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Experts' Newsletter

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Contents

Editorial

Lisa O'Dwyer
Director, Medico-Legal Services

We started 2019, with our series of seminars exploring how experts and lawyers can work better together. Those seminars confirmed that the better the working relationship, the more likely it is that this will lead to repeat instructions.

Following the enactment of Legal Aid Sentencing Prohibition Offenders Act (LASPO) 2012, the clinical negligence market opened up to non-specialist clinical negligence lawyers. This has created a raft of problems: clinical negligence cases are not always properly run; client expectations are not managed at the outset; the wrong counsel and experts are often instructed; cases are under settled.

Some of the key take home message from the seminars were: if the lawyer's instructions are unclear, then experts should seek clarification of what is required before they start work on the case; experts should seek confirmation of what their ongoing commitment to the case is expected to be and to highlight as soon as possible dates they need to avoid; parties should be upfront about terms and conditions of payment and cost estimates should be adhered do. Any changes to cost estimates should be communicated as soon as possible with an explanation for the revised charge; experts should be mindful of the legal test for negligence; lawyers should let experts know what the outcome of the case is

In June the newspaper headlines focused on how NHS negligence payments had doubled following a steep rise in delayed treatment. With that in mind, **Bruno Gill**, barrister at **Old Square Chambers** article on ***"Cancer waiting times and the implications in negligence"*** draws on data from the National Audit Office (NAO) report "NHS Waiting times for elective and cancer treatment" (20.03.19). Bruno explores why standards are falling, what might be done to address the delays and the overall impact of the delays on clinical negligence claims.

On 15th July, the Lord Chancellor announced an increase in the discount rate, up from minus 0.75% to minus 0.25%. According to the government, the increase was justified due to concerns that claimants were being ***"substantially over-compensated, increasing financial pressure on public services that have larger personal injury liabilities, particularly the NHS"*** https://www.gov.uk/government/news/lord-chancellor-announces-new-discount-rate-for-personal-injury-claims The discount rate is applied to awards for future loss in personal injury and clinical negligence claims to prevent over compensating the claimant. The assumption is that a lump sum needs to be discounted to allow for the fact that the claimant will invest the money and earn interest on it over the coming years. Between 2001 – 2017, the discount rate was

fixed at 2.5% but was then reduced to minus 0.75% in 2017 to reflect that fact that since 2001 interest rates have dropped considerably. By applying a discount rate of 2.5%, claimants were being under-compensated.

September saw NHS Resolution publish their **"Early Notification scheme progress report: collaboration and improved experience for families"** https://resolution.nhs.uk/wp-content/uploads/2019/09/NHS-Resolution-Early-Notification-report.pdf This report refers to 746 "qualifying cases" being included in the first year of the scheme (2017/18), 24 families have received an admission of liability within 18 months of the incident. The report compares this with the position pre ENS where ***"the average length of time between an incident occurring and an award for compensation being made was 11.5 years".***

The report raises a number of questions for AvMA, our key concern is around what information families are given about the nature of the ENS process and where they can seek independant advice and information about their situation e.g. AvMA.

When the Morecambe Bay Investigation Report was published in 2015, it revealed a "lethal mix" of serious and shocking failings in the Trust's maternity units. The report called for a national review of maternity care. Sadly, at the time of writing this editorial the NHS finds itself in the wake of yet another maternity scandal. It appears, that a "toxic" culture has been allowed to prevail at Shrewsbury and Telford Hospital NHS Trust over the last few decades. The need for a robust, impartial, thorough, effective and open investigation process has never been greater. Can ENS deliver on that? Perhaps, but it remains to be seen.

October, saw the publication of the Civil Justice Council (CJC) report on fixed costs in lower value claims: **https://www.judiciary.uk/wp-content/uploads/2019/10/Fixed-recoverable-costs-in-lower-value-clinical-negligence-claims-report-141019.pdf**

Medical experts will be pleased to note that despite earlier concerns, the CJC has not sought to change the way in which experts are paid. At least, not for the time being. Thank you to all the experts who completed our questionnaire last year, your responses do help to inform our stance on issues, including fixed costs.

"How to ensure your expert evidence impresses the court" by **Marcus Coates Walker**, barrister at **St John's Chambers, Bristol**, looks at how the court approached the expert witness evidence in the recent case of *Keh v Homerton University Hospitals NHS Foundation Trust [2019] EWHC 548 QB.* Marcus has helpfully set out the factors which a judge should consider when assessing expert evidence.

It can be difficult enough for practicing lawyers to keep up to date with relevant case law, the challenge is amplified for medico legal experts. With that in mind, you may find that Bill Braithwaite QC of **Exchange Chambers *"Clinical Negligence Update"*** a helpful overview of the key points derived from important clinical negligence judgments handed down over the last eighteen months or so. Unsurprisingly, the decision in the case of Montgomery continues to shape current case law.

Dominic Ruck Keene is a barrister at **1 Crown Office Row.** In his article ***"The evidential difficulties in proving a Montgomery case"*** he focuses on two key issues, first proving what advice should have been given to the patient and second, what the patient's choice of treatment would have been, if they had been in possession of the relevant information.

Jonathan Godfrey is a barrister at **Parklane Plowden Chambers**, his article ***"With the best of intentions"*** is a commentary on the case of ***Hazel Kennedy v Dr Jonathan Frankel [2019] EWHC 106 (QB).*** The Frankel case is a salutary reminder of the importance of instructing the right expert and that a duty of care can arise even though experts in the field offer their advice without charge.

The AvMA Expert Data Base: Finally, we have written to each expert on our database, please look out for this letter which is sent by post and make sure you complete AvMA's Medical Experts Database Listing Confirmation form. This information helps us to ensure that we have the most up to date contact information for you. We have also invited you to donate to AvMA although this is by no means compulsory. Your donation will help us to continue to help others who may have been injured as a result of clinical negligence.

The AvMA Christmas Drinks Reception is being held on Thursday 5th December at RSA House in London, from 17.15 – 22.30. Tickets are £60 + VAT, for further details and to book online, please go to **https://www.avma.org.uk/events/avmaxmas19/**, or e-mail **conferences@avma.org.uk** should you have any queries.

We do hope you enjoy AvMA's "Expert's Newsletter", we welcome your feedback and suggestions for any other articles you would like to read about. Please contact Norika **Norika@avma.org.uk** with your comments or with any queries you may have relating to AvMA's Expert Data Base.

Best wishes

Cancer Waiting Times And The Implications In Negligence

BRUNO GIL
OLD SQUARE

The report

The National Audit Office ('NAO'), on 20 March 2019, published its report "NHS waiting times for elective and cancer treatment".

This article focuses on the report's findings in relation to cancer treatment. Its results are eye catching, and clinical negligence practitioners may want to keep a weather eye out for the ramifications.

When analysing cancer treatment, there are two key standards that the report utilises as a measure of whether the NHS is working efficiently. These standards have come about through the NHS taking a policy decision to promote earlier and faster detection and treatment of cancer. These key standards are:

(i) that 93% of patients are to be seen by a cancer specialist within two weeks of a GP referral, i.e. a two-week wait from referral to first appointment; and

(ii) that 85% of patients should wait a maximum of 62 days from referral to treatment.

While there are plenty of other standards, these two are the real focus of the NAO's report.

