Neutral Citation Number: [2015] EWHC 268 (QB)

Case No: HQ13X00078

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 12/02/2015

Before :

MR JUSTICE GREEN

- -

Between :

Anthony Daniel Mulholland	**Claimant**
- and -	
Medway NHS Foundation Trust	**Defendant**

- -
- -

Philip Grundy (instructed by **Irwin Mitchell**) for the **Claimant**
Laura Johnson (instructed by **Bevan Brittan**) for the **Defendant**

Hearing dates: 19th January – 23rd January 2015

- -

Judgment

Mr Justice Green :

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A. The Issue

1. The issue in this case concerns the standard of care owed by a doctor operating in a busy A&E Department. The issues arising raise a number of factors of relevance beyond the narrow confines of the facts of this case. In particular the case concerns: the extent to which such a doctor is entitled to have regard to, and rely upon, the conclusions of other professionals (such as in-hospital GPs, and, stroke specialists) within the hospital; the circumstances when it can properly be said that the doctor should ignore or question the advice and conclusions of those professionals; and, the extent to which an A&E doctor should be required to delve into the details of a patient's illicit drug taking, including as to the details of that patient's drug supply arrangements.

B. Introduction

2. At some point prior to 2010, and possibly a considerable period before, Mr Anthony Mulholland, the Claimant, developed a brain tumour. From around late 2009 Mr Mulholland began to experience a range of unpleasant and disquieting symptoms. At one point his right arm involuntarily stuck out at right angles, and he could not relax it. These symptoms developed and worsened over time. We now know that Mr Mulholland was in fact suffering from an anaplastic oligodendroglioma (grade III), a malignant and aggressive brain tumour and that the symptoms were caused by the tumour. Mr Mulholland attended the Accident and Emergency ("A&E") of the Medway Maritime Hospital ("the Hospital") on 11th January 2010 and then again, the next day, on 12th January 2010. Mr Mulholland believed at the time that he had suffered, and was continuing to suffer from, a stroke. He was assessed variously over the course of these two days by two ambulance teams, two triage nurses, a GP versed in emergency medicine located within the Hospital, a specialist stroke team also located within the Hospital, and then a doctor in A&E who spoke to her Registrar about the case. The outcome however was that no one assessed him as warranting an immediate CT scan until mid August 2010, some 7 months after he first presented.

3. For January 2010 onwards, Mr Mulholland's symptoms gradually exacerbated. He went regularly to see his GP and raised a variety of disorders which included complaints that he felt he was experiencing a stroke. I have no doubt that mentally and physically Mr Mulholland was in fact deteriorating and that the varied symptoms he was experiencing were genuine.

4. In July/August 2010 the symptoms reached a "crescendo". The experts in the case explained that it is not uncommon in brain tumour cases for symptoms to intensify quite suddenly to a "crescendo", even in the case of a slow progressive growth tumour such as that which Mr Mulholland was suffering from. It is possible that the significantly increased symptoms which he experienced at that time were due to the fact that the cyst which surrounded the solid core of the tumour had swelled and was now impacting more forcibly upon the brain. Finally, in mid-August 2010 he was referred for a CT scan. The circumstances in which this came about are not relevant to the issues which I must determine in this case. However, upon the evidence that was placed before the Court, I am of the view that it was at least in some measure down to the persistence and loyalty of the Claimant's wife, Linda Mulholland, that he was

finally sent for the CT scan which then revealed his tumour. The revelation of the tumour led to emergency surgery for its decompression and debulking.

5. In his oral evidence Mr Mulholland complained that the medical profession did not believe him until August 2010 and that he suffered unnecessarily by the delay in diagnosis and treatment. On the other hand, and it is right that I should record this, he was also at pains to explain to me that he wished to praise the Hospital for "*more than 100% effort",* for "*being very kind*" and for "*saving his life*".

6. This case raises what turns out to be a relatively narrow point which is whether the delay in diagnosis was negligent and caused unnecessary pain and suffering and other damage for which Mr Mulholland is entitled to be compensated. Standing back from the minutia of the case the issues raised have a broader significance. They concern the standard of care that must be demanded from nurses and doctors operating in the highly pressurised environment of a busy A&E department. There are 2 features of this that are especially significant to the analysis. First, time is often of the essence in A&E and the medical professionals have a limited amount of that time in which to take a patient's history, to record symptoms and then to assess a patient leading to a diagnosis and a determination on future treatment. Secondly, the nurses and doctors acting within such an A&E department operate collectively and they, perforce, must rely upon each other to act in a professional manner.

7. The simple fact that Mr Mulholland has been proven to be correct in that he was, all along, suffering from a serious neurological condition does not, inevitably, mean that a delay in the making of a correct diagnosis is negligent. The position is complex and, as the facts of this case amply demonstrate, the process of diagnosis may be as much an art form requiring sophisticated judgment, and about which reasonable professionals might disagree, as it is one of precise medical science.

8. In this scenario there is considerable common ground. It is accepted:

   i) That it was <u>not</u> negligent to fail to diagnose the tumour;

   ii) that had the Claimant, however, been diagnosed as at risk of having a transient ischemic attack (TIA) or a cerebral vascular accident (CVA) he would have been sent to a specialist stroke clinic and that he at least might and possibly would thereafter have been referred for a CT scan;

   iii) that had this occurred the tumour <u>would</u> have been identified and the tumour diagnosed;

   iv) that in such circumstances it would have been treated;

   v) that the earliest the surgical procedure would have been carried out would have been mid-May 2010 and therefore the maximum period of delay caused by the failure to make a correct diagnosis would have been circa 3-4 months (i.e. the difference between May and August 2010);

   vi) that even if the tumour had been identified earlier the long-term prognosis would not have changed;

9. A feature of the present case is that the Particulars of Claim have identified only Medway NHS Foundation Trust as a Defendant. However, during the period between January and August 2010 the Claimant was seen and treated by a variety of other professionals (including GPs located at the Hospital to whom patients triaged in A&E were sent, and stroke specialists), employed by Medway Community Healthcare NHS Trust, a separate body which has not been included as a Defendant to these proceedings. It accordingly becomes necessary, from amongst the professionals providing medical services to Mr Mulholland, to identify those who were employed by the Defendant and those who were not; and then to assess the respective roles of each professional in the context of advice and treatment provided by others. In the section on the relevant facts (below) I have therefore differentiated between the different roles of the medical professionals involved relative to each other.

C. The Claim

10. The Particulars of Claim focused upon the conduct of 2 professionals employed by the Defendant: Mr Nathan Hunt (the triage nurse who streamed Mr Mulholland on his arrival in the Hospital on 11th January 2010); and, Dr Wei Li Chong ("Dr Chong") who assessed Mr Mulholland in A&E on 12th January 2010 and who devised a care path for him. Upon the conclusion of evidence, and shortly prior to commencement of closing submissions, Mr Grundy, for the Claimant, informed me that the claim against the Defendant based upon Mr Hunt's conduct was not pursued and that the Claimant's case therefore rested solely upon the conduct of Dr Chong. Mr Grundy did however say that the events of 11th January 2010 remained relevant by way of context to the events of 12th January 2010.

11. In this judgment I have concentrated upon the allegations against Dr Chong. However, at paras [84] – [91] below I summarise the reasons for the conclusion that I reached relatively early on in the trial that the claim against the triage nurse was misconceived. It seems to me that, notwithstanding the abandonment of the claim in respect of Mr Hunt, there is utility in my setting out the conclusions I arrived at about the standard of care to be expected of a triage nurse – such as Mr Hunt - in an A&E Department.

12. In relation to Dr Chong, in his closing submissions, Mr Grundy took me back to his pleaded Particulars of Claim in which he specified the acts and omissions said to reflect failings amounting to a breach of duty. I set the relevant part of the pleading out below. It will be seen that, in broad terms, the allegations encompass claims that Dr Chong failed adequately to extract relevant parts of Mr Mulholland's history, failed to exclude drugs as a possible attribution for the presented symptoms and signs, and failed to adopt a sufficiently cautious approach to choice of care path. The pleaded particulars of breach were as follows:

> "a. Failed to carry out an adequate examination
>
> b. Failed to take any or any adequate history of his presenting complaint, including the history set out in paragraphs 2 and 3 above
>
> c. Failed to interrogate the Claimant as to whether he, as a long-term user of cannabis, had experienced such

symptoms in the past when using cannabis: if he had been so interrogated he would have been emphatic in denying any such past experience

d. Placed undue emphasis on the complaint of hallucinations e.g. advised GP follow-up if his hallucinations recurred when follow-up was manifestly more important for the focal, specific and sustained neurological symptoms if they remained or recurred

e. Inappropriately diagnosed cannabis-induced symptoms when his main presenting complaint of unilateral limb weakness did not fit into such a diagnosis

f. Inappropriately attributed the Claimant's symptoms and signs to long-term cannabis use when a recent neurological cause for those signs and symptoms had not been excluded

g. Failed to act appropriately on his/her own neurological assessment and the specific, focal and sustained neurological signs obtained

h. Failed to take any or any appropriate steps to exclude TIA/CVA; it was especially important to do so given his re-presentation with further neurological symptoms

i. Failed to admit him for review by the physicians

j. Failed, in the alternative, to advise his GP that he should be referred to the hospital's TIA/CVA clinic for follow-up

k. Failed to refer him directly to the TIA clinic for the said follow-up

l. Discharged him when it was inappropriate to do so".

13. By the time the case reached the point of closing submissions the pleaded case had boiled down to some more limited and specific allegations about Dr Chong's decision making. It is these specific allegations that I have focused upon.

