think in the passages I have read out, you deem 5 that to be the equivalent of the modern position but 6 within ethics rather than within law. Is that a fair 7 summary? 8 PROFESSOR MCNAIR: It is. You've very comprehensively 9 described that and I think really does demonstrate the 10 ethical alignment behind patient-centred care that was 11 happening in that period, despite the, for example, 12 Montgomery ruling some time afterwards. 13 Q. And there are a number of aspects to that which may 14 resonate with the earlier section that we've looked at 15 to do with the particular features of surgery and even 16 more so neurosurgery that might be deemed, on the basis 17 of that guidance, to give rise to the conclusion that 18 there is a further or a greater requirement in 19 neurosurgery that doctors at the time would have 20 required to adhere to. Now, if I can mention some of 21 these factors that might exist, and we can see whether 22 you think that that would be the case. 23 So, in neurosurgery, because of the nature of the 24 surgery, the context is often that the surgery is 25 high-risk, the patient is anxious, may have suffered Page 165	1 I'm sure there are lower risk neurosurgical procedures 2 and I'm not a neurosurgeon, but, yes, I accept -- 3 Q. Understood. Neither am I. As we've discussed before 4 many procedures, if not all procedures, are, as a result 5 of some of the factors we've discussed already, attended 6 by a significant degree of uncertainty, including in 7 some cases we've seen in the literature the possibility 8 that the surgery actually may cause further harm to 9 a patient? 10 A. That's correct. 11 Q. And would that, as well as these other factors again, 12 push the index or requirement for information to be 13 shared and there to be an extensive informed consent 14 process upwards? 15 A. It would. 16 Q. Trust, in these circumstances, is at a premium? 17 A. Yes. 18 Q. Meaning that time would need to be taken fully to 19 explain all of these various things as well as to 20 comprehend the views and wishes of an individual 21 patient? 22 A. Yes, and by modern standards, that second part of your 23 phrase is important because time is needed to understand 24 the individual in front of you in order to best tailor 25 the information to suit their needs. Page 167
1 trauma, either physical or emotional, and it is possibly 2 in some circumstances to do with the head which affects 3 the patient's decision-making ability. First of all, 4 would you accept those things can exist, at least in 5 certain neurosurgeries and that they would all be 6 relevant factors which would gravitate the requirement 7 to seek consent upwards, if I can put it that way? 8 PROFESSOR MCNAIR: That's my interpretation, yes. 9 Q. The conditions that patients would be suffering from or 10 the issues that they would have would be likely to be 11 serious with potentially serious consequences if 12 untreated? 13 A. That's correct. 14 Q. The complexity of the surgery is likely to be high, such 15 that it's unlikely that any normal patient will 16 understand much about it already, and in some cases the 17 nature of the complexity of the surgery will, to any 18 average person, be almost impossible to comprehend? 19 A. I agree with the principle. I'm just hesitating about 20 defining "normal people" and other things. But I accept 21 the general premise, yes. 22 Q. Thank you. The risks of the surgery in most cases are 23 likely to be very high, very complex and potentially 24 variable? 25 A. So, yes. Agree with the premise, notwithstanding Page 166	1 Q. Thank you. Bear with me two seconds. (Pause). One 2 aspect of this I'd just like to follow up with you. 3 Paragraph 17.1, please. This is to do with -- we have 4 seen this in some of the contexts about consent forms 5 and even some of the earlier literature, but it says: 6 "According to the 1998 GMC guidance on consent, 'You 7 must use the patient's case notes and/or a consent form 8 to detail the key elements of the discussion with the 9 patient, including the nature of information provided, 10 specific requests by the patient, details of the scope 11 of the consent given'." 12 So those would be components of that discussion that 13 we've just talked about. But what this is telling us, 14 I think, is that in the case of every patient of 15 Mr Eljamel from at least 1998 onwards, they should be 16 able to find, in their medical records, a written 17 account of these key elements of the discussion, is that 18 right? 19 PROFESSOR MCNAIR: That's correct. 20 MR DAWSON: Sir, that would be a convenient moment for 21 a break. 22 THE CHAIR: Gentlemen, we'll take a 15-minute break and 23 resume again after that. Thank you very much indeed. 24 PROFESSOR MCNAIR: Thank you. 25 PROFESSOR HUXTABLE: Thank you. Page 168

1 (3.22 pm) 2 (A short break) 3 (3.39 pm) 4 THE CHAIR: Right, can we have the witnesses back, please. 5 Gentlemen, good afternoon. We're ready to resume again, 6 Mr Dawson. 7 MR DAWSON: Thank you, sir. Can you see and hear me okay? 8 PROFESSOR MCNAIR: We can, yes. 9 Q. Great, thank you. In broadly, the second half of the 10 report, after all of the areas we've covered, the 11 particular aspects of the ethics of surgery, the ethics 12 of neurosurgery and informed consent, we asked you 13 a number of quite particular questions and you've 14 referred us in many cases to a number of professional 15 guidance sources, as you said at the beginning of the 16 report would be your focus. And so I have less 17 questions in these areas simply because you've provided 18 the answer by reference to the appropriate guidance in 19 many cases and the answer is clear. But what is 20 actually more often the position is that in fact we've 21 already covered the ground in the general territory as 22 to what one should do by looking at the general 23 principles and that helps one understand, I think as 24 I said earlier, why the rules are the way that they are, 25 which for present purposes is really quite important to Page 169	1 a whole account of what shared decision-making is, it 2 is, in my opinion, a very useful way to describe it 3 especially in visuals that I think are helpful. So 4 I just sort of start with that. 5 Q. Okay. 6 PROFESSOR MCNAIR: We have, on the screen, the visual and it 7 touches on things I described yesterday. So on one hand 8 there is "patient reasoning" and that patient reasoning 9 is related to a number of different factors, things like 10 culture, values, experience, skills, knowledge, 11 motivation. And on the other side is "practitioner 12 reasoning" and that's based on similar sorts of factors 13 related to the practitioner as well as guidelines, 14 training, multi-disciplinary teams and other sorts of 15 infrastructure. And it's the interaction and coming 16 together of these two different reasonings that, in this 17 framework, describes shared decision-making. 18 Q. Okay. Is this something that is an innovation in this 19 area in particular with regard to the ethics, or is it 20 just an innovation in the way that it's being presented 21 and thought about? 22 A. This is, I guess, a recent characterisation of shared 23 decision-making that is presented with a particular 24 purpose. A colleague of mine, Hilary Bekker, who is 25 based in Leeds University developed it specifically to Page 171