The findings

The overall picture is of an increasing number of people being referred through the two-week wait urgent pathway - an inevitable outcome of a drive towards early cancer detection. Numbers have gone from 1 million people in 2010-11, up to 1.94 million in 2017-18 (i.e. an increase of 94%).

Seven out of eight cancer standards were being met from 2013-14 to the end of 2017, despite patient numbers increasing. There has, however, been a decline since then. It is no longer the case that most standards are being met. Compliance with the high-profile "two-week wait" standard was breached in April 2018 and has not recovered.

The one standard that has not been met for any quarter since the end of 2013 is the 62-day wait, which is considered by the NAO to be the most important standard as it measures the entire patient pathway. By November 2018, only 38% of NHS Trusts met the standard. This is an improvement from June 2018 when only around 33% did.

Instead of 85% of patients being treated within 62 days, in July to September 2018 only 78.6% were. The NHS is not meeting this critical target.

It is, of course, wrong to speak of the NHS as though it is one entity - there is variation across the CCGs of England. Percentages of patients treated within 62 days varied from 59% in some to 93% in others.

It is also wrong to speak of cancer as though it is a single disease - there is variation across cancer types. Performance against the standards tends to be significantly lower for lung, lower gastrointestinal and urological cancers.

Why are standards falling?

It is an obvious question with an obvious answer. The NHS cannot cope.

An ageing population inevitably means an increase in cancers in the population. Meanwhile, a policy of encouraging early referrals into a system with finite capacity causes a backlog. The NHS is unable to keep up with the referrals, causing performance against waiting standards to fall.

The constraints on capacity are irrefutably linked to a lack of finance and infrastructure. Persistent staff shortages in diagnostic services only compounds the problem.

Performance is also correlated with pressures from urgent and emergency activities. Trusts struggling with A&E wait times tend to perform worse with cancer wait times, again indicative of an overall lack of resources.

Interestingly, the analysis also found that the more service providers involved, the more likely it is that cancer

treatment is delayed; a particularly interesting finding in these times of prolific sub-contracting of services.

What might be done?

It used to be the case that there were financial sanctions for breaching waiting times standards, but these have been gradually removed since 2015-16. The logic of monetarily penalising a financially-strained organisation always seemed dubious.

The answer appears to be that significant investment is what is required, which will allow the additional staffing and infrastructure required. The report estimates an extra £700 million would reduce the waiting list to the size last seen in March 2018. Of course, far more will be needed if the situation is to improve rather than just return to the state it was in one year ago.

Clinical negligence claims

The report opines that longer waiting times may lead to patient harm and clinical negligence claims. Of that there can be no doubt.

There is currently no analysis available to show the extent to which patient harm has occurred as a result of these increasing waiting times, but it stands to reason that delays are leading to cancer progression, leading to harm, leading to clinical negligence claims.

According to the report, 40% of clinical negligence claims are because of delays in diagnosis or treatment. With more cancer patients having to wait for treatment, and with no sign of a significant cash injection to address this specific issue, there will invariably be an increase in the number of these claims.

Clinical negligence practitioners (when dealing with new cancer delay and treatment enquiries) would be well advised to pay particular attention to the time taken for each stage of treatment, as well as the entire patient pathway. It is now clear that NHS Trusts are falling behind standards and patients are having to wait longer as a result, with some CCGs being worse offenders than others. These longer delays, sadly, are likely to have very serious consequences for patients.

How To Ensure Your Expert Evidence Impresses The Court

MARCUS COATES-WALKER
ST JOHN'S CHAMBERS

St John's
CHAMBERS

1. In clinical negligence litigation, the assessment of expert evidence is often fundamental to the prospects of success of a claim. However, what makes an impressive expert? How does a Court undertake such an assessment? What principles and considerations do they have in mind? The answers to these questions are worth thinking about at the start of every claim and will help in the conduct of the litigation as a whole.

2. In *C v North Cumbria University Hospitals NHS Trust [2014] EWHC 61*, Green J analyzed the case law on breach of duty and distilled a number of principles and considerations that apply to the assessment of expert evidence. The following passage from his judgment is a useful touchstone for clinical negligence lawyers when assessing the likely weight that will be attached to the parties' respective expert evidence:

> *"It seems to me that in the light of the case law, the following principles and considerations apply to the assessment of such expert evidence in a case such as the present:*
>
> *(i) Where a body of appropriate expert opinion considers that an act or omission alleged to be negligent is reasonable, a Court will attach substantial weight to that opinion.*
>
> *(ii) This is so even if there is another body of appropriate opinion which condemns the same act or omission as negligent.*
>
> *(iii) The Court in making this assessment must not however delegate the task of deciding the issue to the expert. It is ultimately an issue that the Court, taking account of that expert evidence, must decide for itself.*
>
> *(iv) In making an assessment of whether to accept an expert's opinion the Court should take account of a variety of factors including (but not limited to): whether the evidence is tendered in good faith; whether the expert is "responsible", "competent" and / or "respectable"; and whether the opinion is reasonable and logical.*
>
> *(v) Good faith: A sine qua non for treating an expert's opinion as valid and relevant is that it is tendered in good faith. However, the mere fact that one or more expert opinions are tendered in good faith is not per se sufficient for a conclusion that a defendant's conduct, endorsed by expert opinion in good faith, necessarily accords with sound medical practice.*
>
> *(vi) Responsible / competent / respectable: In Bolitho, Lord Brown-Wilkinson cited each of these three adjectives as relevant to the exercise of assessment of an expert opinion. The judge appeared to treat these as relevant to whether the opinion was "logical". It seems to me that whilst they may be relevant to whether an opinion is "logical", they may not be determinative of that issue. A highly responsible and competent expert of the highest degree of respectability may, nonetheless, proffer a conclusion that a Court does not accept, ultimately, as "logical". Nonetheless, these are material considerations... The following are illustrations... "Competence" is a matter which flows from qualifications and experience. In the context of allegations of clinical negligence in an NHS setting particular weight may be accorded to an expert with a lengthy experience in the NHS... This does not mean to say that an expert with a lesser level of NHS experience necessarily lacks the same degree of competence; but I do accept that lengthy experienced within the NHS is a matter of significance. By the same token an expert who retired 10 years ago whose retirement is spent expressing expert opinions may turn out to be far removed from the fray and much more likely to form an opinion divorced from current practical reality... A "responsible" expert is one who does not adopt an extreme position, who will make the necessary concessions and who adheres to the spirit as well as the words of his professional declaration (see CPR 35 and the PD and Protocol).*
>
> *(vii) Logic / reasonableness: By far and away the most important consideration is the logic of the expert opinion tendered. A Judge should not simply accept an expert opinion; it should be tested both against the other*

evidence tendered during the course of a trial, and, against its internal consistency... There are two other points which arise in this case which I would mention. First, a matter of some importance is whether the expert opinion reflects the evidence that has emerged in the course of the trial. Far too often in cases of all sorts experts prepare their evidence in advance of trial making a variety of evidential assumptions and then fail or omit to address themselves to the question of whether these assumptions, and the inferences and opinions drawn therefrom, remain current at the time they come to tender their evidence in the trial. An expert's report will lack logic if, at the point at which it is tendered, it is out of date and not reflective of the evidence in the case as it has unfolded. Secondly, ... it is good practice for experts to ensure that when they are reciting critical matters, such as Clinical Notes, they do so with precision... Having said this, the task of the Court is to see beyond stylistic blemishes and to concentrate upon the pith and substance of the expert opinion and to then evaluate its content against the evidence as a whole and thereby to assess its logic. If on analysis of the report as a whole the opinion conveyed is from a person of real experience, exhibiting competence and respectability, and it is consistent with the surrounding evidence, and of course internally logical, this is an opinion which a judge should attach considerable weight to."