14. I turn now to set out the relevant factual background.

D. Relevant facts

(1) The onset of symptoms

15. The Claimant, Anthony Daniel Mulholland, was born on 16th December 1971. He is now married to Linda Mulholland who was born on 18th November 1969. Together they have four children born between 1992 and 2009. The Claimant works in the

construction industry. In his witness statement, at paragraphs 4 and 5, Mr Mulholland stated:

> "4. On 20th November 2009 police officers attended my house and I was arrested on suspicion of growing cannabis. This was completely unfounded and no charges were brought. However, when I was being taken into the back of the police car I was effectively bent double and one of the police officers held their knee into my back. I felt at the time that I couldn't breathe and had an almost blackout sensation.
>
> 5. It was around the time of this incident that my behaviour started becoming very aggressive. I would snap at Linda for no reason and start arguments with her over nothing. I have always been a loud, in-your-face type character, however towards the end of 2009 my behaviour started to change and I started becoming more aggressive around Linda and the children which at the point was not normal for me".

16. Expert evidence was to the effect that a tumour will exist for some time before the onset of symptoms and, further, that typically a patient may experience symptoms for some time before they become evident to family and loved ones. The Claimant traces the onset of symptoms to this event involving the police. In fact the experts gave evidence that medically an incident such as this could not trigger a tumour. But, on the evidence before me, I accept that it was at about this time that Mr Mulholland began to experience symptoms caused by the tumour. This suggests that the tumour pre-existed this point in time by some margin. According to Mr Mulholland's evidence in January 2010 he was working laying drains in Eden Park School, Bromley, a job which had commenced in December 2009. He was a few weeks into the job when there was an incident when he was down a hole and he was unable to pull himself out which he should have been able to do easily. A ladder was provided for him to exit the hole. The foreman told him that he had to go home to sort himself out because he was limping and not acting safely. There were cranes on the site and, apparently, the foreman was concerned. The foreman stated that there would always be a job for him provided he got better but he could not let Mr Mulholland work in the condition that he was in.

(2) 11th January 2010: First visit to A&E

(i) The ambulance call out

17. There is a conflict of evidence between the Claimant and the Defendant as to Mr Mulholland's condition and symptoms on 11th January 2010. I should state that Mr and Mrs Mulholland gave evidence in Court. Both did so with total candour and with dignity. Mr Mulholland accepted that his recollection of events was confused and he could not now be certain as to when precise symptoms came and went. Mrs Mulholland also gave evidence and she was able to corroborate some of her husband's evidence. But, quite understandably, she also could not be exact or certain about when symptoms came or went. It seems to me that there is no reason to doubt either Mr Mulholland's evidence or the medical notes prepared by the medical professionals. It is entirely possible that they are both accurate and the differences

between them reflect the occurrence of symptoms which were transient and came and went at different times.

18. Mr Mulholland's evidence was that on the morning of 11th January 2010 he had what he described as a "mild seizure". He said he felt light headed as though he was going to pass out and he had lost control entirely of his right arm. He said that it was sticking out involuntarily and he thought he might be having a stroke. He explained that the feelings that he was experiencing were quite unlike anything that he had ever experienced before. His wife called an ambulance which took him to the A&E at the Hospital. He says that he told staff that he was concerned that he had had a stroke.

19. Not all of the medical professionals who were working in A&E at the Hospital, and who saw Mr Mulholland, have a specific recollection of treating him. However, there is a detailed record of the treatment set out in contemporaneous medical records. In the text below I describe what happened by reference to the clinical notes which, where appropriate, I supplement with the oral and written evidence given in Court.

(ii) The ambulance records

20. The ambulance arrived at A&E at 11.50am. The first contemporaneous record relating to Mr Mulholland are the ambulance records.

21. These show that the ambulance staff conducted a "FAST" test. This is a validated tool to screen for the diagnosis of a TIA or stroke. "F" refers to facial weakness (Can the person smile? Has the eye or mouth drooped?); "A" stands for arm weakness (Can the person raise both arms?); "S" stands for speech problems (Can the person speak clearly and understand what is said to them?); and "T" stands for test (i.e. test all three symptoms): See NICE, "Stroke Diagnosis and Initial Management of Acute Stroke and Transient Ischemic Attack (TIA)" (July 2008), Appendix D.

22. The ambulance records are in the following terms:

> "C/O numbness L side
>
> O/E FAST checks clear
>
> Pt fully mobile
>
> [Increased] resp rate – anxiety
>
> H/O No FH
>
> Episode occurred following sexual activity
>
> Smoked cannabis last night
>
> ? induced by hyperventilation
>
> Plan Pt adamant to be seen @ A/E".

(iii) Triage

23. Upon arrival at A&E Mr Mulholland was first seen by Mr Nathan Hunt. Mr Hunt is a Registered Nurse who qualified in 2008 having obtained a BSc Honours Degree in Nursing Studies from Canterbury Christ Church University. He began working as a newly qualified nurse at the A&E Department in the Hospital. Following qualification he completed a course in the Manchester Triage System. Mr Hunt did not have any personal recollection of having assessed Mr Mulholland. However he reviewed a copy of the medical records relating to his assessment of the Claimant and he produced a Witness Statement and gave oral evidence, based upon these records. At the time he saw the Claimant he had been practising as a registered nurse in the A&E Department of the Hospital for 18 months so that he had considerable experience of triaging patients in A&E. On average during a normal shift the Department would assess up to 200 patients. He gave evidence to the effect that he had extensive experience of assessing patients who were complaining of altered sensation or who could potentially have suffered a stroke. He recorded the following note in the records:

> "TRIAGE TREATMENTS:
>
> TRIAGED COMMENTS
>
> PT developed numbness to left side passed FAST TEST. No facial droop or slurred speech no limb weakness, no chest pain or sob, no nausea or vomiting. Pt c/o pins and needles in left arm. Pt says this followed an episode of sexual activity. Insisted on coming to A&E for assessment. Pt clearly anxious concerned for health of his heart and family hx of epilepsy.
>
> Sdtc 12.03.
>
> Time: 12:03".

24. The clinical note also records that Mr Hunt took Mr Mulholland's pulse which was 70, and he recorded his respiratory rate which was 18 and his blood pressure at 131/79. His O_2 saturations were 99%. The records note that he came into the Department by ambulance and was unaccompanied.

25. Mr Hunt gave evidence as to the standard triage practise that he says, and I accept, would have been carried out. Mr Hunt would also have had a copy of the ambulance notes. These, as set out above, indicated that the ambulance crew performed a FAST test and found this to be negative, i.e. not indicative of a TIA/CVA. Mr Hunt would have assessed the Claimant's gait. If there had been any evidence that the patient was incapable of walking in a straight line, or was slouching, or that his gait was abnormal in any way, he would have recorded that. Mr Hunt would also have taken a history from the patient. He noted that Mr Mulholland was complaining of pins and needles in his left arm commencing following an episode of sexual activity. Mr Mulholland informed Mr Hunt that there was a family history of epilepsy. Mr Hunt would have examined to see whether there was any facial droop or slurring of speech. The notes record that there was no such presentation. Mr Hunt would have asked the patient whether he had any chest pains or shortness of breath and whether there was any history of nausea or vomiting, which there was not. Mr Hunt would then have conducted a neurological examination which would have taken the form of looking at the patient's pupils and checking whether they were equal and reactive to light. If

there had been any abnormality this would have been recorded. Mr Hunt deduces from the records that the results of the examination were normal. According to normal procedure Mr Hunt would also have checked for signs of limb weakness and he would have asked Mr Mulholland to squeeze his hand with both hands in order to check whether there was any weakness in his left or right hands. He would then have placed his palms outwards towards the patient and he would have asked the patient to push his hands away. Patients who are suffering from a stroke often suffer from weakness in the arms and the test discloses whether there is any weakness in the patient's upper limbs. He would then have asked the patient to hold his arms out straight in the air to check whether there was any sign of weakness or deficit in movement. Again, had there been any abnormality this would have been recorded. Mr Hunt, once again, deduced from his records that this test proved normal. If the patient had been on a trolley it would have been his normal practise to check legs strength but Mr Mulholland walked into the cubicle before taking a seat and there was no evidence from his walking that he had leg weakness. Mr Hunt would also have checked for any history of involuntary abduction in the patient's arms and had there been any problem this would have been recorded. Again, Mr Hunt deduced from the absence of any such record that there was no such problem.

26. In his witness statement Mr Hunt stated as follows (and there was no challenge to this):

> "14. I am certain that I conducted a comprehensive neurological examination because I specifically recorded that the patient had passed the FAST test (which is an acronym for a test comprising of assessment of the patient's Face, Arms, Speech and the final part of the acronym relates to Treatment).
>
> 15. Although I would not strictly record in my Triage notes I would also have assessed the patient's Glasgow Coma Score when assessing the patient, to check whether they potentially have had a stroke. A patient who is walking and talking without difficulty would usually be assessed as having a Glasgow Coma Score of 15".

27. An important issue lies in the limitations under which a staff nurse, in the position of Mr Hunt, would have been working under. Mr Hunt explained, and I accept, that he did not have authority to discharge a patient. Once he had completed a triage he had a limited number of options open to him. These were, first, to ask one of the doctors in the A&E Department to assess the patient; secondly, if he concluded that there were clinical signs that the patient had suffered or was suffering from a stroke he could refer the patient immediately to the stroke team; or thirdly, where appropriately he could refer the patient for further assessment to a GP in the Hospital at the Same Day Treatment Centre ("SDTC").