1 the Inquiry to understand. 2 There are some specific areas that I would like to 3 dwell on and one area which I suspect Professor McNair 4 could speak about for many, many hours but we won't is 5 the shared decision-making that we've discussed earlier. 6 And you've very helpfully provided to us a detailed 7 breakdown of how shared decision-making works or should 8 work. 9 But in particular, you tell us, at paragraph 21.3, 10 if we could have a look at that, about something called 11 "Making Informed Decisions Individually and Together in 12 Healthcare", the acronym being "MIND-IT" and you've 13 provided to us a diagram on that page which I think sets 14 out some of the concepts and processes and objectives 15 involved. Could you, fairly broadly, tell us what the 16 importance of that is in shared decision-making? 17 PROFESSOR MCNAIR: The purpose of me including a reference 18 to this particular framework and the accompanying image 19 is to try and distill a whole body of work into 20 something that I hoped this Inquiry would find helpful. 21 I prefaced the paragraph to define or describe all the 22 different definitions of "shared decision-making". So 23 I have listed here 161 out of a systemic review in 2006. 24 And so I want to make it clear to the Inquiry that this 25 is not a specifically endorsed framework, this is not Page 170	1 help people develop interventions or ways to improve 2 shared decision-making because she felt that these ideas 3 could potentially become targets by which one could make 4 improvements to care and so it is framed around that 5 much. But my involvement in broader international 6 organisations such as the International Society of 7 Shared Decision Making, really helps me to give 8 a further context, that there is no one single version 9 of this and I use this mostly for illustrative purposes 10 and it really is not the last word on the subject. 11 Q. Because, in looking at the diagram, there are a lot of 12 concepts there that we've talked about as being integral 13 to, in particular the ethical position that we've been 14 discussing before the break; culture, values, 15 experience, skills, knowledge, motivation, for example, 16 the need for that to be considered from the point of 17 view both of the patient and the health practitioner and 18 there being a requirement for interaction, for 19 discussion, for understanding and for shared 20 decision-making to get to a point where there's 21 an exchange of understanding, reason about preferences 22 and the implementation of an agreed choice. 23 Although this may be a helpful way of illustrating 24 it, I wondered whether this was, in fact, perhaps 25 an extension of the process that we've discussed of Page 172

1 ideas coming through academic literature, getting into 2 guidance, getting into law. Is this perhaps returning 3 to academic literature and academics to try to make 4 things better in the detail; is that kind of what this 5 is? 6 A. Yes, so in a way the process of developing this is built 7 upon the academic and professional literature and it was 8 created with a particular purpose in mind and as I say, 9 others are available. But for me, personally it 10 resonates with a lot of these ethical ideas that we've 11 been discussing and that's why I chose this particular 12 one to include in the report. 13 Q. Thank you. At paragraph 21.4 you provide some more 14 information about the components of the MIND-IT 15 framework and you talk about three in particular: 16 "Patient reasoning in the context of their life 17 (... culture, values ..." 18 Etc, we just discussed: 19 "Professional reasoning in the context of 20 evidence-based medicine (... knowledge, skills, 21 experience, interactions [and] multi-disciplinary 22 opinions. 23 "Shared reasoning resulting from understanding both 24 perspectives." 25 But then you go on to say that: Page 173	1 So what this is trying to do is to set out, based on 2 literature some of which comes I think from an earlier 3 period in time from 2012 and has evolved since then, of 4 the practical operation of the process that we have been 5 talking about in a more conceptual sense. So we've 6 mentioned a couple of times, I have asked you on more 7 than one occasion, the need for time to be able to do 8 this and this is what the time should be filled with; is 9 that roughly what we're being told here? 10 PROFESSOR MCNAIR: Yes. So this particular model was 11 developed by colleagues in Cardiff and formed part of 12 a national quality improvement programme called the 13 "Magic Programme" that was conducted at the time around 14 of the Three Talk model and as you say, this was their 15 proposed operationalisation of shared decision-making to 16 support people to actually deliver it with patients on 17 the ground. You're right, it takes time. 18 Q. Thank you. And from paragraph 21.8 onwards you look 19 back over how ethical obligations have changed in this 20 regard over the last 40 years, the process that we've 21 discussed. And of course, the Inquiry has 22 an interest -- and you talk about defining the SDM 23 agenda, I think, in the period when the 2012 model came 24 about. The Inquiry has an interest in this sort of 25 thing in particular with regard to what the Chair will Page 175
1 "Other academic literature describes how this may be 2 operationalised into clinical practice. A highly-cited 3 UK-based example is called the 'Three Talk model' 4 (2012), which was later refined and renamed as 5 'Implement-SDM' ... This involves the following 6 components: 7 "Preparation phase before the concept of choice is 8 introduced. This allows professionals to gain 9 information about the suitability of different 10 treatments (eg obtaining medical history or test 11 results) and patients to reflect on their values and 12 priorities in a held health context (eg recent cancer 13 diagnosis). 14 "Choice introduction where the availability or 15 rationale of choices [is] presented. 16 "Tailored discussion of options integrating 17 patients' values/preferences with professionals' 18 knowledge/experience. 19 "Planning to implement decisions. 20 "Eliciting patient preferences occurs throughout, as 21 does emotional and practical decision support. 22 "This model recognises that decision-making is not 23 a single event, but [as you've said before] 24 a multi-stage process that involves a multi-disciplinary 25 team." Page 174	1 ultimately learn about potential defects in this area 2 that may have occurred in and around the practice of 3 Mr Eljamel, how that could help with regard to making 4 recommendations for the future. And you tell us, in 5 paragraph 21.9.3, which is the final section of your 6 historical summary, that the period from the 2019 to 7 present, it could be characterised as implementing the 8 SDM process across the NHS: 9 "The NHS Long Term Plan 2019 defined personalised 10 care as key objective for the following 5 years, 11 including SDM [shared decision-making]. NHS England 12 simultaneously published guidance, Universal 13 Personalised Care: Implementing the Comprehensive 14 Model ... which sets out actions needed to implement SDM 15 in the NHS ... This period also included the publication 16 of regulatory and professional guidance that describes 17 surgeons' obligation to practice SDM, as described 18 above." 19 So a couple of questions about that. One is that 20 process there of the regulatory and professional 21 guidance incorporating the shared decision-making models 22 that you've set out, is that another example of 23 a further particularisation of those types of models, 24 this time not the particularisation of guidelines but 25 the particularisation of practical steps that one might Page 176