3. A recent practical example of the application of these principles is illustrated in *Keh v Homerton University Hospitals NHS Foundation Trust [2019] EWHC 548 (QB).* The key facts can be summarised as follows:

(a) On 16 September 2013, the Deceased (who was 40 years old, a Jehovah's Witness and in her third trimester) was re-admitted to the Defendant's hospital. A Consultant Obstetrician and Gynaecologist concluded that an induction of labour (IOL) was the safest option for the Deceased.

(b) On 18 September 2013, an emergency caesarean section (C-section) was performed and the Deceased's child was delivered.

(c) On 9 October 2013, the Deceased died as a result of sepsis caused by an infection in the operation wound in her uterus. The cause of death was also recorded as 'the refusal of a transfusion on religious grounds'.

4. The Claimant, the Deceased's widower, brought a claim in negligence against the Defendant under the Law Reform (Miscellaneous Provisions) Act 1934 on behalf of the estate, and under the Fatal Accidents Act 1976 on behalf of the dependents, namely the Claimant and their child. Damages were agreed, subject to liability, in the sum of £150,000. The Claimant's claim was premised on three grounds:

(a) The Deceased: (i) should have been warned of the risk that IOL would be unsuccessful; (ii) should have been warned that labour would result in an urgent C-section; and (iii) should have been offered a C-section at the outset. In those circumstances, the Claimant's case was that the Deceased would have elected to opt straight for a planned C-section.

(b) The Deceased should have been offered a C-section on 18 September 2013 (at least) an hour earlier than had been the case. Further, the C-section had negligently taken 18 minutes longer than it should have done.

(c) Between 22 September 2013 and 5 October 2013, there had been a negligent failure to consider and perform a hysterectomy.

5. The Court considered evidence from the parties' respective Obstetric experts: Professor Steer (for the Claimant) and Mr Tuffnell (for the Defendant). Stewart J specifically cited the passage above from *C v North Cumbria* before conducting his assessment of the experts' evidence as set out below.

6. In respect of the Defendant's expert (Mr Tuffnell), the judge stated that although there were questions suggesting he should have put in more detail on some matters, he did not find that there was any shortcoming in that regard. His evidence was given in an objective and measured way. It is of note that he had from the outset accepted that there were some failings by the Defendant which were below the level of acceptable practice.

7. In closing submissions, Defendant's Counsel made a number of criticisms of Professor Steer's evidence. The judge found that these criticisms carried weight and must affect the court when assessing the reliability of the expert's evidence:

(a) Professor Steer had not been in regular clinical practice (on call and on the labour ward) since August 2007. This was a factor which must be taken into account in evaluating his ability to give reliable evidence of the range of acceptable clinical practice, notwithstanding his continued involvement in research and teaching (including teaching junior doctors about aspects of clinical practice).

(b) Professor Steer gave his views without acquainting himself with the pleadings or witness statements. On the first day of his evidence, he said he had not been supplied with these documents by those instructing him. He was unable properly to explain why he took

no steps to obtain them, either: (i) from his knowledge as an experienced expert that they must have existed by the time that he came to sign his report; (ii) when he received the report from Mr Tuffnell, whose report made reference to those documents; (iii) before he met Mr Tufnell, in order to be properly prepared for the joint meeting; or (iv) at any point before stepping into the witness box.

(c) At the outset of the second day of his evidence, he said that he had checked and had in fact been supplied with some, but not all, of the witness statements and pleadings. However, he did not feel that they added anything factual or material to his view of the events.

(d) The bulk of Professor Steer's professional career had been spent at the Chelsea & Westminster Hospital, which has a very high C-section rate. In 2012 / 2013, it had the highest of any hospital in the country. Professor Steer did not seem to accept that this might affect his view as to the likelihood of Mrs Keh requiring a section following IOL.

(e) Professor Steer gave his view on the factual question of the decision that Mrs Keh would have taken if offered a C-section on the basis of all the risk factors that he considered were applicable. This was not merely evidence of what proportion of women would and would not elect for C-section on the basis of the advice he would have given.

(f) He appeared on a number of occasions to be unable to recognise a range of obstetric opinion extending beyond his own. This was illustrated by his criticism of not performing a vaginal examination before the plan to induce labour was agreed. The paper that he himself had cited demonstrated that even in 2015 there was a range of opinion (based on apparently reputable studies) as to the utility of the Bishop Score in decision-making in relation to IOL. Even having been taken to that paper, he seemed unwilling to acknowledge the existence / reasonableness of the alternative view.

(g) It was unexplained how an allegation that it was negligent to induce labour could have been pleaded and reasserted in Reply if it was based on a misunderstanding of Professor Steer's view.

(h) In cross-examination he sought to advance (for the first time) criticisms of one of the clinicians in relation to her attendance on 23 September 2013. He stated that there should have been: (i) a vaginal examination; and, potentially, (ii) an examination under anaesthetic. He stated that these examinations would have led to a conclusion that the uterus should have been removed. These criticisms had not been put to the clinician even though Professor Steer had been present throughout the trial. Despite them being obstetric matters, no satisfactory explanation as to why they had not been mentioned previously was forthcoming. It was an inadequate explanation to suggest that they were in some way included in his criticism of the lack of a formal multidisciplinary meeting.

8. Having considered the evidence, the Court ultimately found for the Defendant for the following reasons:

(a) The Deceased had not been told that she was at significantly higher risk than the average woman of having to have a C-section nor that she could have had the option of a planned C-section. That constituted a breach of duty.

(b) However, had the Deceased been properly advised, on the balance of probabilities, she would not have chosen to have a planned C-section on 16 September 2013. Further, she would not have opted for a C-section at the IOL stage unless it had been positively recommended. There was no evidence that it had been or would have been recommended.

(c) The evidence was insufficient to prove a negligent 18-minute delay in carrying out the Deceased's C-section (based on the difference between the target of 75 minutes and the actual time taken of 93 minutes).

(d) There had been no breach of duty in failing to remove the uterus. Mr Tuffnell's opinion that it had not been negligent to fail to carry out a hysterectomy at any stage was accepted. In all the circumstances, it had been reasonable that the clinicians had not removed the uterus.

It is clear that the assessment of the obstetric evidence in *Keh* formed an important part of the rationale behind the Court's decision on breach of duty in this case. From a practical perspective, clinical negligence lawyers ought to have the principles identified by Green J in *C v North Cumbria* and their application in *Keh* firmly in mind when dealing with experts at each stage of the litigation process (whether it is opening a report for the first time or holding a pre-trial conference). Experts must give their evidence in good faith. They must be responsible, competent and respectable. However, most importantly, their opinion must be reasonable and logically sound. Each case will

turn on its own circumstances, but experts must properly engage with the claim, apply their minds to the detail and be prepared to adapt to the factual evidence as it evolves. If they do not, then they must be challenged. Ultimately, if your expert fails to approach their evidence as set out above, then the claim is at risk of being dismissed.