(iv) The streaming to a GP in SDTC

28. The concluded view of Mr Hunt was that the Claimant's neurological assessment was normal and that all his vital signs were normal. In these circumstances he considered it appropriate to refer Mr Mulholland to the SDTC for assessment by one of the centre's GPs.

29. There is no challenge brought by the Claimant to the assessment then made by the GP in the SDTC. In closing submissions, Mr Grundy, for the Claimant, accepted that, on balance, he could not submit that the GP's assessment was negligent. It is plain from the records of the assessment made by the GP that the GP in question (Dr Boachie) did not come to the conclusion that Mr Mulholland was suffering from a neurological condition but, rather, that his symptoms suggested anxiety or were cannabis related ("*strong weed*"). Dr Boachie's records are in the following terms:

> "History: pt developed numbness to Lt side passed FAST TEST – no facial droop or slurred speech no limb weakness no chest pain or [shortness of breath] no nausea or vomiting [patient complaining of] pins and needles in Lt arm – pt says this followed an episode of sexual activity – insisted on coming to a&e for assessment pt clearly anxious and concerned for the health of his heart and family [history] of epilepsy.
>
> [history] as above, patient says took 'strong weed' last night, and wondering if that could be the cause of how he is feeling, very worried about stroke,
>
> Examination: looks well but very anxious, no hallucinations or thought disorder, good rapport, no suicidal ideations, bp – 131/79, 18/min, CNS-tone power reflexes, normal
>
> Diagnosis: anxiety/effects of drugs
>
> Treatment: tried to reassure not stroke, not heart attack, diazepam [to] help relaxation and sleep
>
> Prescription items: diazepam tablets 5mg (14) tablet(s) 1 twice daily as required".

30. The Claimant was discharged by Dr Boachie with a prescription for diazepam.

(3) 12th January 2010: The second visit to A&E

(i) The ambulance call out

31. I turn now to the events of 12th January 2010 which is the day upon which the Claimant was examined by Dr Wong.

32. On the morning of 12th January 2010 Mr Mulholland explained that he experienced a second seizure. Mrs Mulholland called an ambulance and he was brought back to the Hospital. He arrived at about 09.17am. Mr Mulholland says that at this time he was feeling light headed and experiencing dizziness and blurred vision. He says he was disorientated and gazing through people, not engaging and finding it difficult to concentrate. It was his evidence that he could not control his right arm and leg and that his right arm would go "straight out and to the right at shoulder height" which he said was an embarrassment and a problem. He said that he was also walking with difficulty as his right leg was weak. He says he remembers feeling upset because he believed that nobody considered that anything was seriously wrong with him. Mrs

Mulholland explained that, so far as she can recall, she followed on behind the ambulance.

(ii) The ambulance records

33. The ambulance notes record that a FAST test was performed and that the Claimant failed, i.e. that on this occasion Mr Mulholland showed signs of a TIA. The notes record a right side weakness. The record made by the ambulance staff reads:

> "P/C 38 yrs male generalised headache
>
> R arm R leg weakness 999
>
> Symptoms onset 11am yesterday
>
> HPC – admit yest by amb – told possible anxiety attack. Discharged 1500
>
> O/A male on scene quite anxious.
>
> Family on scene
>
> O/E GCS 15 Fast Test reveals R arm R leg weakness
>
> Seen at A&E yest a/m same symptoms. Baseline
>
> obs ok. Well perfused. Very worried that he is having
>
> a CVA. 5/10 frontal lobe headache. ?anxiety ?TIA.
>
> PMH smoked skunk last time 48 hours ago.
>
> Head injury 4 years ago.
>
> Meds Diazepam prescribed by MMH.
>
> SHx Lives with wife and family
>
> Allergies nkn Meal 2/7 ago".

(iii) Triage

34. Upon arrival at A&E he was triaged. The triage notes record:

> "[Patient] states is having a stroke, pt attended with same issues yesterday and was discharged with anxiety, pt is known cannabis user, pt states had a joint last night".

35. At 09.30am the nursing records state:

> "[Patient brought in by ambulance] … [complaining of] weakness and dizzy spells. Neuro observations taken and recorded. GCS 15/15 MMEWS 0".

(iv) The streaming to the specialist stroke team

36. Mrs Mulholland gave evidence that she attended A&E with her husband and she was insistent that her husband be seen by stroke specialists. Although this is not recorded in medical notes I have no reason to disbelieve her evidence. Assuming the triage nurse knew what the conclusions of the ambulance team were in relation to the FAST test he would have been streamed to stroke services anyway. At 09.40am the Claimant was seen by the Stroke Services team. This is a nurse led specialist unit. This team is not part of the Defendant. The Claimant was seen by Ms Gill Willard. I assume that she was a nurse but there was no direct evidence before me to this effect and it is possible that she was a doctor. The distinction however is not relevant to my conclusions. The records prepared by Ms Willard contain the following:

> "[History of] headaches x [two days].
>
> Yesterday morning felt light headed and thought he was going to pass out, [?] loss of control over right upper limb. Came to A&E [diagnosed with] anxiety – prescribed diazepam + discharged. – symptoms still present today. Therefore called ambulance + came back to A&E.
>
> [Examination] – Appears anxious. Still [complaining of] light headedness.
>
> No family history of stroke – father has epilepsy
>
> Regular cannabis user
>
> [No] alcohol
>
> Concentration decreased + patient tearful
>
> Full power all 4 limbs
>
> Slight [decrease] coordination [right] upper limb
>
> [No] visual disturbances. [No] speech disturbance
>
> Impression: symptoms + history not suggestive of TIA / CVA
>
> Plan: refer back to A&E team".

37. There is no record which indicates whether the stroke team saw the ambulance records which, as set out above, record that the Claimant <u>failed</u> the FAST test. However, since Mr Mulholland was triaged <u>to</u> stroke specialists it is likely that the ambulance records played a part in that triage decision and that the stroke services

would have been aware of the earlier FAST test outcome. As the note records the specialist stroke team however concluded that the symptoms and history were not indicative of a TIA or CVA. The clinical notes indicate that the stroke team conducted a full neurological assessment for TIA or stroke.

(v) The assessment by Dr Chong

38. Following having been assessed by the stroke team, the Claimant was referred back to A&E where he was then assessed by Dr Chong. The premise underlying this decision on the part of Ms Willard was that the signs and symptoms were something *other* than a TIA or stroke and that therefore Mr Mulholland should be assessed by an A&E doctor.

39. It is necessary to dwell upon the assessment made by Dr Chong because her decision lies at the heart of the Claimant's case of alleged breach of duty. Dr Chong gave evidence during the trial. She qualified with MBChB from the University of Edinburgh in 2007. Upon obtaining her degree she completed the usual course of foundation training in Edinburgh. She commenced employment as a FY1 in the Acute Receiving Unit at Western General Hospital in Edinburgh between 1st August 2007 and 4th December 2007. Subsequently she worked as FY1 in the Colorectal Unit at Western General Hospital between December 2007 and April 2008 before completion of a period of four months training in palliative care at the Victoria Hospice in Kirkcaldy between April and August 2008. Thereafter she gained relatively extensive experience in emergency medicine, including at the Hospital. She has been studying for a Masters degree in Health Economics Policy and Management at the LSC since 2012 and became a member of the Royal College of Physicians in 2010. She completed the primary MCQ for the Royal College of Anaesthetists in 2011.

40. Dr Chong, in readiness for this trial, viewed the medical records of the Claimant, including those prepared by her at the time. She explained that following this review she recollected the consultation with Mr Mulholland on 12th January 2010 and hence her evidence was a combination of her records and her own personal recollection. Dr Chong saw Mr Mulholland at 10.50am and she took a full contemporaneous note of her assessment. In oral evidence she explained that whilst she considered her note to be full she did not, nor would as a matter of normal practice, record every single detail of the assessment of Mr Mulholland. The record was in the following form, which seeks accurately to reflect the form in which it was recorded by Dr Chong:

> 38(M) PC: same complaint as yesterday
> C/O inability to control R arm plus leg. R arm/
> Shoulder spasm and R leg weakness.
> Feels light headed and dizzy. Blurred vision.
> Denies any head trauma. Smokes marijuana x3 at
> night.
> HI of CO yesterday had marijuana @ 7am then
> had sex. Immediately had pain in testicles. C/O ↑ volume
> of urine. Then ↑ panicky + agitated and could (not) [SIC] feel
> arm/leg. Couldn't walk. Collapsed and brought in.
> Given diazepam by GP and that relieved spasm.

Smoked marijuana for 15 years.
Anorexia for past 2/7, hallucinations yesterday
PMH MED NKDA
Head injury 3 years ago. Diazepam 5mg
skull R temporal area. C x 3 doses
° smokes cigarettes L R
° ETOH CNS: opthal N ↓
BP126/64 V2: ↓ N
O/E obs stable HR 61 V3: ↓
98% RA RR 16 Chest
Neuro. CN II – XII → no nystagmus clear
nil
added
Denies Pupils C=R= perla3. HS I+II+0
any Pulse 7
testicular LUL RUL LLL RLL gait
pain Tone _____ N _____ Abdo
now Power 4/5 4/5 4/5 4/5 SNT
Reflexes + + + + BS present
equivocal
Sensation N ↓ N ↓
Coordination N N N N
Proprioception N N
IMP: ? marijuana induced
Symptoms
P urinalysis → trace proteins other N
Bloods D/W for → for 2/7 off
Home diazepam Chong.