1 be able to take to implement the ethical standards? 2 A. I see them as somewhat of a convergence of disciplines 3 I guess, in that in the more historical realm, the 4 concepts of informed consent and shared decision-making 5 are clearly closely aligned but shared decision-making 6 generally is considered to be a broader concept about 7 how we approach healthcare decisions, whereas I think in 8 a more modern form, informed consent perhaps is 9 typically considered more in a sort of narrow view, or 10 perhaps even a legal-type construct, around supporting 11 autonomy in a very specific way. 12 I think what we're seeing in this time period -- and 13 if we compare the sorts of timelines that we've got -- 14 what we have just discussed in the last session with the 15 movement in the GMC in 1995, 1998, 2002, along with the 16 SDM literature as presented here, where we're sort of 17 understanding this concept and things are becoming 18 convergent, what we see in some of the most recent GMC 19 guidelines is actually even the most recent GMC document 20 is "Shared decision-making and consent". So these 21 terminologies are starting to become part of one sort of 22 professional ethical obligation that in my mind extends 23 beyond a relatively narrow construct of informed consent 24 into the broader idea of shared decision-making, both of 25 which are important. Page 177	1 to maintain the standard of care. 2 Q. Because that's an important consideration, isn't it? We 3 tried to shy away, to a certain extent, from 4 organisational ethics where we have said on a number of 5 occasions there must, logically, be organisational 6 obligations perhaps even ethical obligations even if 7 you're reluctant to talk about them and indeed legal 8 obligations to provide systems in which this sort of 9 approach can flourish because without the practical 10 environments in which these important initiatives can 11 work, there is a significant restriction in the ability 12 of individuals acting collectively to deliver the kind 13 of healthcare system that these principles envisage; is 14 that correct? 15 A. Very much so and I would hope this Inquiry is 16 an opportunity to elevate the issues that you feel are 17 important enough to define well, to create some sort of 18 standard or obligations in the future, because there are 19 various points where perhaps efforts to do this have 20 maybe waxed and waned and I'll draw attention to this 21 paragraph, where the universal personal care plan, so 22 this particular initiative was set up by NHS England and 23 had a five-year remit, and again, I haven't been 24 intimately involved with it but public information tells 25 me that that process, along with NHS England as a whole, Page 179
1 Q. Okay and I suppose the characterisation of the last 2 period is 2019 to present, leading to, I'm assuming 3 towards the end of that period, regulatory and 4 professional guidance that describe surgeons' obligation 5 to practice shared decision-making. Does that represent 6 a culmination of this or is it really very much 7 a process that is still ongoing into the future? 8 A. I can tell you that I'm still in meetings with people 9 arguing the definition of "shared decision-making", 10 I think that's probably fair. I think that this 11 construct will continue to evolve and it will evolve in 12 ways that will keep pace with, I guess, demands of 13 society and the ever-changing sort of, I guess, social 14 norms, to go back to that term before. 15 The other thing to mention is that while sort of 16 clearly the definitions and things are important, 17 I think what the period, and especially the last 18 five years has been about is that actually implementing 19 this is seen to be a key challenge, where the preceding 20 sort of decades really presented challenges in kind of 21 deciding what the policy position might be, but I think 22 a lot of academic field are now moving towards that 23 there is an ethical obligation to do this, so how do we 24 do this and how do we do this and enable people to have 25 the time and the resources and the other things in order Page 178	1 has been wrapped up. 2 And so I would expect those sorts of infrastructure 3 or resources in order to support what I consider to be 4 an important ethical obligation will continue in some 5 form in the later situation of the health service. As 6 priorities shift, then we start to see, well, I guess 7 different priorities coming through and perhaps it 8 doesn't feature quite so prominently in the more recent 9 health plan. 10 Q. Thank you. Could we go, please, to question 23 at 11 page 109. We asked you, in this section, about -- some 12 of the aspects of this we've already covered in some 13 detail, but we asked you some particular questions about 14 what ethical responsibility surgeons have to inform 15 their patients or their representatives about various 16 aspects of their healthcare and in (a) we asked you 17 about a particular aspect as to whether there was 18 an obligation on a surgeon to inform a patient about his 19 or her technical competence or experience of 20 a particular contemplated surgical course. 21 And you say, at paragraph 23.2, that: 22 "... Good Medical Practice [from GMC] and RCS Good 23 Surgical Practice define an obligation for surgeons to 24 work within [the] limits of [their] competence and scope 25 of practice ... This obligation means that surgeons must Page 180