MARCUS COATES-WALKER

13 MAY 2019

Clinical Negligence Update

BILL BRAITHWAITE QC
EXCHANGE CHAMBERS

1. Updating in clinical negligence is not always easy, because the principles usually stay the same, and only the facts change. However, Montgomery was a huge change, and we've got recent examples of how judges need to re-think in the light of that decision.

2. The case of *Webster v Burton NHS Trust [2017] EWCA Civ 62* seems to have been straightforward negligence because, at no time prior to the appellant's birth, did Mr Hollingworth note that the foetus was small for gestational age, nor did he note the recorded asymmetry nor the polyhydramnios. He treated the pregnancy as being without these features. It was agreed that he acted negligently. The Judge followed the *Bolam* approach of basing his judgment on whether Mr Hollingworth acted in accordance with a responsible body of expert medical opinion, whereas it is now clear from *Montgomery* that this is no longer correct. The doctor's obligation (apart from in cases where this would damage the patient's welfare) is to present the material risks and uncertainties of different treatments, and to allow patients to make decisions that will affect their health and well-being on proper information.

3. The Court of Appeal had to consider a judge's decision that the surgeon had not been negligent in *Duce v Worcestershire NHS Trust [2018] EWCA Civ 1307,* on the 7th June 2018; *Montgomery* was said to undermine the judge's decision. The appellant, after consultation with her surgeon, was insistent that she wanted a total abdominal hysterectomy, notwithstanding that he had explained it as a "major operation which has associated risks". She wanted it "all taken away". The operation was carried out non-negligently, but the Claimant was left with pain due to nerve damage.

4. In *Montgomery*, the Supreme Court highlighted the importance of patient autonomy and the patient's entitlement to make decisions whether to incur risks of injury inherent in treatment, highlighting a fundamental distinction between the doctor's role when considering possible investigatory or treatment options, as against the role in discussing with the patient any recommended treatment and possible alternatives, and the risks of injury which may be involved. The former role is an exercise of professional skill and judgment, whereas in the latter role one cannot leave out of account the patient's entitlement to decide on the risks to health which he or she is willing to run. However, those principles did not invalidate the trial judge's decision against the Claimant.

5. Another *Montgomery* case is *Hassell v Hillingdon NHS Trust 2018] EWHC 164 (QB)*, in which the judge decided as a fact that the spinal surgeon did not warn the patient about the risk of paralysis, and that, if he had done, she would not have undergone the operation. Therefore, even though he performed the operation competently, he was liable.

6. For those like me, who see the tragic results of traumatic birth leading to cerebral palsy, it's always disappointing that families aren't considered very much in the resulting claims. On the 5th November 2018, though, the Claimant in *Yah v Medway NHS 2018 EWHC 2964 (QB)* recovered £76,000 damages for psychiatric injuries associated with the traumatic birth of her child.

7. In *Clements v Imperial College NHS Trust [2018] EWHC 2064 (QB)*, the baby stopped breathing within an hour of birth because her mouth and nose were obstructed and her breathing was compromised by her mother's breast during skin to skin contact. It was held that the midwife should have advised mother to keep her baby's nostrils free at all times, and failure to do so was negligent. I must say that that seems a surprising result.

8. A decision where a judge was less willing to see fault was *H v Southend Hospital NHS Trust, Lawtel,* in which the midwives had been observing properly, but failed to record anything for the critical 20 minute period. The judge said that "neither a positive nor negative inference could be drawn from that fact". Without that piece of evidence, the claim in breach failed. That also seem to me to be a surprising result. The judge also held that, even if bradycardia had been observed earlier, the claimant would not have been delivered quickly enough to avoid the hypoxic ischaemic event.

9. The case of *TW v Burton NHS Trust 2017 EWHC 3139 (QB)* reminds me very much of one of mine which was finalised late last year for just under £20 million. The only breach of duty of care alleged was in failing to invite or advise the Claimant's mother to come into hospital when the first telephone call was made to the midwifery unit. She was told that she should not come in ie she was **positively discouraged** from attending hospital. No evidence was called by the Defendant as to why the midwife made that decision. Had mother been advised less negatively, the Claimant would have been spared his injuries by an earlier delivery.

10. *DS v North Lincs and Goole NHS Trust 2016 EWHC 1246 (QB)* was one of those sad cases where the midwives had been negligent, but it was not possible to prove causation. Labour lasted 13 hours, and the Claimant suffered a period of acute, damaging hypoxia around the time of birth, which caused brain damage resulting in spastic cerebral palsy. The judge decided that, given that low risk pregnancies are midwife led and decelerations in fetal heart rate occur frequently towards the end of labour whereupon spontaneous recovery is usual, it was not mandatory for the midwives to call for an obstetrician until later in the process. Until then, the midwives could have reasonably instituted continuous monitoring, determined whether the mother was fully dilated, tried to make adjustments to enable the FHR to recover, and seek to determine for themselves what the cause of the deceleration was and whether it could be counteracted. However, by a certain time a deceleration of the fetal heart lasting at least 4 minutes had to be assumed (in the absence of continuous monitoring), and it was mandatory to obtain obstetric assistance. The delay thereafter was in negligent breach of duty. I have to say that I really wonder about those findings, but one cannot be sure without more detail. Given those findings, there was a maximum of three minutes of negligent delay, which was not enough to establish causation. Yet again, that seems to me to be a surprising result, because the midwives could, on the face of it, have avoided the catastrophe simply by calling a doctor.

11. Mrs Justice Yip is giving some really good judgments, and *Welsh v Walsall NHS Trust 2018 EWHC 1917 (QB)* is one of them, in relation to the scourge of experts being presented with more than one agenda for their discussions. "It certainly should not become routine to provide two versions which, as here, travel over much of the same ground. That approach tests the patience of the experts (and frankly of the court); produces a lengthier joint statement; potentially increases costs and is simply not the best way to focus on the issues. I do not think that anything further needs to be said or done in this case. However, if this worrying trend continues, parties may find that courts begin considering costs consequences."

12. Another of her decisions is Kennedy v Frankel 2019 EWHC 106 (QB). Mrs Kennedy was diagnosed with Parkinson's disease and advised to take dopamine agonist medication. It caused her psychiatric side effects, including an impulse control disorder and eventually psychosis. She sued Dr Frankel, alleging that he failed to advise her of the risk of impulse control disorder associated with dopamine agonist medication, and that he failed to respond in a timely or appropriate way when she developed the condition. It was agreed that levodopa probably would have controlled her symptoms, but without the side effects, but Dr F did not explain that to the Claimant, or recommend a change in medication.

13. Even though the judge found that failure to be a breach of duty, she held that, at first, it was not causative. However, when the specialist ignored the Parkinsons nurse, who alerted him to the possibility of changing medication, the judge held him to be in causative breach.

As always, the evidence was the deciding factor. Once the nurse's consultation and advice was established, the judge was effectively bound to find that the Defendant was liable.

14. There are two consistent features running through all clinical negligence litigation. First, evidence, both lay (sometimes) and expert, is supremely important. Secondly, the identity of the judge is determinative, which makes the whole process a lottery!