41. For ease of reference I set out below the "translation" of the substantive conclusions in Dr Chong's notes by Ms Johnson, counsel for the Defendant:

> "[patient complaint]: same complaint as yesterday
>
> [complaining of] inability to control [right] arm + leg. [right] arm / shoulder spasm and [right] leg weakness
>
> Feels lightheaded and dizzy. Blurred vision.
>
> Denies any head trauma. Smokes marijuana x 3 at night.
>
> [history] yesterday had marijuana at 7am then had sex. Immediately had pain in testicles. [complaining of increased] volume of urine. Then [increased] panicky + agitated and could [not] feel arm/leg. Couldn't walk. Collapsed and brought in. Given diazepam by GP and that relieved spasm.
>
> "Smoked marijuana for 15 years"
>
> Anorexia for past 2/7, hallucinations yesterday

PMH

Head injury 3 years ago

[fractured] skull R temporal area

Meds NKDA

Diazepam 5mg

C x3 doses".

42. The Claimant's blood pressure was 126/64mm Hg. His heart rate was 61 beats per minute. His heart sounds were normal and his chest was clear. His abdomen was soft and not tender with bowel sounds present. With regard to the transgeminal nerve there was some decrease in sensation in V2 and V3 on the left and the ophthalmic branch on the right. The cranial nerves II-XII were otherwise normal. The pupils were equal and both were reactive to light. Power was 4/5 in all limbs. There was, however, some reduced sensation in the right upper and lower limbs but coordination and proprioception were normal and equal.

43. Dr Chong explained in evidence that when she conducted her assessment of the Claimant she noted that he had already been seen by the Stroke team at 09.40am that morning (i.e. just over an hour earlier) and she would have looked at the notes prepared by them. She also had access to the notes relating to the presentation on the previous day. She felt that she had taken a full history from Mr Mulholland. She recollected that she conducted a neurological examination testing the power in all four of his limbs by first asking him to push her hands away using his hands. She explained also that she laid him on the couch and asked him to raise his legs and resist when she tried to push his legs down. She also tested the strength in his feet by asking him to push her hands away with his feet. She recollected that he was a young man and that he did not make much effort in terms of demonstration of strength when she was testing for power in his limbs. It was for this reason that she only gave him 4 out of 5 when assessing power. She was cross-examined about this and said that she would have given him 5/5 but for her conclusion that the Claimant was not making a full effort. She also gave evidence that she tested for tone by moving his hand up and down to ascertain whether there was any resistance in his joints but noted that the tone was normal throughout. She explained further that she tested his reflexes with a tendon hammer and the results were also normal. She tested for sensation by running her fingers along his arms and legs and noticed that sensation was reduced over the right upper and right lower limbs but was normal in the left upper and left lower limbs. She tested his coordination by asking him to move his finger from the tip of his nose to the tip of her finger with both hands and then to run his left foot down his right shin and vice-versa. Coordination was normal in all four limbs. The test for proprioception was also normal. Her analysis of his pupils was that they were equal and reactive to light; there was no nystagmus (involuntary eye movement) present. In relation to the Claimant's cranial nerves there was left sided reduced sensation over the left cheek bone and jaw area with reduced sensation over the right forehead. In her witness statement Dr Chong articulated her conclusion in the following way:

> "24. Taking into account the history of marijuana use, I conclude that Mr Mulholland's symptoms were likely to have been induced by marijuana usage. I would also have considered alternative diagnosis such as the possibility of the onset of Multiple Sclerosis but my findings on examination of reduced sensation over the left side of the face and over the right side of the rest of his body was confusing because he also admitted to hallucinations and there was a history of taking cannabis. Neither did these results of examinations, together with the history I took from Mr Mulholland fit with a history of TIA/CVA".

44. Dr Chong discussed the case with the Registrar on duty. Although she cannot be certain which Registrar it was she suspects it was Dr Verlyn Tolat. She explained to the Registrar that her management plan was to perform a urine analysis and to obtain blood tests but that her principal conclusion was that the Claimant's symptoms were likely to be due to marijuana usage. She explained in evidence that the Registrar agreed with her management plan and in addition advised the prescribing of further diazepam, bearing in mind that Mr Mulholland had been prescribed this drug by his GP the previous day and that this had assisted in relieving the muscle spasms which Mr Mulholland had been complaining of. She explained the logic behind this: She suspected a cannabis attribution but could not be certain. If he ceased taking cannabis any symptoms due to drug use would cease within that period so that if they in fact persisted they could then be attributed to a non-drug cause. This assessment could be made by the Claimant's GP.

45. Following her discussion with the Registrar Dr Chong recalls advising Mr Mulholland that he should cease smoking cannabis and that her diagnosis was that the symptoms were likely to be related to his drug use. She says that she would also have advised him that if the symptoms were not due to cannabis usage then this would not become clear until he ceased smoking the drug. The urine analysis results were returned and showed trace proteins but were otherwise normal and his blood test was normal. Dr Chong explained that given that the neurological examination did not disclose any problems with his mobility, strength or coordination and that otherwise his test results were normal it was appropriate for him to be discharged. She explained that in reaching this decision she had conducted a fuller examination than would be normal practice in A&E and also that she took account of the fact that the stroke team had also taken a history from him when they assessed him at 09.40am that same morning. She took into consideration that the results of the stroke team analysis did not suggest TIA or CVA.

46. In relation to the clash of evidence between the Claimant and Dr Chong as to whether Mr Mulholland presented with a complaint of unilateral limb weakness, Dr Chong disputed this evidence. As I have already observed I do not need to resolve this dispute. I do not doubt that Mr Mulholland did experience these symptoms. The strong probability is that this was at a different moment in time and not therefore during the medical assessments themselves. Dr Chong gave evidence that Mr Mulholland complained of right arm and shoulder spasm with there only being weakness in the right leg. In her witness statement she stated:

> "29. The finding of reduced sensation of the right V1 distribution, and in the left V2 and the left V3 distribution and the finding of reduced sensation over the right side of the body and the history of hallucinations did not fit the diagnosis of stroke. It is important to note that cannabis can have neurological effects. The history which I was given by Mr Mulholland was discordant because the history which he gave on 11 January was of pins and needles in his left arm whereas the complaint on 12 January was of inability to control his right arm and leg and of the presence of right arm shoulder spasm and right leg weakness. Again this history did not fit with the history of TIA/CVA".

47. In relation to the suggestion that Dr Chong should have admitted the Claimant she explained that as a CT1 doctor in training she did not have admitting rights. But in any event she had discussed the Claimant's case with her Registrar who did not consider it necessary or appropriate to admit Mr Mulholland or to perform a CT scan. She explained that it would not be usual to admit a patient who was complaining of loss of sensation but who was otherwise well or to perform a CT scan. In the circumstances Dr Chong considered that it was reasonable to discharge Mr Mulholland with advice that he should see his GP if symptoms persisted once he had ceased taking cannabis for a few days. And to provide him with a prescription for two days worth of diazepam, as recommended by the Registrar.

48. A written referral document was sent by the Hospital to the Claimant's GP very shortly afterwards and appears to have been received by the practice on 15th January 2010. This records the diagnosis of Dr Chong as *"Simple intoxication of cannabisoids. Excludes poisoning T407, Site: O Side: Right*". The document however records that Mr Mulholland "*Presented with: numbness to Left Side"*. Under the heading treatment it is stated: "*1. GP for follow up, Verbal advice"*. Under "Patient Diagnose" it simply states: "*Referred to GP"*. The reference to "verbal advice" is a reference to the fact that Mr Mulholland had been given oral advice in A&E (as to which see para [45] above).

(4) Events subsequent to 12th January 2010

49. Subsequent to the Claimant being discharged from the Hospital, he made a number of visits to his GP. On 13th January 2010 he telephoned his GP to report the symptoms he was suffering. A record of the telephone conversation was made by Dr Christine Huxham and is in the following terms:

> "Telephone encounter pt on phone, angry at hospital, government, our system, asking someone give him a call in the morning to make him a pt, explained policy of practice, more agitated, convinced had mild stroke, smoking weed and claims had heart failure but not happy how treated a Medway hospital and discharged without tests etc, hung up".

50. On 15th January 2010 the Claimant saw Dr Sophie Bagley. It is his evidence that he explained to her that he had suffered a stroke but that he was advised there was no evidence of stroke and that his symptoms were likely to be due to drugs. He says he

requested a brain scan but this was refused. The note of the consultation made by Dr Bagley is in the following terms and suggests that a FAST test was performed:

> "Patient reviewed insistent that has had a stroke, felt [right] side went numb and right arm shaking. Admits to heavy use of drugs cocaine, cannabis etc – but says has stopped. o/e CN intact PERLA, no facial droop PN tone power sens[ation] reflex intact. Advised that no evidence of stroke, symptoms likely to be due to drugs, advised of help with drug problems".

51. On 2nd February 2010 the Claimant again attended his GP. The record made by Dr Huxham is in the following terms:

> "[History] Assault alleged by police. Happened before Christmas in drugs [raid]. Now convinced having stroke although has been diagnosed with panic attacks. Feels light headed. Says was given whiplash by 17 stone officer on back".

52. Mr Mulholland gave evidence that by about March 2010 his aggression had increased and he would fly into rages at trivial matters and he became verbally abusive to friends and family. He says that his sleeping pattern changed and he was unable to sleep more than a few hours at a time and became anxious in crowds. The Defendant points out that during this period the Claimant was seen upon (at least) three occasions by his GP for other complaints when these alleged symptoms were not reported. It appears that on 21st January 2010 he complained of muscle strain in his upper back; on 23rd February 2010 he complained of a lump following on from a vasectomy and a concern about prostate cancer; and that on 26th February 2010 he complained of urinary symptoms.