1 have sufficient technical competence or experience to 2 deliver proposed surgical options, or refer patients to 3 another suitably qualified professional. 4 "In the context that a surgeon has met professional 5 ethical obligations described above ...surgeons have an 6 additional obligation to achieve high quality SDM ... 7 This includes an obligation to explore and understand 8 their patients' values and preferences, which may 9 involve discussions about technical competence or 10 experience if this is important to the individual." 11 I think this sets out certain ethical principles 12 that are relevant to the question that's been asked but 13 I wondered whether it really pulled together any sort of 14 conclusion because there are obligations, of course, to 15 work within the scope of one's competence, there are 16 obligations to conduct quality SDM in earlier periods, 17 achieve informed consent. I suppose the specific 18 question related to whether it was incumbent upon 19 a surgeon to be honest with the patient in circumstances 20 where they perhaps had limited competence or limited 21 experience of a certain area. 22 If I might give an example. One of the 23 neurosurgical experts candidly told us last week that 24 there was a period in which he, because of lack of 25 exposure to the work, had approached the board, the Page 181	1 probably encompasses the ideas that you want to get 2 across here because the scope of practice, I think and 3 I believe, is going to evolve as somebody is, for 4 example, job plan or experience or a number of different 5 things happen to them over the course of their career. 6 And this might be best explained perhaps when somebody 7 first qualifies as a consultant, where they've completed 8 their training and will have met certain competencies 9 across the entire curriculum of a specialist in 10 a particular field. 11 But that does not necessarily mean that their future 12 job description would include all those elements from 13 which they're trained. And so very quickly that 14 person's scope of practice might become more narrow and 15 so it would then be an obligation on that individual to 16 explain to a patient that: having once trained in this, 17 I no longer have this within my scope and practice and 18 I would like to refer you to a colleague. 19 I think you've also highlighted the interface here 20 between the organisational responsibilities because 21 I believe in your example that the individual surgeon 22 was discharging their individual duty to raise a limit 23 of their scope of practice, and I would hope then that 24 there was an ethical responsibility of the organisation 25 to listen to that and to adapt somebody's job plan to Page 183
1 health trust in which he worked to say that he felt, at 2 a stage, reluctant to continue to offer paediatric 3 neurosurgery for when he was on-call because he hadn't 4 offered it electively for some years. Effectively, that 5 was a situation in which he realised professionally that 6 although he might have to offer it in an on-call 7 situation, he did have limited experience and that might 8 be something which, in an elective situation, he might 9 have wished to bring to a patient's attention in order 10 that a fully informed decision could be made. Is that 11 the sort of thing that it would be incumbent upon 12 a professional to bring into the discussion, because we 13 have recognised, I think, in our discussions, and indeed 14 in our discussions with the neurosurgeons, that 15 different surgeons or different medical professionals 16 will have a variety of different specialties which they 17 feel they can cover and that some may be covered in 18 certain circumstances like on-call situation, but you 19 wouldn't necessarily be the best person to go to in 20 an elective situation. 21 So, reflecting on some of the concepts we've 22 discussed, I wonder if we can reach a clear answer as to 23 what ethical principles we think are in play here? 24 PROFESSOR MCNAIR: Yes and I think that the ethical 25 obligation to work within your scope of practice Page 182	1 address their self-identified limitations, which I guess 2 may or may not have been operationalised in your 3 example. 4 Q. By way of consolation, I can tell you that in fact 5 a plan of that nature was put in place which meant that 6 the plan was to operationalise but then an agreement was 7 reached, as I understood it from the individual surgeon, 8 that he would get more training to be able to up his 9 level to what he would consider professionally 10 responsible. So effectively both the organisational 11 requirements and his personal ethical requirements were 12 satisfied. 13 PROFESSOR MCNAIR: Very good. 14 Q. One further aspect that I wanted to ask you about -- 15 you've covered this in some detail so I won't go into 16 the details of it, but one aspect that we've covered 17 this morning and on which I'd like to ask you a specific 18 question relates to training. I think maybe the answer 19 to this is self-evident, but as we're asking the ethical 20 experts, it may be useful to have some reflections on 21 this. 22 We discussed, I think yesterday, the importance of 23 team working in neurosurgery in particular and I think 24 we identified that that was the case -- I think 25 Professor McNair said internal to the operating theatre Page 184

1 but also externally, given the multiplicity of different 2 disciplines that neurosurgeons would require to work 3 with, even quite historically. Therefore I think we 4 discussed the importance of good team working and that 5 there was a significant ethical component to that, in 6 particular in the field of neurosurgery. 7 Would it then follow that it would be unethical for 8 a consultant neurosurgeon over the relevant period in 9 which we're interested to have behaved in a way which 10 amounted to bullying or intimidation of junior 11 colleagues? 12 A. Correct. 13 Q. I'm interested, in particular, in a sort of particular 14 aspect of this and what the ethical implications are. 15 It is, of course, unethical to behave like that, as 16 you've just confirmed. However, in a situation where 17 the force of personality of an individual may create 18 a certain environment in which the unit and perhaps 19 junior doctors or other doctors are forced to work, what 20 are the ethical implications and responsibilities in 21 a situation where because someone behaves in 22 a particular way people feel inclined to limit the way 23 in which they behave as a result? Because that is 24 a matter where there is a body of evidence that means we 25 may require to look at that. Page 185	1 the priority but also the staffing one. 2 Q. So I suppose both have a patient-facing element. One is 3 for the immediate care of patients there and then and 4 the other is related to the throughput of good quality 5 neurosurgeons for future patients, is that what you're 6 saying? 7 A. Correct. 8 Q. Thank you. You've already provided us with some helpful 9 reflections on something we touched on, I think earlier, 10 which is the ethical obligations connected to the broad 11 subject of workload management. And again, this is 12 a topic of interest to the Inquiry. I think the broad 13 assertion that you have made from an ethical perspective 14 is that where obligations, for example, to one's 15 employer to carry out multiple activities conflict with 16 patient care, the latter must predominate; is that 17 correct? 18 PROFESSOR HUXTABLE: Yes. 19 Q. And that is obviously important because it is a feature 20 of the sort of foremost obligation to put patient care 21 at the front of things but as far as workload management 22 is concerned, we touched earlier in some of the 23 neurosurgical literature on the importance of presence 24 in neurosurgical practice, both physical presence but 25 also a broader concept of presence. Does that mean that Page 187