The Evidential Difficulties In Proving A Montgomery Case.

DOMINIC RUCK KEENE
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Introduction - the world of Montgomery

As all legal practitioners in the field and increasing numbers of clinicians are aware, *Montgomery v Lanarkshire Health Board [2015] AC 1430* marked an important paradigm shift in the legal and practical relationships between patients and those medical professionals advising them as to their treatment options. The Supreme Court held that a clinician must take reasonable care to ensure that a patient is aware of any material risks and of any reasonable alternative treatment. In doing so, the Supreme Court placed a significantly greater practical burden on clinicians to prove in the event of challenge that they had both *considered* what all the reasonable alternative treatment might be, and also the full spectrum of potential risks, but also that they had *communicated* those options and risks in an appropriate manner. On its face, the judgment in *Montgomery* therefore offers a powerful alternative route for claimants to argue that there should be liability imposed even for the consequences of treatment that in and of itself was not negligent, provided that treatment was not properly consented to.

It is the case that in reality the number of cases where liability has been found in a failure to ensure informed consent has been very much lower than was initially anticipated following *Montgomery*. However, potential allegations of a lack of consent are doubtless a factor in a material number of settlements: in my own experience very often due to the difficulty of satisfying evidential burden on clinicians to prove that informed consent was in fact given when they often only have their notes and 'standard practice' to rely on rather than an individual memory of the critical consultation.

The parameters of the post *Montgomery* principles and practicalities of successfully running an informed consent continue to be worked out, and two recent cases provide helpful illustrations of how this important area of practice is being considered by the courts. In particular they demonstrate which illustrate the critical importance of both limbs of proving a lack of informed consent post *Montgomery* - proving what advice should have been given *and* what as a matter of a causation a patient would do if given appropriate advice.

Lucy Diamond v Royal Devon & Exeter NHS Foundation Trust [2019] EWCA Civ 585

Background

The Claimant alleged that she had not given informed consent prior to proceeding to a mesh repair of a post-operative abdominal hernia. HHJ Freedman's judgment in the High Court had held that the surgeon had not given appropriate information for the purpose of informed consent, however the judge concluded that had she been so informed the appellant would have chosen to proceed with the mesh repair which in fact took place. That was on the basis that "looking at the matter both objectively and subjectively in the face of the advice which would have been given to her, it would have been irrational for her to opt for a suture repair; and I find that she is not a person who would act irrationally." Further, HHJ Freedman rejected a claim that a negligent non-disclosure of information by a doctor of itself creates a right for the patient to claim damages.

Both the experts had agreed that the surgeon should have discussed the potential implications of a mesh repair in terms of any future pregnancy, and further that he should have mentioned the possibility of a primary suture repair.

The issues before the Court of Appeal

The primary ground of appeal was that in considering the issue of causation the judge was wrong to apply a test of 'rationality'. Alternatively, having held that the respondent was under a duty to offer a sutured repair by way of an alternative treatment option, the judge erred in holding that it would have been *"objectively and subjectively... irrational"* for the appellant to have accepted that offer.

The Claimant relied on both *Chester v Afshar* [2005] 1 AC 134 and *Montgomery* to argue that a fundamental

purpose of the requirement for properly informed consent was to ensure that respect was given to a patient's autonomy, dignity and right to self-determination. Such a right included the choice to make decisions that others, including the court, might regard as unwise, irrational or harmful to their own interests.

The Defendant argued that the judge had not applied a rationality test in the sense of imposing on the Claimant the actions of a hypothetical rational person, but had reached a finding of fact about the decision which the Claimant would have made as to her preferred method of surgery if properly advised.

An alternative ground of appeal had been that where there has been a negligent disclosure of information, that could of itself create a right of the patient in question to claim damages. The Claimant accepted that the issue had been determined in *Shaw v Kovac* [2017] EWCA Civ 1028 and *Duce v Worcestershire Acute Hospitals NHS Trust* [2018] EWCA Civ 1307, and she had to prove that the breach of duty had caused her to suffer injury. However, the Claimant sought to persuade the Court of Appeal that if the claim for psychiatric injury could not succeed on conventional foreseeability principles she could succeed under the principle identified in *Correia v University Hospital of North Staffordshire NHS Trust* [2017] EWCA Civ 356. This was said by the Claimant to be that her shock, distress and consequential depression was, at least, "intimately connected" to the failure to obtain properly informed consent.

The Judgment

Nicola Davies LJ began her analysis by emphasising that that *"the conventional 'but for' test for causation applies to consent cases in that it is for the patient to prove that had he or she been warned of the risks, the patient would not have consented to the treatment."* She went on to hold with respect to the test of materiality under Montgomery that *"in considering what a reasonable person in the patient's position would attach significance to, account must be taken of the particular patient."*

Nicola Davies LJ described with approval the approach taken by HHJ Freedman: noting that he had *"considered the clinical facts in the context of the appellant's character and circumstances."* He had taken account of hindsight and noted that it would be *"quite impossible"* for the Claimant to divorce her thinking about what she would have chosen to do from the subsequent events and that the *"sad outcome"* had coloured and informed her view of what she would have done had she been appropriately warned. She noted that HHJ Freedman had concluded that the Claimant *"genuinely believes and has convinced herself that she would have opted for the suture repair had she been provided with all the relevant information. Critically he held that her evidence accorded with her honestly held belief, however it did not follow that what she now believes would in fact have been the position at the material time."*

She concluded that the judge had *"met the requirement set out in Montgomery in that he took account of the reasonable person in the patient's position but also gave weight to the characteristics of the appellant herself. He did not apply a single test of "rationality" without more to the issue of causation."*

With regards to the alternative argument as an 'intimate connection' between the shock and depression to the alleged failure to obtain informed consent, Nicola Davies LJ noted that *"Montgomery lends no support for the proposition that a failure to warn of a risk or risks, without more, gives rise to a free- standing claim in damages."* She cited with approval passages in *Correia, Shaw* and *Duce* holding that that the majority decision in *Chester* did not negate the requirement for a claimant to demonstrate a 'but for' causative effect of the breach of duty, and that there was no reasonable interpretation of the decision of the House of Lords in *Chester* which justified extending liability for negligent failure to warn of a material risk of a surgical operation to a situation where it has been found as a fact that, if she had been warned of the risk, the claimant would still have proceeded with the operation when she did. Nicola Davies LJ found given the finding of fact that even if the Claimant had been warned of the relevant risk she would have still proceeded with the mesh repair at the material time, there was no factual basis for any argument as to an 'intimate connection.'

Ollosson v Lee [2019] EWHC 784 (QB)

Background

The Claimant alleged that he had not given informed consent to an elective vasectomy as he had not been given adequate information about the risk of chronic testicular pain. He had been given an advisory booklet which stated that *"there is a small possibility of post-vasectomy pain, which can be chronic."*

The Judgment

Stewart J. cited Simon LJ's judgment in *Webster v Burton Hospitals NHS Foundation Trust* [2017] EWCA Civ 62 as authority for the core principles from Montgomery being:

> *"i) a change of approach as to the nature of the doctor and patient relationship;*
>
> *ii) the extent of the patient's right to information;*
>
> *iii) whether a risk is material cannot be reduced to percentages;*
>
> *iv) the importance of dialogue between patient and doctor as part of the doctor's*
>
> *advisory role;*
>
> *v) the Bolam approach is no longer appropriate in cases of informed consent."*

With respect to the final principle, he also cited Hamblen LJ in *Duce v Worcester Acute Hospitals NHS Trust* [2018] EWCA Civ 1307 to the effect that it was a matter for expert medical evidence as to what risks associated with an operation were or should have been known to the medical professional in question, but that it was a matter for the court as whether the patient should have been told about such risks by reference to whether they were material, with this issue not being the subject of the Bolam test.