53. The Claimant returned to his GP on 26th March 2010 to consult with Dr Huxham. The note of the consultation records:

> "Had chat to patient really poor sleeping pattern. Wants help. No depression. Advised re addictive nature. Can have short course use very small prn".

54. He was prescribed with Zopiclone (an insomnia medication). The note makes no reference to the Claimant's hospital visits and there is no suggestion within the record that the diagnosis of Dr Huxham was based upon other than the presenting history and discussion.

55. It is the Claimant's evidence that during this consultation he was advised to take exercise and accordingly commenced attending a gym and swimming. However, he said he felt unsafe to swim because of his right arm symptoms.

56. He was seen by an out of hours doctor on 19th June 2010. The history reported was "*not feeling well – very anxious – not able to straighten his leg properly – asking for app*". On examination the GP recorded:

> "Not anxious but poor eye contact and fears he has brain damage. Was able to answer all my questions and no associated

> slurry speech. Saying unable to straighten leg, no bruises and no pain or swelling. Patient very concerned about the way he was treated by the police in November and he felt his head was pushed in between his legs and has caused him to be hypoxic. Tried to reassure and advised if very concerned to return to GP for review".

57. The diagnosis was *"?? Anxiety of health*".

58. On 22nd June 2010 the Claimant was seen by Dr Maddoc. She agreed to refer him to a specialist. Her record of the consultation reads as follows:

> "Anxiousness pt says he is anxious and doesn't want medication and he got leg problem and a small cyst on forehead. [on examination] good eye contact. The leg – rt – movements full no pain ? functional. Asking for a referral to physiotherapy – also asking for the cyst removal. o/e ? small infected skin lesion – on forehead. Pt disagrees with any examination. Raises voice and started to be difficult. Kept going on no end. Refused medications prescribed – agreed to refer the pt to specialist. Still not happy has been told that I am going to call the police and he started getting worried and started requesting not to call. On the whole this was a warning from surgery for such behaviour".

59. Mr Mulholland explained – and this was confirmed by Mrs Mulholland - that in about June 2010 Mrs Mulholland asked him to move out of the family home because of the considerable psychological distress he was causing and because of safety issues relating to the children. He said that as time went on his symptoms deteriorated: his right arm had curled up into his body; he had commenced shuffling when walking; his concentration and memory deteriorated and he began to lose his balance, falling over on several occasions; his coordination deteriorated such that he could no longer write his own name or use a knife and fork; and he felt suicidal. Mrs Mulholland gave evidence about a series of incidents (in which Mr Mulholland acted in a dangerously forgetful manner, such as leaving the gas on and the front door open when he went out) which left her very concerned about her husband's mental health. My conclusion is that all these events were caused by the growth of the tumour which was now impacting more forcibly upon the brain and reaching a crescendo in its effects.

60. On 5th July 2010 Mr Mulholland saw his GP and he expressed concern about his continuing and deteriorating symptoms. The GP records states:

> "…was apparently assaulted in back of Police car in November…since then daily headaches and R sided weakness, worse since Jan, getting v anxious, not sleeping as worrying something wrong with his brain…o/e [on examination] tremor and weakness settle with distraction. Imp [impression] psychosomatic symp. Will refer to neurol as not responding to my reassurance".

61. A neurology appointment was offered for 25th September 2010.

62. On 14th July 2010 the Claimant attended A&E at the Hospital. The full note of triage, which recorded a negative FAST (i.e. no indication of a TIA or CVA) was:

> "pt went to gym, c/o that he cannot move R arm/leg, thinks he is having stroke, no facial problems, pt was attacked by police in November and thinks this has caused this, diagnosed with whiplash, neurological app in Sept. pt would like to see brain surg, pt abrupt and rude in triage, FAST neg".

63. On 19th July 2010 the Claimant attended his GP and requested an MRI of his head and spine. However no investigations were ordered. On 26th July 2010 the GP records document that the Claimant was once again reviewed reporting symptoms of uncontrolled shaking.

64. On 2nd August 2010 the Claimant says he suffered a fall at home and on 4th August 2010 he attended A&E at the Hospital where a soft tissue injury to the chest was identified and documented.

65. On 12th August 2010 the Claimant says he suffered another seizure and that Mrs Mulholland telephoned the GP practice reporting that he was not sleeping. She asked that the neurology appointment be expedited. The GP agreed to write to the neurologist to see if the appointment could be brought forward. But Mrs Mulholland was not satisfied with this so that same day she took him to A&E at the Hospital. He was referred to the SDTC but the Claimant decided not to wait and sought assistance elsewhere. The Claimant saw the out of hours doctor later that afternoon. That doctor was aware that the Claimant's GP had promised to contact the neurologist to bring forward his appointment.

(5) 15th and 16th August 2010: Admission and diagnosis of the tumour

66. On 15th August 2010 Mr Mulholland once again attended A&E at the Hospital with his wife. The front sheet of the notes indicate that the complaint was *"a mental health problem"* and recorded that the Claimant was very down and tearful, had weakness in his left side and was awaiting a neurology review. Mrs Mulholland was very concerned that his memory was going and that he kept wandering off, was not engaging in conversation and was having serious problems with sleep. He was assessed by a specialist Registrar who noted the presenting complaint as depression. The history was recorded in the following way:

> "Had an accident. House was raided by police in November 2009 and physically [illegible]. Two weeks later right sided weakness then went to the GP. Diagnosis psychological. Recently deteriorating, fidgety and wandering, down and depressed. Awaiting neurology OPD. On examination right sided weakness old, v down, diagnosis depression. Mild suicidal intent. Refer MASTT tt medically fit for discharge".

67. The Hospital's MASTT team (the mental health team) assessed the Claimant and recorded that he did not have a psychological problem but that he needed to be re-assessed by the medical team. Ultimately it was agreed that he would be admitted and kept overnight. On 16th August 2010 he was assessed on a medical ward as presenting

with right-sided weakness and altered mood and behaviour. An organic underlying cause was to be excluded by "*CT head*".

68. A CT head scan was subsequently performed and revealed a large mass in the left frontal lobe measuring 6.3 x 5.3cm. Thereafter cranial MR imaging was performed and this recorded that the mass was suggestive of an astrosytoma. It turned out that Mr Mulholland had a large tumour comprising a cyst (containing plasma which was approximately 90% of the total mass) and a solid core (the other 10%).

69. On 21st August 2010 the Claimant was referred to Kings College Hospital where he underwent emergency surgery. His diagnosis was confirmed following surgery as anaplastic oligodendroglioma (grade III).

E. Observations on the evidence

70. In the course of this trial I received oral evidence from the Claimant and his wife (Linda Mulholland); and from Mr Nathan Hunt and Dr Chong.

71. I now set out my observation on the evidence of the non-experts.

72. First, as to the Claimant, Mr Mulholland: He gave evidence with dignity and integrity. It was plain to me that he had suffered significantly over the period to August 2010. He described to me the symptoms that he experienced. He explained, with candour, that because his short term memory had been adversely affected (not least because of the effects of a return of the tumour in 2013 which was addressed with chemotherapy), he could not recall the minutiae of his treatment history or when symptoms came and went. But in broad terms he was clear, first, that his symptoms were transient and varied; and, secondly, that they became increasingly worse reaching a crescendo in July/August 2010.

73. Secondly, as to Mrs Mulholland: She also gave evidence in an honest and fair way. She explained how her husband's symptoms impacted adversely upon her and the family. She corroborated Mr Mulholland's evidence. I have no basis for disbelieving the basic thrust of her evidence.

74. Thirdly, Mr Nathan Hunt, the nurse who triaged Mr Mulholland on 11th January 2010. Mr Hunt gave concise and to the point answers to questions which I found to be fair and convincing.

75. Fourthly, as to Dr Chong, she gave full and candid answers in response to vigourous cross-examination by Mr Grundy. Her evidence was thoughtful and balanced. In her evidence she painted a picture of the pressures that an A&E doctor confronted on a daily basis. She gave a comprehensive account of how she had dealt with Mr Mulholland and her reasons for her conclusions. There is one matter of substance in relation to her evidence that I address now. In her witness statement she said, in relatively unqualified terms, that her diagnosis was that Mr Mulholland's symptoms <u>were</u> due to drug usage. In her oral evidence her explanation was fuller and more nuanced. She explained that she did not make a definitive diagnosis of drug taking as the cause of the symptoms. Rather, that this was, in effect, a provisional diagnosis or impression and it was for this reason that she decided that the care pathway was that Mr Mulholland should cease drug taking for a few days in order for any cannabis

toxicity to be eradicated from the body and then visit his GP. If symptoms persisted a drug attribution could be excluded. I accept this evidence because it is consistent with the clinical notes prepared at the time and the inherent logic of the care path actually adopted. It is also consistent with other parts of her witness statement which were in not quite so emphatic terms (see e.g. at para [24] above and the reference to "*likely*" in para [42] of the witness statement).

76. I also heard evidence from experts in three disciplines. In relation to Emergency Medicine I heard evidence from Ms Longstaff (Claimant) and Dr Campbell-Hewson (Defendant). In relation to neuro-surgery I heard evidence from Professor Pickard (Claimant) and Mr Jellinek (Defendant). In relation to neuro-oncology I heard evidence from Dr Rees (Claimant) and Professor Price (Defendant). In the event in this judgment I have concentrated upon the evidence and conclusion of Ms Longstaff and Dr Campbell-Hewson since it was their evidence that went most directly to the issue of breach of duty.