1 PROFESSOR MCNAIR: So I think this is important because if 2 you have highly trained members of the team, and 3 I'm going to include my resident or formerly known as 4 junior doctor colleagues in that, because I don't want 5 to do them a disservice that they haven't had many years 6 or even decades of training despite not being 7 consultants. If you are in a situation where you 8 inhibit those people from performing their ethical 9 duties be it to improve patient care in that way, 10 characterised as beneficence and non-maleficence, or 11 other aspects of that and create a poorly functional 12 team then, in my view, patient care will suffer. 13 I think there's a broader aspect here as well, if 14 I bring in justice which is always the slightly tricky 15 one of the principles to bring in here but if part of 16 our ethical responsibility is to ensure future 17 generations of highly functional neurosurgeons, then 18 creating that environment both, I think, creates the 19 wrong role model and therefore risks a sort of 20 perpetuating the bad behaviour through generations or, 21 on the converse, risks putting off highly skilled 22 trainees from wishing to fulfil their potential within 23 a field which they consider to be so unpleasant. So 24 I would put the ethical obligations in those two 25 framings, the patient-focused one which is, of course, Page 186	1 workload management issues are ones that could be 2 particularly acutely felt in the neurosurgical field, if 3 they were not managed correctly? 4 PROFESSOR MCNAIR: I think so. I hesitate a little bit on 5 presence within a modern healthcare workforce. Partly 6 because one of the theoretical benefits of a strong 7 multi-disciplinary team is the ability to work 8 effectively to deliver high quality patient care without 9 an individual being physically present at all times. 10 And I don't mean that to mean that there would be a less 11 qualified person but I'm more specifically thinking 12 about a team of consultant neurosurgeons who have the 13 combined shared aim of looking after patients and 14 therefore managing a workload in such a way that they 15 rotate duties to enable appropriate activity to take 16 place. 17 So, as a specific example it might be that a surgeon 18 who has an operating list on a particular day will be 19 occupied perhaps for 10 hours and in that timeframe 20 a fully qualified consultant colleague may complete the 21 inpatient ward round and see patients on behalf of their 22 colleagues who were discharging other highly relevant 23 duties and so I think that this sort of model which is 24 widely implemented within the NHS is important 25 contextual information when considering the physical Page 188

1 presence of an individual. 2 THE CHAIR: Does that create any potential, at least, for 3 tension between what you've just described and 4 where I've read elsewhere about the benefits associated 5 with continuity of care and by that I mean continuity of 6 care with a particular surgeon and a particular patient; 7 do you follow me? 8 PROFESSOR MCNAIR: I do. And I recognise the tension here 9 and in my mind it's one of the reasons why the GMC 10 professional guidance highlight issues around handover 11 and continuity of care being important because 12 historically -- bearing in mind I went to medical school 13 in 1999 and this pre-dates my arrival at medical 14 school -- perhaps patients were looked after solely by 15 a consultant, a specific named consultant and their 16 junior team who were all, in effect, line managed by 17 an individual consultant. And in my experience of the 18 current health service that's not really a model that 19 exists in that way because of the way that activities 20 are structured which, from an ethical perspective, one 21 would hope would strike a balance in which productivity 22 and efficiency would increase while acceptably 23 maintaining a continuity of care. 24 THE CHAIR: Thank you. 25 MR DAWSON: A couple of aspects of that to pick up, Page 189	1 the time period that we're talking about. The evidence 2 you gave a moment ago was based on current practice and 3 perhaps best practice to maximise efficiency in 4 a current system. The considerations that you've 5 mentioned might be deemed, ethically, to work very 6 differently in a situation where one is in, perhaps, 7 a smaller hospital, a district hospital, or offering 8 a smaller service with a fewer number of people, where 9 individual presence might be deemed to be more of the 10 norm; would that be fair? 11 PROFESSOR MCNAIR: So, I think I'll caveat this whole 12 section by saying that we didn't look into this in 13 detail within our report and so I am somewhat providing 14 evidence on the fly which, if you're happy with me to 15 continue with that caveat, I will do so. I recognise 16 that there are hospitals of different size and 17 complexity. And so one would assume that when local 18 organisations are designing their services, they will 19 take into account local staffing levels and in a context 20 where there are a smaller number of, for example, 21 consultants, then they won't be able to work in the same 22 way as perhaps a larger unit. And so the way that those 23 organisations will discharge their ethical obligations, 24 I imagine, will be different within those contexts but 25 I guess the purpose would remain the same, to produce Page 191
1 Professor McNair. The first is that in circumstances 2 where the efficiency considerations would mean that the 3 modern model that you refer to would perhaps be 4 preferable in certain circumstances, it would, would it 5 not, remain the ethical responsibility of the doctor who 6 is not there for his patients on the ward round because 7 he's attending to other important duties, he would still 8 retain overall ethical responsibility for the situation, 9 such that any arrangement he put in place for other 10 doctors to take over his responsibilities to maximise 11 efficiency would require to be adequate for that 12 purpose, is that fair? 13 A. Yes and that, again, sits with the interface of the 14 organisational ethics because -- and again, this is 15 stretching my limits of expertise, but the decisions 16 around how teams are structured will be, I anticipate, 17 completed at a local level with the input of specialists 18 to design a service that those specialists believe 19 maximise patient benefit while operating at peak 20 efficiency, would be my assumption here. But I do not 21 have all the knowledge in front of me to describe how 22 this system might work across a range of health services 23 or hospitals. 24 Q. And just for clarity, in order to put things in context, 25 because we've recognised the importance of recognising Page 190	1 the highest quality care for the resources of that that 2 organisation has and to organise it in such a way that 3 supports best patient care. But again, I am not 4 an expert in how these services are designed. 5 Q. Thank you, but in terms of workload management, it 6 wouldn't ever be ethical, would it, for a consultant 7 neurosurgeon to be working privately while on-call for 8 the NHS? 9 A. So that's clear within the evidence that we've 10 identified in this report. 11 Q. Thank you. You also provide some helpful other evidence 12 that I'd just like to look at briefly in relation 13 because it relates to a point that was raised on behalf 14 of one of the core participant groups at an earlier 15 hearing relating to private referral and the rules 16 relating to that. Could we go to paragraph 116 of the 17 report, please. This relates to the specific rules 18 around making private referrals in particular from the 19 NHS? 20 THE CHAIR: Was that page 116? 21 MR DAWSON: Page 116. So what you've referred us to here, 22 you were asked: 23 "What ethical principles and practices should govern 24 a surgeon's decision-making/advice about referring NHS 25 patients to private care?" Page 192