Stewart J. set out the evidence of the Claimant and his wife as to what advice he had been given orally, and in the form of information leaflets, prior to the procedure, and commented that while both the Claimant and his wife, and also the treating GP had been honest *"honesty does not necessarily equate to reliability, especially when people are trying to recall facts through the prism of later events."*

Stewart J. noted that the issue was not whether no warning had been given of a material risk, namely that of chronic pain, but whether the warning given was adequate. The Claimant argued that he needed to have been given information that gave a proper indication of the magnitude of the risk, i.e. the percentage chances of it occurring, and also of the range of consequences if it did occur. He also stated that he thought that because there was no figure given for the risk of post vasectomy pain, he thought it was less than 1:2000 since figures were given for the two other stated risks in the booklet provided to him. Stewart J. held that the Claimant was mistaken in his memory. He also commented that it was not a "logical conclusion" as *"If anything, the adjective 'small' would suggest a greater, not a lesser risk, than the adjectives 'rare' and 'remote'."* While the illogicality did not mean that the Claimant could not have formed that view, it made it less likely.

Stewart J. held that following the Claimant's reading of the booklet *"he did know was that there was a small risk of (in his words) long-term bad pain, described in the blank consent form as "Serious or frequently occurring".* The risk was unquantified, but had not been interpreted by him as less than 1:2000." He went on find that the Claimant had been told by the GP that chronic testicular pain was a potential complication and that the risk was referred "in terms that conveyed that it was a small risk, but greater than the rare and remote risks of early and late failure."

Stewart J. concluded that "In terms of the quality of the risk, it was communicated to Mr Ollosson that it was a risk of long term persisting pain which could range from mild to severe. That is sufficient information."

He then went to consider *"In terms of the magnitude or quantification of the risk, was it sufficient for Doctor Lee to say that it was small, adding that it was greater than the rare/remote risks of early or late failure?"* He held that it was not necessary to give *"percentages of the risk of chronic post vasectomy pain, unless asked."* Further, that while the risk of chronic pain appeared to be about 5%, the risk of pain at the level suffered by the Claimant was very much smaller. Accordingly, he concluded that it was adequate to describe that level of risk as *'small'* – *"the word 'small' is clearly an everyday word which encompasses and satisfactorily conveys the level of risk involved.... While adequate information must be given to a patient without him having to ask a question, a patient told of a 'small' risk can ask for further clarification."*

Comment

The *Lucy Diamond* judgment shows that the Court of Appeal has once again emphasised both that there is no free standing 'right to be informed' cause of action that is capable of sounding in damages without more. It therefore also serves as another reminder of the critical importance of the causation limb of an informed consent case and the difficulties of proving causation of the injury in question. A court will almost inevitably wish to seek to test rigorously a claimant's assertion that they would have made a different choice in light of any effect of hindsight. This is particularly so where the first limb of the test as to what additional information should have been given to them may well be relatively.

The test is ultimately what this particular claimant would have made of the information given to them at that particular moment in time, not what a hypothetical reasonable claimant would have done. As an aside, it is worth noting that the post *Montgomery* focus on individual patient choice also can weaken a claimant's argument that they would have listened to the advice of their partners or families in such a way. Even while that is very often the case, and other witnesses may be able to give their own evidence as to what advice they would have given the patient, the defendant will often seek to undermine that evidence by emphasising that absent any issues as to capacity, it is for the claimant to give the informed consent, not their family.

While the judgment in *Ollosson* may reassure doctors concerned about the adequacy and accuracy of the advice that they give to patients about the likelihood of particular risks as stating a percentage risk is potentially significantly harder than using everyday language to describe a risk, this case does illustrate the difficulties for claimants in proving that the material risks were communicated in an effective way. The more latitude that is given to doctors to use 'everyday' language, and arguably language that is open to varied and subjective interpretation, the greater the potential for miscommunication and misunderstanding that in part *Montgomery* sought to alleviate.

As demonstrated by the number of cases that have come before both the High Court and the Court of Appeal over the last year, the boundaries and practical implications of the decision in *Montgomery* are still being worked out. Successfully establishing a lack of informed consent combined with causation of a material injury has become something of a chimera for many claimant. The first limb is understandably significantly easier to satisfy that the second.

What these two cases illustrate once again that while not impossible to win a case solely on the basis of a lack of informed consent those representing claimants must ensure that they apply a honest and dispassionate assessment as to the realistic prospects of establishing what their client would have done if given more information. What were their preconceptions and their expectations? What did they want to hear or not hear? What other information could they reasonably have been expected to ask for? How much would they have listened to the advice given by the clinician as to the 'best' or the 'safest' option? How much would they have listened to the advice of non-clinicians?

Ultimately, requiring a client to try to put aside their hindsight and their natural wish to put the clock back to a point where there might have been an another alternative road taken, and to give an objective consideration as to what they would actually have done with sufficient information to make an informed choice can be uncomfortable, yet is unavoidable.

With The Best Of Intentions

A commentary on Hazel Kennedy v Dr Jonathan Frankel [2019] EWHC 106 (QB)

JONATHAN GODFREY
PARKLANE PLOWDEN CHAMBERS

PARKLANE PLOWDEN CHAMBERS

Introduction

The Claimant is a retired primary school teacher. She is married to a retired Consultant Neurologist, Dr Kennedy. In 2006, when aged 44, the Claimant developed a tremor in her left upper limb. Her husband harboured suspicions that she may have Parkinson's disease. As a result, he arranged for her to see a former colleague of his, Dr Jonathan Frankel (" the Defendant ") , a Consultant Neurologist with a specialism in movement disorders. The Defendant agreed to see the Claimant on a private basis and to not charge for doing so. He made a diagnosis of Parkinson's disease and he advised on her treatment. Medication, dopamine agonist, which the Claimant took on the Defendant's advice, unfortunately caused the Claimant to suffer from serious psychiatric side effects, including an impulse control disorder (" ICD ") and more latterly psychosis.

The Claimant brought a claim as against the Defendant for:

i. failing to advise her of the risk of ICD associated with dopamine agonist medication ; and

ii. that he failed to respond in a timely or appropriate way when she developed ICD.

Causatively, the Claimant accepted that she would have taken the medication initially had the appropriate warning been given, but that had she been properly advised she would have ceased taking it far earlier and consequently she would have avoided the serious effects that developed.

The Claimant brought a claim based on the losses sustained from ICD and psychosis. The elements of the claim consisted of the customary claims for loss of earnings and care, but also comprised of more novel elements relating to the increased costs of spending caused by the ICD.

The matter was heard by Yip J at the Royal Courts of Justice over a five day period between 17th to 21st December, 2018.

Legal Standpoint

It was accepted that the standard of care to be expected of the Defendant was that of a consultant neurologist with a speciality in movement disorders, including Parkinson's disease.