77. I have set out below (at paras [79ff]) the law in relation to experts. I can summarise my conclusions about the professionalism of the experts briefly. As a group they were impressive. They all had enormous experience in their respective fields. They exhibited true depth of knowledge. They made appropriate concessions and worked well together to produce helpful joint statements which they developed in the course of the trial as thoughts evolved and as various new pieces of evidence came to light.

78. Finally, in relation to the evidence I should record that the cross-examinations conducted by Ms Johnson (for the Defendant) and Mr Grundy (for the Claimant) were concise, courteous and effective. Their professionalism throughout eased my task in evaluating some complex, technical, evidence.

F. Relevant law

79. I turn now to the law. There is no significant dispute as to the relevant law to be applied to the facts of this case. It is common ground that the Defendant owed a duty of care to the Claimant. The standard of care is contained within the articulation of principle known as the "*Bolam*" test which derives from a direction given to a jury by McNair J recorded in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 583 at 586, 587, where the Judge stated:

> "The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art…
>
> I myself would prefer to put it this way, that he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art… Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view".

80. Re-formulating the *Bolam* test the question in this case is whether no reasonable doctor acting and exercising judgment in the way that Dr Chong did would have failed either to refer Mr Mulholland to a specialist neurological clinic for further assessment, or, direct a CT scan of the Claimant at or about the time of his presentation to A&E on 12th January 2010.

81. The task of the courts in cases such as this is invariably assisted by expert evidence. In *C v North Cumbria University Hospitals NHS Trust* [2014] EWHC 61 (QB) at paragraphs [22] – [25], in the context of an allegation that a nurse had been negligent in the administration of the second dose of a particular drug used in labour, I set out a summary of the principles which applied to the assessment of an allegation of breach of duty made by competing experts:

> "22. It is therefore insufficient for a Claimant to demonstrate only that there exists a body of competent expert opinion which disagrees with the judgment which was taken upon the facts of the present case. This is no more than a recognition of the fact that in an area where professionals exercise a high degree of technical and medical expertise that there may be a range of different views all of which might quite legitimately be held about the same matter. Accordingly, if there exists a body of competent professional expert opinion which supports the decision as reasonable in the circumstances it matters not that other experts might disagree. Lord Scarman in *Maynard v West Midlands RHA* [1984] 1 WLR 634 at 638E stated:
>
> > "Differences of opinion and practice exist and will always exist in the medical and other professions. There is seldom only one answer exclusive of all others to problems of professional judgement. A Court may prefer one body of opinion to the other, but that is no basis for a conclusion of negligence".
>
> 23. The test was subjected to analysis in *Bolitho v City and Hackney Health Authority* [1997] UKHL 46; [1998] AC 232. An issue was whether a Court was required to accept the views of one truthful body of expert professional advice even though the Court was unpersuaded of its logical force. It was submitted that to adopt such an approach was "wrong in law" because it was ultimately for the Court, not for medical opinion, to decide what was the standard of care required of a professional in the circumstances of a particular case. Lord Brown Wilkinson stated as follows:
>
> > "My Lords, I agree with the submissions to the extent that, in my view, the Court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. In the Bolam

> case itself, McNair J stated…that the defendant had to have acted in accordance with the practice accepted as proper by a "*responsible* body of medical men".

Later, he referred to "a standard practice recognised as proper by a competent *reasonable* body of opinion". Again, in the passage which I have cited from Maynard's cases, Lord Scarman refers to a "respectable" body of professional opinion. The use of these adjectives – responsible, reasonable and respectable – all show that the Court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular, in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts directed their minds to the question of comparative risks and benefit and have reached a defensible conclusion on the matter".

24. Later, having cited various authorities, Lord Brown Wilkinson stated:

> "These decisions demonstrate that in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence (I am not here considering questions of disclosure or risk). In my judgment that is because, in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied upon is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily pre-supposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.
>
> I emphasise that in my view it will seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence. As the quotation from Lord Scarman makes clear, it

> would be wrong to allow such assessment to deteriorate into seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported. It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the benchmark by reference to which the defendant's conduct falls to be assessed".

25. In the present case I have received evidence from 4 experts, 2 on each side. 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 tendered 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. In the course of my discussions with Counsel, both of whom are hugely experienced in matters of clinical negligence, I queried the sorts of matters that might fall within these headings. The following are illustrations which arose from that discussion. "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. Such a person expressing an opinion about normal clinical conditions will be doing so with first hand knowledge of the environment that medical professionals work under within the NHS and with a broad range of experience of the issue in dispute. 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 experience within the NHS is a matter of significance. By the same token an expert who retired 10 years ago and 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. "Respectability" is also a matter to be taken into account. Its absence might be a rare occurrence, but many judges and litigators have come across so called experts who can "talk the talk" but who veer towards the eccentric or unacceptable end of the spectrum. Regrettably there are, in many fields of law, individuals who profess expertise but who, on true analysis, must be categorised as "fringe". A "responsible" expert is one who does not adapt 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 CPR35 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. For example, a judge will consider whether the expert opinion accords with the inferences properly to be drawn from the Clinical Notes or the CTG. A judge will ask whether the expert has addressed all the relevant considerations which applied at the time of the alleged negligent act or omission. If there are manufacturer's or clinical guidelines, a Court will consider whether the expert has addressed these and placed the defendant's conduct in their context. There are 2 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 in which it is tendered, it is out of date and not reflective of the evidence in the case as it has unfolded. Secondly, a further issue arising in the present case emerges from the trenchant criticisms that Mr Spencer QC, for the Claimant, made of the Defendant's two experts due to the incomplete and sometimes inaccurate nature of the summaries of the relevant facts (and in particular the Clinical Notes) that were contained within their reports. It seems to me that it is good practice for experts to ensure that when they are reciting critical matters, such as Clinical Notes, they do so with precision. These notes represent short documents (in the present case two sides only) but form the basis for an important part of the analytical task of the Court. If an expert is giving a précis then that should be expressly stated in the body of the opinion and, ideally, the Notes should be annexed and accurately cross-referred to by the expert. If, however, the account from within the body of the expert opinion is intended to constitute the bedrock for the subsequent opinion then accuracy is a virtue. 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".

82. Counsel in the present case agreed that this fairly encapsulated the principles relevant to the assessment of expert evidence in the context of the *Bolam* test. In this case Ms Longstaff expressed the opinion that Dr Chong's assessment and decision fell outside of the realms of decision making of the reasonable A&E doctor. Dr Campbell-Hewson expressed the opinion that whilst some doctors might have referred Mr Mulholland to a specialist or directed a CT scan, the decision that Dr Chong took was in his view still four square within the bounds of the decision which a reasonable A&E doctor would take. Indeed, he commended her upon taking a note (set out at para [40] above) which he considered was in the upper bounds of that which he would expect from an A&E doctor.

83. The present case also involves a dispute as to causation. There is no material dispute between the parties as to test to be applied. The Defendant brought to my attention a passage from Clerk & Lindsell on Torts (21st Edition) at paragraph 2-46 which encapsulates the relevant principles. This was uncontentious and was in the following terms:

> "37. The exercise required to establish causation in a clinical negligence case of this sort is summarised in *Clerk & Lindsell on Torts* 21st edition at 2-46:
>
> > "There must be some evidence to link the defendant's breach of duty to the claimant's harm, other than the simple assertion that it increased the general risk of harm, before an inference that it must have made a material contribution can be drawn. In *Tahir v Haringey HA*,[157] the claimant alleged that the delay in providing medical treatment rendered his condition worse than it would otherwise have been, on the basis that, in general terms, delay in operating in his type of case increases the neurological deficit and impairs the prospect of recovery. The Court of Appeal held that where there has been negligence resulting in delayed medical treatment it was not sufficient for the claimant to show that there was a material increase in the risk or that delay *can* cause damage. He has to go further and prove that damage was *actually* caused by the delay. In the absence of findings of fact that identify or quantify the additional harm, it was not appropriate for a judge to adopt a proportionate approach by quantifying the total disability and then asking what proportion of that disability is attributable to the delay"".

G. Breach of duty I: The triage nurse (Mr Hunt)

(i) Introduction

84. I turn now to consider the question whether the Defendant was in breach of duty in consequence of the acts or omissions of Dr Chong. I have already explained (see paras [10] and [11] above) that the Claimant abandoned the allegations initially made against Mr Hunt but that I consider it desirable (and due to Mr Hunt whose professional reputation was fully in issue until the 11th hour of the trial) that I should set out my conclusions on the position of Mr Hunt. I therefore address the issue of breach in two stages: (i) the decisions taken by the triage nurse, Mr Hunt, on 11th January 2010; and (ii), the decisions taken by the A&E doctor, Dr Chong, on 12th January 2010.

85. I have come to the clear conclusion that the Defendant cannot be made liable for any decisions taken on 11th January 2010. For the following reasons I conclude that the actions of Mr Hunt upon this day did not give rise to a breach of duty.