1 And you've referred us to: 2 "The NHS Code of Conduct for Private Practice: 3 Recommended Standards of Practice for NHS Consultants 4 [which you say] defines professional ethical obligations 5 about referring NHS patients to private care, stating: 6 "In the course of their NHS duties and 7 responsibilities consultants should not initiate 8 discussions about providing private services for NHS 9 patients, nor should they ask other NHS staff to 10 initiate such discussions on their behalf' ..." 11 And you say, at paragraph 28.1.3: 12 "Except where immediate care is justified on 13 clinical grounds, consultants should not, in the course 14 of their NHS duties and responsibilities, make 15 arrangements to provide private services, nor should 16 they ask any other NHS staff to make such arrangements 17 on their behalf unless the patient is to be treated as 18 a private patient of the NHS facility concerned'." 19 So the document you referred to there is 20 a Department of Health document, I think, from 2004 but 21 that sets out what I'm assuming you would be thinking 22 would be at least contemporaneous to that, broadly 23 required ethical obligations in this area, despite its 24 limited jurisdiction, if you like, the Department of 25 Health document; would that be fair? Page 193	1 matter right if that's possible'." 2 So again, this may be at the interface between the 3 organisational and the individual, but there is 4 an obligation to take action, if I can put it as broadly 5 as that, in circumstances where you feel that you cannot 6 deliver ethical patient care because of inadequate 7 premises, equipment, other resources, policies or 8 systems; is that right? 9 PROFESSOR HUXTABLE: Yes, that's right. 10 Q. And again, I think this is one which comes from a recent 11 iteration of the General Medical Council guidance, but 12 I think it looks like it's consistent with other 13 principles we've seen from much earlier, would that be 14 fair? 15 PROFESSOR HUXTABLE: I think that is fair, particularly 16 given that centrality over various decades of, first and 17 foremost, make the care of patients one's first concern. 18 Q. Thank you. At paragraph 41.2, please, specifically 19 dealing with whistleblowing obligations. This emanates 20 from a GMC publication from 2012: 21 "There is a general obligation to raise concerns 22 according to GMC guidance: 'All medical professionals 23 have a duty to raise concerns where they believe that 24 patient safety or care is being compromised by the 25 practice of colleagues or the systems, policies and Page 195
1 PROFESSOR MCNAIR: That is fair and just to disclose I do 2 not have and never had a private practice. So this is 3 all done on the basis of the evidence and without 4 personal experience. 5 Q. Thank you. We've already covered, in some helpful 6 detail, obligations of doctors with regard to issues 7 arising in the practice of their professional colleagues 8 but there are a few specific aspects of this I just 9 wanted to cover with you which you've helpfully set out 10 in your report. If we could have up, please, page 136, 11 please. I think this was a section which, 12 Professor Huxtable, you completed with Dr McMillan, if 13 I have got my notes correct. You were asked here about 14 the obligations of medical professionals relating to 15 events occurring in the practice of others and you tell 16 us, at paragraph 36.2: 17 "The GMC's Good Medical Practice states: 'You must 18 act promptly if you think that patient safety dignity 19 is, or may be, seriously compromised'." 20 Which is from the recent GMC iteration. And in 21 particular, you tell us from that same document, at 22 36.2.2, which is over the page, that: 23 "If patients are at risk because of inadequate 24 premises, equipment or other resources, policies or 25 systems, you should first protect patients and put the Page 194	1 procedures in the organisations in which they work. 2 They must also encourage and support a culture in which 3 staff can raise concerns openly and safely'." 4 I wonder if we could look also at 41.4, where you 5 say: 6 "Clinicians should also comply with the GMC's 7 specific guidance on Reporting criminal and regulatory 8 proceedings. This also applies to whistleblowing: 'If 9 you have concerns that a colleague may not be fit to 10 practise and may be putting patients at risk, you must 11 ask for advice from a colleague, your defence body, or 12 us. If you are still concerned, you must report this, 13 in line with your workplace policy and our more detailed 14 guidance on "Raising and acting on concerns about 15 patient safety'." 16 Then it says: 17 "Those with leadership or management roles have 18 further obligations to make sure that staff can talk 19 about concerns [or] errors: 'If you have a formal 20 leadership or management role, you must take active 21 steps to create an environment in which people can talk 22 about errors and concerns safely. This includes making 23 sure that any concerns raised with you are dealt with 24 promptly and adequately, in line with your workplace 25 policy and our more detailed guidance on "Raising and Page 196

1 acting on concerns about patient safety"." 2 And in particular, if I could look at 42.4, which 3 says: 4 "On raising concerns about others, GMC guidance 5 states that: 'Wherever possible, you should first raise 6 your concern with your manager or an appropriate officer 7 of the organisation you have a contract with or which 8 employs you -- such as the consultant in charge of the 9 team, the clinical or medical director or a practice 10 partner. If your concern is about a partner, it may be 11 appropriate to raise it outside the practice -- for 12 example, with the medical director or clinical 13 governance lead responsible for your organisation. If 14 you are a medical professional in training, it may be 15 appropriate to raise your concerns with a named person 16 in your training organisation'." 17 So to take all of these things together, I think 18 these pieces of guidance recognise that there are 19 a number of potential difficulties with the broad 20 concept of raising concerns which is the primary 21 obligation, not least that those concerns, in particular 22 in circumstances where they are concerns about senior 23 members of staff, require to be raised with some agency 24 that would have the capacity to do something about it. 25 Is that broadly what we're seeing from these rules. Page 197	1 all other things. There may be issues of practical 2 difficulty, professional embarrassment that may get in 3 the way, but as soon as there is an inkling of 4 a suspicion that something may jeopardise patient safety 5 action is mandated ethically; is that correct? 