The allegation that the Defendant failed to warn the Claimant of the risk of ICD and to advise as to alternatives to dopamine agonists was decided according to the well versed test set out in *Montgomery v Lanarkshire Health Board [2015] AC 1430* , and recently summarised by the Court of Appeal in *Duce v Worcestershire Acute Hospitals NHS Trust [2018] EWCA Civ 130*. The judgment of Yip J at Paragraph 12 sets out the comprehensive yet compact aide memoire of Hamblen LJ's dicta in Duce (at Paragraphs 32 and 33), namely :

" 32. The nature of the duty was held to be " a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment , and of any reasonable alternative or variant treatments .

33. In the light of the differing roles identified this involved a twofold test :

(1) What risks associated with an operation were or should have been known to the medical professional in question . That is a matter falling within the expertise of medical professionals.

(2) Whether the patient should have been told about such risks by reference to whether they were material. This is a matter for the Court to determine. The issue is not therefore the subject of the Bolam test and not something that can be determined by reference to expert evidence alone ".

The advice tendered by the Defendant was to be considered according to the test in *Bolam v Friern Hospital Managament Committee [1957] 1 WLR 582,* whereby the advice would be considered reasonable if it was in accordance with a responsible body of consultant neurologists with a particular subspecialty interest in movement disorders, notwithstanding that other such neurologists may have given different advice.

Establishment of breach would require that causation was established. The mere failure to warn of a *Montgomery* " material risk " is not in itself sufficient to give rise to liability. It is necessary to establish that had the Claimant been given the appropriate warning/advice she would have ceased taking in dopamine agonist medication at an earlier point in time and thereby reduced the severity and/or the duration of the side effects.

Expert Evidence

The Claimant relied on Dr Guy Sawle, a Consultant Neurologist with an appropriate sub-specialism in movement disorders. The Defendant relied on the expert evidence of Dr CMC Allen, a recently retired Consultant Neurologist. Dr Allen was a " general " neurologist with experience of seeing and treating patients with Parkinson's disease. Yip J noted at Paragraph 31 of the judgment that *" unlike Dr Frankel and Dr Sawle, he does not have a specialism in movement disorders ".* The evidence of Dr Sawle was found to be *" balanced and fair "* and Dr Allen's evidence *" was less impressive . It was apparent that he was less knowledgeable than Dr Sawle in this field ".*

At Paragraph 33 of the judgment Yip J commented that " I bear in mind that the appropriate standard of care is that of a consultant neurologist with sub-specialism in movement disorders and that Dr Sawle falls into that category, but Dr Allen does not ".

Breach of duty and Causation

The Claimant first saw the Defendant in January, 2007. No treatment was recommended at that juncture. By August 2007, the Claimant felt that her symptoms had worsened and she returned to see the Defendant. He advised medication in the form of amantadine with the idea of moving onto selegeline and after that a dopamine agonist.

By February, 2008 a little more tremor and some other symptoms were noted and the Defendant recommended a " gentle introduction to dopaminergic medication " in the form of rotigotine patches.

The Claimant did not see the Defendant again until April 2010. She was having difficulties with the rotigotine patches. There was a reluctance on her part to change to another form of treatment as she considered that the rotigotine was " otherwise working well ".

In his evidence, Dr Sawle was clear that he was not critical of Dr Frankel's advice at any time prior to 2010. The knowledge of ICD as a side effect of dopamine agonist medication was evolving and ICD was " clinically invisible" and was regarded as a very rare side effect for a number of years. While Dr Sawle and some other neurologists were themselves giving warnings about ICD earlier in time, other neurologists in the sub-speciality disorder movement were not.

The Claimant saw the Defendant on 26th April 2010. In view of the difficulties with the rotigotine, he recommended that the Claimant should start taking ropinirole (an oral dopamine agonist). There was no mention in the medical notes or a subsequent letter to the Claimant's GP of any discussion about ICD or behavioural issues per se. The Defendant could not say one way or the other whether he gave any warning about behavioural symptom risks in April, 2010. He confirmed that he did not specifically warn patients about the risk of ICD until 2013.

Yip J concluded that the Claimant was not given any warning about ICD or behavioural changes in April 2010. Dr Sawle was clear that it was mandatory to give specific warnings about ICD by April 2010. Dr Allen did not agree that a specific warning about ICD was required at that time. He did however agree that a general warning about behavioural problems should be given. The difference as between the experts was not considered by Yip J to be material to the case. Yip J considered that the risk of developing compulsive behaviour was a material risk as per *Montgomery*, and that accordingly the Defendant was in breach of duty for failing to give a warning at that time.

Notwithstanding, Yip J did not find that any such breach was causative of loss as medication change was unlikely to have occurred had the correct warning been given.

In August 2010 the Claimant wrote to Dr Frankel indicating that side effects were worse with rotigotine but that they had settled.

The Claimant indicated in evidence that she first suspected that things were not right towards the end of 2010. She described doing " silly things ". Dr Kennedy described their house as becoming " like a shop". Numerous deliveries were being made to the house. Dr Kennedy formed the view that his wife had developed ICD at that juncture.

He did not however instantly report his suspicions to the Defendant.

In January 2011, Dr Kennedy wrote to the Defendant requesting an appointment for his wife. It took a form more akin to that of a medical report than a general letter with separate headings. One heading was " impulse control disorder " which was noted as having " been recognised since we last met and has taken various guises ". Details were supplied about weight loss ; hobbies and impulse buying.

The Defendant saw the Claimant on 18th January 2011. The experts were agreed that Dr Kennedy's letter had " put the Defendant on notice that the Claimant had ICD " and that it was therefore essential to discuss discontinuing the dopamine against medication. The Claimant should have been informed that her ICD was due to her medication and that her options included stopping the medication and taking an alternative drug (levodopa) , which was likely to eradicate the ICD symptoms without any deleterious effect on her Parkinson's symptoms. There were no contra-indications for the Claimant in moving drugs.

Yip J considered that the Defendant did not clearly explain to the Claimant that levodopa was likely to eradicate her ICD symptoms and at the same time providing good control of the symptoms of her Parkinson's. He had however canvassed the possibility of a change in medication before making a positive recommendation that the Claimant remain on dopamine agonist medication which was apparently providing excellent control of her symptoms of Parkinson's disease. She considered that it was reasonable at that time to recommend the continuation of the drug. However, with regard to the fact that the Defendant did not sufficiently discuss levodopa as an alternative, as both experts were agreed he should have done, Yip J did not consider that omission to be causative of any loss. Yip J found as a fact that the Claimant would have followed the Defendant's advice to continue with her existing medication. On Yip J's assessment, this was the case as:

i. " Her Parkinson symptoms were well controlled ;

ii. In the past she had expressed some reluctance to change a treatment that was working well in controlling a disease;

iii. She did not feel that her ICD symptoms were out of control or significant;

iv. Even had levodopa had not been specifically discussed, the Claimant was well aware of alternative drugs, and was happy to continue on her existing medication; and

v. Dr Kennedy was aware if levodopa as a drug option and had been ready to recommend alternative treatment previously, but he considered the advice reasonable at that time. "

In April 2011 the Claimant attended upon her GP complaining of feeling down. The GP raised the possibility of the Claimant seeing the specialist Parkinson's nurse, Nurse Morgan. In August 2011 the Claimant attended upon Nurse Morgan. Nurse Morgan advised the Defendant that she thought that she had ICD and should change her medication. Following the discussion with the Claimant, Nurse Morgan wrote to the Defendant setting out that the Claimant appeared to have developed an ICD in the form of compulsive buying, which had caused problems with her husband. She was noted by Nurse Morgan as " she is struggling to control, is out of character ". She informed the Defendant that there had been a discussion about decreasing or withdrawing the dopamine agonist medication, but that the Claimant was reluctant to consider this as her motor function was stable. The Defendant in fact had discussed matters with Nurse Morgan before her letter reached him.