(ii) The allegation that the nurse failed to perform a full diagnosis

86. Mr Hunt gave evidence that A&E was busy and that the Department would routinely see up to 200 patients per day. He stated that sometimes they had the ambulance records but this was by no means inevitable. It was not his job to diagnose a patient. His job was to record symptoms and to take a history and then to direct the patient in one of 3 directions. The options available to him were: to refer a patient to a doctor in

A&E; to refer a patient to the specialist stroke team; or to refer the patient to a GP within SDTC. He explained that he streamed Mr Mulholland to a GP in SDTC. This was because it was the triage practice within the Hospital to send patients to A&E only if they had acute, immediate, life-threatening symptoms (which Mr Mulholland did not) or to the specialist stroke unit if a FAST test showed negative signs (which it had not). He elaborated upon the limits of the diagnosis he would form. It was for the specialist, subsequently, to conduct a full assessment and form a diagnosis. To the extent therefore that any diagnosis could be said to be made by him it was by its very nature limited and served only to inform the decision as to which professional should, thereafter, assume responsibility for a patient. There is no challenge to the correctness of this evidence and I accept it. It is, in my judgment, not open to the Claimant to challenge Mr Hunt for failing to conduct a full assessment or failing to form anything other than the minimum evaluation required to determine how to stream the patient. In my judgment no reasonable triage nurse can be expected to do more than perform the limited assessment which Mr Hunt, upon this occasion, conducted.

87. In this connection, the experts in emergency medicine both analysed Mr Hunt's (alleged) diagnosis and the Claimant's expert, Ms Longstaff, was critical of it. Ms Johnson, for the Defendant, challenged in cross-examination, Ms Longstaff on her competence to give expert evidence on the conduct of a triage nurse. Ms Longstaff accepted that she was not qualified to give expert evidence on this topic and she accepted that her evidence on this should, in effect, be struck through. In my mind, this highlighted a significant point which is that the typical (reasonable) triage nurse does not, in the conventional sense, conduct a diagnosis when confronted with a patient presenting with a significant complaint. It is true that the nurse may very well receive evidence from an ambulance team, and may be experienced in emergency nursing, and may also take a history and record symptoms. But what is inescapable is that the purpose of this is not to determine a care path. On the contrary, it is to do no more than to stream the patient appropriately to a professional, down the line, whose task it is then to conduct a substantive assessment and diagnosis. In my judgment, it is hence nothing to the point for an expert to criticise the triage nurse upon the basis that he/she failed to perform a full (and accurate) diagnosis of the sort that would be conducted by the professional to whom the patient is streamed.

(iii) The allegation that the nurse erred in failing to refer to the stroke team

88. I reject the suggestion that following the performance of the negative FAST test (i.e. one not suggesting TIA or stroke) it was unreasonable to do anything other than refer to the stroke team. On the contrary, the logical course was to stream the patient away from the stroke team. Indeed, given that it is clear that the GP in SDTC (Dr Boachie) could also refer the patient to the stroke team and/or for a scan it is very hard to see how or why a reference to the SDTC would be negligent even where a TIA or CVA was a possibility. In any event, the Claimant's claim as particularised was against the Defendant for conduct occurring over the course of two days. On 12th January 2010 the triage nurse did refer Mr Mulholland to the stroke services. Accordingly, when the conduct of the Defendant's employees is examined over the course of the two days the triage nurses did precisely what it is said they should have done.

(iv) Implications of the fact that there is no challenge to the decision of the GP in SDTC

89. It is relevant also that the Claimant does not challenge the conclusion of Dr Boachie in SDTC which was that Mr Mulholland was not having a stroke and that he could simply be discharged. The Claimant's position therefore was that Mr Hunt was negligent in streaming Mr Mulholland to a GP, who was competent to assess Mr Mulholland, who was more experienced in forming a diagnosis than was Mr Hunt, who could have referred-on Mr Mulholland to stroke specialists had it been considered necessary, and whose diagnosis is not challenged. Framed thus, the artificiality of the claim becomes evident.

(v) The significance of context

90. In forming a conclusion about the conduct of a practitioner working within triage within an A&E Department context cannot be ignored. The assessment of breach of duty is not an abstract exercise but one formed within a context – which here is that of a busy A&E where the task of the triaging nurse is to make a quick judgment call as to where next to send the patient. The A&E department was busy seeing up to 200 patients per day. There is no opportunity for a triage nurse to devote a great deal of time to the taking of a detailed history or the performance of an extensive diagnosis. Such an exercise would be beyond the minimum necessary to enable that nurse to form a decision as to how to stream the patient. The reasonable nurse is one who operates in a busy A&E which has a procedure which the nurse will follow for streaming and which does not contemplate an exhaustive diagnosis being formed.

91. For all these reasons Mr Hunt acted reasonably and professionally. He was not negligent. The Claimant was correct to abandon the claim against Mr Hunt.

H. Breach of duty II: The assessment of Dr Chong

92. I turn now to consider the decisions of Dr Chong made on 12th January 2010. This lies at the heart of the Claimant's case.

93. I have come to the conclusion that none of the decisions taken by Dr Chong are capable of giving rise to a breach of duty. In the text below I have set out my conclusions under [5] headings:

i) The decision making chain in A&E: The extent to which an A&E doctor can rely upon the decisions of others (the "barn door" error point).

ii) The A&E environment and time constraints: The extent to which the process of diagnosis involves a counsel of perfection.

iii) An analysis of the assessment of symptoms and signs.

iv) A&E and illicit drug taking: What level of inquiry and knowledge is to be expected of an A&E doctor?

v) Diagnosis: Provisional or definitive?

(i) The decision making chain in A&E: The extent to which an A&E doctor can rely upon the decisions of others (the "barn door" error point)

94. The first issue concerns the *extent* to which Dr Chong was entitled to rely upon the views and conclusions of the other medical professionals who saw Mr Mulholland. In my judgment Dr Chong cannot be criticised for relying upon the previous conclusions of Dr Boachie, and, the stroke team. Nor can she be criticised for seeking the advice of her Registrar, or for placing faith in the ability of the Claimant's GP to perform future assessments. In my view her conduct was entirely reasonable.

95. First, I start with the basic proposition that an A&E doctor is entitled to rely upon the assessments and conclusions of others. Dr Chong was operating within the A&E department of a busy hospital and her decision making must be seen as one part or component of the chain of decision making which routinely operates within such departments. In the present case it is relevant to take account of: (i) the decisions taken by Dr Boachie the previous day; (ii) the assessment made by the specialist stroke team on 12th January 2010; (iii) Dr Chong's own assessment; (iv) the decision of Dr Chong to seek approval for her chosen care pathway from the on-duty Registrar; and (v), the decision of Dr Chong (and the Registrar), that a further assessment of Mr Mulholland by his GP be made within a few days. The decision made by Dr Chong cannot be assessed in isolation; the relevant context is both the past assessments and conclusions, and, the prospect of future assessments to be made by GPs in the community. Dr Chong was aware of Dr Boachie's conclusions and the assessment of the stroke team. She noted that the specialist stroke team had performed a full neurological assessment which had not revealed symptoms consistent with a TIA or CVA. And she relied upon this assessment and did not re-perform a FAST test though did conduct some tests which could reveal neurological signs. She did take a history and record symptoms and she stated in evidence that these showed positive signs (e.g. tingling, hallucinations, anxiety) and not the negative signs associated with a stroke.

96. Secondly, there is a related question, which is: Even if an A&E doctor is entitled to rely upon the views and conclusions of other professionals, are there exceptions to this, and if so when do they arise? The experts agreed that a negative FAST test (i.e. one indicating no TIA/CVA) did not rule out altogether the possibility that a patient was indeed suffering from a TIA or stroke; but it does make it materially less likely. However, no one was able, with any degree of precision, to say exactly *how much* less likely. But there was consensus that the FAST test is generally reliable as an indicator. In the present it appears from the stroke team notes that a more extensive neurological assessment than a FAST test was carried out and this was evident to Dr Chong and this suggests that the conclusions of the stroke team could be taken, at least prima facie, to be reliable. In my judgment Dr Chong got it right: She accepted when she gave evidence that the mere fact that the specialist stroke services had found no stroke was not conclusive and that if the patient then presented with obvious symptoms of a stroke that a doctor in A&E should form his or her own view and conduct a new neurological test, and then act accordingly. However, she was of the view that, more generally speaking, a doctor in A&E was entitled to rely upon the specialist advice of the stroke team and indeed that an A&E Department could not function sensibly without mutual reliance on the professionalism of others involved in the overall A&E process of assessing a patient. Dr Chong was asked to describe the sort of case where in her view an A&E doctor should second-guess the conclusions of a specialist stroke team. She said: when the error was "*barn door*"; by which she self-evidently meant something big and obvious. I agree with this analysis. An A&E doctor can *prima facie* accept the conclusions of prior professionals. But this does not

extend to blind or slavish subservience. When that prior decision looks obviously wrong (the "barn door") the A&E doctor might fall below the requisite standard of care if he/she proceeds to accept the conclusion without taking steps to verify it and, if needs be, correct it. But it is likely that this will be very much the exception and not the rule. After all, the *raison d'être* for the locating of a specialist stroke team in or proximate to A&E is to inject specialism into the assessment process and to enable other professionals, such as a hard pressed A&E doctor (who may not be a specialist in strokes or other neurological conditions), to rely upon that specialist assessment. Indeed, it would defeat the purpose of having specialist services located within A&E if their conclusions were not routinely to be relied upon. I also accept the expert evidence of Dr Campbell-Hewson, which was to the same effect.

97. Thirdly, in my view on the evidence before the Court this was not a "barn door" case. As I explain below (see paras [102] - [106]) the experts agree that the signs and symptoms were "*confusing*" and not "*text-book*" and that cannabis use can mask symptoms. The facts of this case do not, in my judgment, come close to being such as to deny Dr Chong the right to rely upon the conclusion of the specialist stroke team that Mr Mulholland was not suffering from a stroke; and it cannot be overlooked that the bottom line of the Claimant's complaint is that Dr Chong was negligent in failing to reject a correct assessment by the stroke team because we know (now) that Mr Mulholland was indeed not suffering from a TIA or CVA.