6 PROFESSOR HUXTABLE: That's my understanding, yes. 7 Q. Thank you. Because all of those rules would tend to 8 gravitate towards that conclusion, in particular the 9 fact that one does not need to wait for proof or go 10 through an exhaustive process before raising a concern, 11 with perhaps the caveat that we mentioned earlier that 12 there would also be an obligation, which I think we saw 13 in the 2007 rules, that courtesy and respect towards 14 other professional colleagues may mean that raising the 15 matter with them first would be the appropriate act to 16 take. Is that a fair summary of what these rules tell 17 us? 18 A. I think it is, yes. 19 Q. And I think it's fair to say in this area, although in 20 this general area of the report we're relying quite 21 heavily on the most modern versions of GMC guidance, we 22 saw there, for example at 44.2, that was in the 2012 23 guidance; is that right? 24 A. That's right. 25 Q. Now for fear, Professor Huxtable in particular, that Page 199
1 PROFESSOR HUXTABLE: That's my understanding, with the 2 caveat of course that Dr McMillan led on these sections 3 of the report. 4 Q. And as regards the importance or I suppose the guidance 5 related to when the duty to act in some way by raising 6 concerns taking other action is concerned, 7 paragraph 44.2 is helpful in that regard, where it says: 8 "In terms of overcoming obstacles to reporting, in 9 its 2012 guidance on raising concerns, the GMC instructs 10 clinicians to bear the following factors in mind: 11 "... You have a duty to put patients' interests 12 first and act to protect them, which overrides personal 13 and professional loyalties. 14 "... The law provides legal protection against 15 victimisation or dismissal for individuals who reveal 16 information to raise genuine concerns and expose 17 malpractice in the workplace." 18 Finally, and perhaps importantly: 19 "You do not need to wait for proof -- you will be 20 able to justify raising a concern if you do so honestly, 21 on the basis of reasonable belief and through 22 appropriate channels, even if you are mistaken." 23 So I think what the rules here are trying to help us 24 with, even from 2012, is to try to make clear that the 25 impetus -- the incentive is to protect patients above Page 198	1 I may be opening up an entire thesis in what will be 2 amongst my last questions, because I know this is 3 an area of particular interest to you, and also of 4 particular interest to the Inquiry, you've provided to 5 us already a very comprehensive and useful analysis of 6 ethical obligations relating to research which I don't 7 intend to go through with you in particular relating to 8 the various steps that are needed for research to comply 9 with the extensive and complex rules of relating to 10 clinical trials. They focus, I think, on there being 11 a multitude of ethical obligations which broadly seek to 12 make it clear that a patient must be informed of 13 absolutely every step just about that's being taken so 14 that there can be no dubiety over the question of the 15 patient's consent and willingness to be involved in the 16 trial. Is that broadly what the rules tell us, although 17 with an incredible amount of detail in places? 18 A. Yes, that's right. 19 Q. The particular matter I wanted to raise with you is 20 I think the thing that you are particularly interested 21 in which is the difference, if you like, between 22 research and surgical innovation. Because you tell us 23 that this is an important distinction, and I know this 24 is a research area of interest to you, and it is, as you 25 anticipate in the final sections of the report, of Page 200

1 potential interest to the Inquiry because what you 2 identify, although you may not be conscious that you're 3 doing, what you're doing is in fact trying to help us 4 with the interpretation of our Terms of Reference which 5 do in places refer to research but what you've posed to 6 us is an interesting legal question I think which we 7 will have to resolve as to whether we should interpret 8 that as covering research per se, if I could call it 9 that, or it should cover surgical innovation. 10 And in fact it would be very helpful I think to that 11 decision of legal interpretation, which will be a matter 12 for the Chair to undertake in due course, if you could 13 tell us a bit about the importance of surgical 14 innovation pertaining to the matters of interest to us, 15 in particular the sorts of ethical issues that might be 16 thrown up in that regard? 17 PROFESSOR HUXTABLE: Yes, so I'll offer a few opening 18 remarks and then I'll turn to Professor McNair because 19 this is also an area of great research interest to him. 20 So from my own perspective, amongst the observations 21 I make would be that I tend to see this as something of, 22 again to use a phrase I used a lot yesterday, 23 a complicated Venn diagram. So we have three bubbles in 24 that Venn diagram, as I see it. On the one hand, 25 clinical care and treatment. Over in another bubble, Page 201	1 does rather fall at the judgment again of the individual 2 surgeon as to whether or not they take this through 3 a new procedure committee, or they go to a research 4 ethics committee or indeed they claim that what they are 5 doing is standard or routine clinical care or treatment 6 such that it doesn't need to go through all the research 7 ethics processes or indeed other processes associated 8 with some forms of innovations. 9 So there are big questions there fundamentally about 10 governance. 11 I think following from that you also end up with all 12 the other questions we've been looking at, so questions 13 of what information should be provided to patients about 14 what sort of procedure is going on, how often has the 15 surgeon in question performed said procedure, and so on. 16 So those are amongst the opening remarks 17 I would make but I'll turn to Professor McNair. 18 PROFESSOR MCNAIR: This is, in my view, an area where 19 greater clarity would greatly benefit both patients and 20 surgical innovators. And I usually start by saying that 21 surgical innovation and research is obviously a good 22 thing; we want to improve patient care and improve 23 patient outcomes. So this is in no way meant to be 24 a break on that, but what we've seen through evidence 25 produced by our unit here in Bristol is that the way Page 203