A further appointment took place with the Defendant on 25th October 2011. Following the consultation the Defendant wrote to the Claimant's GP stating that " she had been a little concerned about the effects of ropinirole on her behaviour in terms of buying things ..... both she and Philip did not think it was a significant problem ..... ". There was no evidence of the letter having been copied to Nurse Morgan. It was suggested by Counsel for the Claimant that the inference to be had from the letter of the Defendant and the failure to copy to Ms Morgan was that the Defendant had overlooked the letter from Nurse Morgan to him, or that it was not in the forefront of his mind. Yip J considered that to be a reasonable inference.

Dr Sawle stated, and it was accepted by Yip J, that a specialist receiving the letter from Nurse Morgan " would have started with expectation that a change of drug was required ". To be persuaded otherwise would have needed a " real drilling down " into the symptoms and for something compelling emerging from the discussion so as to justify not making the change. Dr Allen did not disagree in cross-examination. In Yip J's opinion there had only been a brief discussion without any proper documenting of what was discussed, and it was not sufficient to displace the material contained in Nurse Morgan's letter. Yip J found that the Defendant should have advised the Claimant about levodopa and that switching

would probably have removed the ICD symptoms while still giving good control of the Parkinson's symptoms. The additional information from Nurse Morgan should have necessitated a clear recommendation to reduce or discontinue the dopamine agonist to control the ICD. The recommendation to increase could not be considered reasonable. The Defendant breached his duty in failing to properly advise her in October 2011.

In so far as causation, given that real concern had been expressed by the Claimant to Nurse Morgan about her ICD , Yip J considered that she was satisfied that the Claimant would have changed to levodopa had the Defendant properly advised her that her Parkinson's symptoms were likely to have been controlled but her ICD would cease.

Subsequent

No allegation of breach as against the Defendant was maintained after October 2011.

Problems worsened from the end of 2011. The experts agreed that the Claimant may have been developing psychosis by July 2012. She was complaining about her husband and said " she feared him ". If not by July 2012, the psychosis was probably developing in later 2012, and certainly by early 2013. The Claimant made serious unfounded allegations about her husband and in January 2013 she left the matrimonial home and commenced divorce proceedings. This was found to result from the psychosis.

Yip J found that there was no evidence that ICD worsened from October 2011.

In February 2013 roprinole was reduced by the Defendant and in February, 2013 he advised of an appropriate plan to cease the roprinole.

The Claimant had a bad time coming off her medication but went on to make a good recovery. Her ICD and psychosis resolved completely. The marriage was reconciled. Upon withdrawing from roprinole, the Claimant did not develop the motor symptoms she would have been expected to exhibit, and in April 2013 second opinion confirmed that she did not have Parkinson's disease. It was never alleged that a diagnosis of Parkinson's disease had amounted to negligent misdiagnosis.

Housekeeping

At the commencement of the hearing, Counsel for the Defendant raised an additional argument to those which had been set out in the skeleton arguments filed by the parties. Following the Court of Appeal's decision in *Khan v MNX [2018] EWCA Civ 2609*, (which by way chance Yip J was the judge at first instance, and was overturned on appeal), it was contended that the Claimant's psychosis was a coincidental injury, which fell outside the scope of the Defendant's duty, in that the duty to warn related only to the risk of ICD and did not extend to the risk of psychosis, which in itself was a very rare complication.

It was discussed whether the Defendant was entitled to raise the argument proposed at trial and whether it required an amendment to be made to the Defence. As matters transpired, Yip J was not required to make any pronouncement on whether the defendant was allowed to raise the issue, it being proposed by Counsel jointly that consideration of all matters (both procedural and substantive) based on the Khan decision should be deferred pending determination of the issues of breach of duty and causation. Yip J considered the proposal a sensible way forward. It was also canvassed that in view of the sums involved a settlement may be reached on quantum once the issues of breach of duty and causation had been addressed. Accordingly, Yip J adopted the approach and excluded any judgment relating to " scope of duty ". Quantum was adjourned to be determined at a later stage, and at which stage the Defendant's position on Khan could also be considered, if still advanced.

It remains to be seen following Yip J's pronouncement on breach of duty and causation whether the argument on " scope of duty " will be advanced further by the Defendant, particularly given Yip J's views that had the medication been changed in October, 2011, the Claimant would have " recovered quickly from the ICD and not going on to develop the psychosis ". Conversely, given that the psychosis resolved in a relatively short period of time issues of proportionality will have to be factored into account in advancing any " scope of duty " argument.

Commentary

There are a number of issues that fall to be gleaned from the judgment, namely:

1. Yip J's practical application of the legal principles on informed consent enunciated in *Montgomery* and *Duce* relating to the myriad of complex factual issues posed in relation to breach of duty and causation. The methodology of the application of the principles to the facts is a valuable tool for everyday use.

2. The importance of instructing the most appropriate expert. The case was based upon the standard of care required of a consultant neurologist

with a sub-specialism in movement disorders. Dr Sawle on behalf of the Claimant fulfilled the criteria, Dr Allen on behalf of the Defendant, was a general neurologist with experience of seeing and treating patients with Parkinson's disease. While Yip J though that there was *" little of real substance between the experts in the evidence that they gave "* she made clear that *" I bear in mind that the appropriate standard of care is that of a consultant neurologist with a sub-specialism in movement disorders and that Dr Sawle falls into that category, but Dr Allen does not ".* Yip J specified that *" it was apparent that he [Dr Allen] was less knowledgeable than Dr Sawle in this field ".* Ultimately, in the context of this particular case, respective expert evidence was not determinative. In many cases however the distinction between expert evidence is vital, and thereby the instruction of the appropriately qualified expert all important.

3. Despite the best and most reasonable intentions of providing his expertise privately and without charge, it did not alter the duty of care that the Defendant owed to the Claimant. The Defendant readily acknowledged the duty owed to the Claimant as his patient.

Jonathan Godfrey is a barrister practising out of Parklane Plowden Chambers, specialising in clinical negligence.

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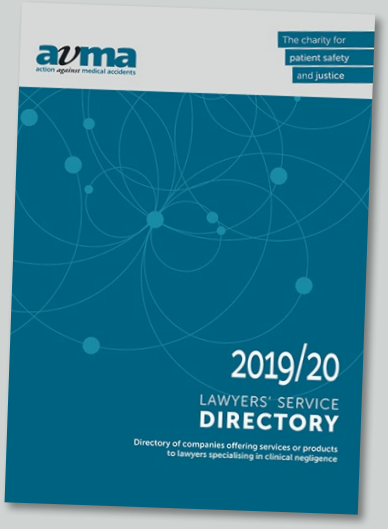

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