1 research. And I sometimes see surgical innovation as, 2 depending on how one views it, overlapping with both of 3 the other bubbles. 4 So innovation can take a variety of forms. It might 5 be quite a minor adaptation of an existing and 6 well-known, well-established existing clinical 7 procedure, all the way through to something that is 8 really through a research lens looks like research but 9 potentially without all the ethical safeguards that are 10 attached to research. 11 So briefly in that regard I would note that in 12 relation to research we have, indeed it's mandated in 13 law, a whole research ethics approval system including 14 approval by for example a research ethics committee. 15 Over on the clinical side we have, although coverage 16 is I think it's fair to say patchy, we do at least have 17 some clinical ethics support systems, such as clinical 18 ethics committees that are there to advise on day-to-day 19 clinical care. I think it's fair to say -- 20 Professor McNair may want to add more to this -- the 21 situation is much more grey in relation to surgical 22 innovation. So there are some new procedure committees 23 or similar committees that attempt to offer advice and 24 support on whether something innovative should or should 25 not proceed, but it does rather, in my impression, it Page 202	1 that governance runs with the sort of outside of full 2 research approvals but not regular practice is highly 3 variable. So systematic reviews of new procedures 4 committees which are one of the governance structures 5 that are meant to sort of support the introduction of 6 new procedures is incredibly variable and that doesn't 7 tell us whether there is an ideal situation or what is 8 right or wrong but currently things are very, variable. 9 Alongside this, there are some sort of emerging 10 recommendations in particular around ideas of informed 11 consent for innovative procedures, and I'll highlight 12 the categories of recommendations produced by NICE. 13 I sit on the Intervention Procedure Advisory Committee 14 of NICE and they produce guidelines which include 15 a statement that: a procedure could be used during 16 a period of evidence generation, including enhanced 17 informed consent. 18 Now, we have produced some empirical research as to 19 what enhanced or informed consent means within this 20 context, but that hasn't been elevated from what we've 21 described before as theoretical ethical obligations into 22 something that is more professional ethical obligations. 23 So in my mind this is right at the frontier of how the 24 modern health service is considering these sorts of 25 surgical innovations and what perhaps, without knowing Page 204

1 the details, you're uncovering within this Inquiry are 2 long-standing deficiencies in the grey area of surgical 3 innovation that may benefit from further scrutiny. 4 Q. Well, for present purposes I will leave the discussion 5 at that. That's a very helpful context because this, 6 gentlemen, is a good example of the sort of area, as we 7 described right at the beginning of your evidence, that 8 in the event that evidence comes forth in our further 9 investigations tends to suggest that this is an area, as 10 you've contemplated that it might be, where there are 11 deficiencies. I think it would be the kind of area 12 where we would be likely to come back to you for further 13 evidence in due course if we end up going down that 14 path, if I can put it that way. But that's a very 15 helpful context in which to contemplate those 16 investigations. 17 MR DAWSON: Sir, those are my questions. 18 THE CHAIR: Very well. Thank you. 19 MR DAWSON: At this stage, gentlemen, I ask all of the 20 witnesses whether they have anything to add. So, 21 Professor Huxtable, is there anything you'd like to add 22 at this stage? 23 PROFESSOR HUXTABLE: Yes, please, there are two very brief 24 remarks. One would be -- and these are personal 25 professional reflections, if you like. The first would Page 205	1 that concept. I'd say probably the other area that 2 I feel this Inquiry could help with is around that 3 operationalisation of shared decision-making and 4 emphasising its I guess importance within the 5 professional ethical obligations that we've designed 6 here, especially with the shifting priorities of the 7 health service as we move forward. But otherwise, no, 8 this has been very comprehensive and thank you. 9 MR DAWSON: Thank you very much. 10 THE CHAIR: Thank you. Gentlemen, we invariably take 11 a short break at this point, just to ensure there aren't 12 any further questions that those participating in the 13 Inquiry might wish to have put forward. So if you could 14 not stray too far from the screen, we'll be back in 15 touch very shortly, I'm sure. Thank you. 16 (4.33 pm) 17 (A short break) 18 (4.46 pm) 19 THE CHAIR: Right, can we have the witnesses back, please. 20 MR DAWSON: Sir, there are no further questions. 21 THE CHAIR: Thank you very much. 22 MR DAWSON: Thank you very much, gentlemen, for your 23 evidence. 24 PROFESSOR HUXTABLE: Thank you. 25 PROFESSOR MCNAIR: Thank you. Thank you very much. Page 207
1 be that I'm mindful of that earlier remark I made 2 yesterday regarding there are situations sometimes where 3 there is tumbleweed regarding professional ethical 4 guidance so there is too little out there. And then 5 there are other situations where there's too much out 6 there. And I have found, I think others on our ethics 7 team found, it quite difficult sometimes to navigate the 8 sheer volume of guidance out there and getting the 9 patchwork together, so there may be something to think 10 about there about clarifying which guidance -- to use 11 a phrase I used in a publication a few years ago -- 12 which one should be pinned and which one should be 13 binned. 14 The second point would be the point about broadly 15 ethics support, ethics governance, those sorts of 16 systems and services. I just offer that remark again 17 that it struck my eye that some of the Royal Colleges, 18 amongst those the surgical colleges, lack, at least 19 according to the public websites, they lack a medical 20 ethics committee or similar. So it's an open question 21 whether that's something to explore in the future. 22 Q. Thank you very much. Professor McNair, anything to add? 23 PROFESSOR MCNAIR: I'm grateful for the chance to speak 24 about the surgical innovation, which was going to be my 25 main point, but I'm grateful for the time to explain Page 206	1 THE CHAIR: Well, as you've just discovered there are no 2 further questions. You've obviously given evidence now 3 over a lengthy period of time and shared many insights, 4 reflections and opinions in what can seem a complex, 5 involved but very interesting field if I may say so. 6 I'm equally conscious that the two of you, and obviously 7 your colleague Dr McMillan who I have not forgotten, 8 have put in a great deal of work preparing the report 9 and ancillary materials. As Professor Huxtable referred 10 to it a moment ago, for navigating the sheer volume of 11 guidance out there, I express the Inquiry's thanks and 12 also my personal thanks to all three of you. We have 13 indeed now reached the end of our session and you're 14 free to go. Thank you. 15 PROFESSOR MCNAIR: Thank you very much. 16 PROFESSOR HUXTABLE: Thank you. 17 THE CHAIR: We'll see you on Thursday everybody. Thank you. 18 (4.47 pm) 19 (The hearing adjourned until Thursday, 20 24 September 2026, at 10.00 am) 21 22 23 24 25 Page 208

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