98. Fourthly, it is relevant that it is no part of the Claimant's formal case that the assessment of the stroke team was in fact negligent; which might not be thought to be surprising since their assessment was correct. Ms Peta Longstaff in her expert report for the Claimant was however critical of the stroke team's decision. The burden of her report was that these specialist services formed a negligent decision, i.e. that they fell below a reasonable standard by, in effect, not forming an incorrect diagnosis of TIA or CVA. She said as follows in her report:

> "The following day [Mr Mulholland] was referred to the stroke team on arrival, they were of the opinion that symptoms he was complaining of were not typical of a TIA despite his description of neurological symptoms and a finding of reduced coordination in Mr Mulholland's right arm. It is my opinion that these two facts should have led to further investigation of Mr Mulholland neurologically.
>
> According to the 2008 NICE Stroke Guidelines Mr Mulholland should have been scored according to the ABCD system…. He would have scored less than 4 and he would therefore not have been eligible for immediate scan but he should, according to the guidelines, have been seen by a specialist within 1 week of presenting.
>
> Mr Mulholland, of course, did not have a stroke but he described neurological symptoms in respect of his right side that could have fitted with the diagnosis of a TIA. Had he been assessed within a week in a TIA clinic, by a neurologist, and had this lack of coordination persisted and been picked up on examination, on the balance of probabilities he would have

> been scanned and the tumour would have been apparent on that scan.
>
> As it was he was told that he had symptoms associated with cannabis use. I have not personally been able to access evidence that indicates cannabis smoking causes unilateral neurological signs, and I think this diagnosis was unacceptable. He had already been assessed by the stroke team however which probably resulted in the Emergency Department doctor having a false sense of security with regards to Mr Mulholland's neurological symptoms and the reduced coordination in his right hand".

There is a gloss to this analysis which arises from the fact that during the course of the trial the ambulance notes for the 12th January 2010 became available (set out at paragraph [33] above) and these suggested that upon the performance of a FAST test upon Mr Mulholland by the ambulance staff he exhibited signs of a TIA. This information was not available to Ms Longstaff when she prepared her expert report but, she explained in oral evidence, that it reinforced her conclusion that the analysis of the stroke team was incorrect. As I have already explained when pressed by me to clarify his position vis-à-vis the stroke team Mr Grundy submitted that the stroke team's conclusions were not negligent. I agree: I do not see how the stroke team can be negligent for correctly concluding that Mr Mulholland was not suffering from a TIA or CVA, especially in circumstances when it is not said that anyone was negligent in failing to diagnose the tumour. In short, Dr Chong's decision was consistent with that of the stroke team and (rightly) their decision was not criticised as negligent. This assists in benchmarking Dr Chong's decision and supports my conclusion that she was not negligent.

99. Finally, there is an inconsistency in the Claimant's logic. In relation to Mr Hunt it was said initially that he should have streamed Mr Mulholland to the specialist stroke services for the simple fact that they were specialists and they would have identified a TIA or CVA and directed a CT scan. But on 12th January 2010 Mr Mulholland was streamed to the self-same stroke services and they did perform a neurological assessment and they recorded no stroke symptoms and sent him back to A&E. Yet in relation to Dr Chong it is now, however, said that no reliance should be placed upon the conclusions of the specialist stroke services. There was hence an element of "cake and eat it" about the analysis.

100. In all of these circumstances Dr Chong acted perfectly reasonably in relying upon the conclusion of the stroke services team formed very shortly before she saw Mr Mulholland. Again, I do not see how Dr Chong can be said to be negligent in relying upon the conclusion of a specialist team that, when forensic push comes to shove, must be accepted as reasonable.

(ii) The A&E environment and time constraints: The extent to which the process of diagnosis involves a counsel of perfection.

101. I turn now to consider the relevance of the fact that a typical A&E doctor must form a judgment under time constraints. The Claimant argues that, upon analysis, various neurological diagnoses should have been considered by Dr Chong as real and distinct

possibilities and the failure by Dr Chong to treat these symptoms as sufficiently serious as to warrant immediate action was negligent. An example (from amongst others) put to Dr Chong in cross-examination was that of a Jacksonian seizure. This arises where a simple focal seizure spreads from the distal part of the limb towards the ipsilateral face. This leads to a progression or spread of the motor presentation of the symptoms. It was put to Dr Chong that Mr Mulholland's symptoms could be attributed to a Jacksonian seizure. Dr Chong accepted that she had heard of Jacksonian seizures but she also accepted that she had not identified it as a possibility. In my judgment this criticism was unwarranted and is based upon a false premise as to what can reasonably be expected from a doctor in a pressurised A&E environment. The idea that Mr Mulholland might have experienced a Jacksonian seizure was a possibility postulated by the Claimant's legal and expert team after mature consideration of the evidence in the course of preparation for trial. But doctors in A&E do not have the luxury of long and mature consideration. They take decisions at short notice in a pressurised environment. They cannot (ordinarily) consult the country's leading experts at the drop of a hat having given those experts months or even years to prepare their expert opinions. If Dr Chong had been given the week off in order to research Mr Mulholland's case she might, just possibly, have listed a Jacksonian seizure on her list of possible causes. But in my judgment the standard of care owed by an A&E doctor must be calibrated in a manner reflecting reality. It was not, in the circumstances confronting her, negligent of Dr Chong to omit this sort of specialised neurological condition from her assessment.

(iii) An analysis of the assessment of symptoms and signs.

102. The next issue concerns the extent to which the signs and symptoms presenting on 12th January 2010 were such that a reasonable A&E doctor should have appreciated that the patient was or might be suffering from a serious neurological condition of such seriousness as to warrant immediate action including reference to neurological specialists and/or referral for a CT scan. The Claimant submits that the symptoms and signs were sufficiently clear and unequivocal to give rise to the very real possibility of a neurological condition and that as such Dr Chong was negligent in failing: (a) to rule out a drug (cannabis) attribution; and (b), to diagnose a neurological condition. The issue, put more colloquially, is whether the presenting signs and symptoms amounted to a "barn door" (see para [96] above).

103. In closing submission both counsel identified the symptoms and signs emanating from Dr Chong's assessment which it was variously submitted were/were not so clear as to, in substance, place Dr Chong on notice that immediate, urgent, neurological treatment was called for. I have set out below the analysis of each party as set out in their written closings:

(a) Claimant:-

Symptoms = what patient reports
Signs = what medic observes/elicits from examination

Symptoms

i) inability to control right arm+leg - focal symptoms
ii) right arm/shoulder spasm – more in keeping with a seizure

iii) right leg weakness – focal symptom
iv) light headed and dizzy – non-specific
v) blurred vision – non-specific (would require more questions)
vi) panicky and agitated – anxiety (probably due to his physical symptoms)
vii) Could not feel arm/leg, couldn't walk, collapsed…. - focal symptoms

Signs

i) Trigeminal nerve. V1 right reduced. V2/V3 left reduced – neurological – confusing presentation because of the right/left differential.
ii) Reduced power 4/5 bilaterally all four limbs – neurological sign – would be unusual for a stroke/TIA because four limbs
iii) Reduced sensation right arm and leg – neurological sign particularly for TIA/stroke

(b) Defendant:-

Symptoms	**Stroke / TIA sign?**	**Why?**
Inability to control right arm and right leg	Atypical / very unlikely for stroke / TIA	Apparently positive symptom, stroke/TIA almost invariably presents with weakness or loss of power. 'Loss of control' implies arm is active independently of patient's intentions rather than weakness. The description of the right shoulder in fixed abduction would be regarded as inconsistent with a stroke.
Right arm / shoulder spasm	Atypical / very unlikely for stroke / TIA	Positive symptom involving very localised lesion. Atypical for stroke which would almost always present with loss of power.
Right leg weakness	Possible but unlikely	Dr C-H: very localised manifestation of brain ischaemia, usually a much large motor area would be affected.
Lightheaded dizzy	Neutral / Unlikely	Global symptom, not consistent with focal localised area of brain ischaemia. Not a recognised symptom indicative of stroke / TIA.
Pain in testicles	No	No apparent connection to stroke / TIA.
Increased volume of urine	No	No apparent connection to stroke / TIA
Panicky	No	No apparent connection to stroke / TIA. Positive symptom, common in drug usage.

Collapse	Possible	Does not add anything to more specific limb symptoms reported (see above). Dr C-H: regarded as making TIA unlikely (too diffuse brain involvement).
Anorexia	Unlikely	Appears to predate the 'neurological' symptoms. Global symptom typical in anxiety
Hallucination	No	Not a recognised sign of stroke / TIA.

Signs	**Stroke / TIA sign?**	**Why?**
Decreased sensation V1 right side	Yes (in isolation)	Consistent with left sided brain lesion / stroke but very unusual because so localised
Decreased sensation V2, V3 left	Yes (in isolation)	Consistent with right sided brain lesion / stroke but very unusual because so localised
Combined facial sensation findings	No	The finding of bilateral altered sensation on the face would be very unusual in stroke / TIA as it would require simultaneous, very localised events, affecting similar parts of the brain on both sides, not explicable by a blood clot or thrombus obstructing a single vessel
Power 4/5 all 4 limbs	No	This would require simultaneous, symmetrical, well localised, mild obstruction of arteries on opposite sides of the brain. This would be incredibly unlikely.
Decreased sensation right arm and right leg	Possible but unlikely	Sensory symptoms are not identified by anybody as a clear sign of stroke / TIA.
Equivocal plantars	No	Common finding, little significance, stroke / TIA would be expected to produce unilateral plantar reflex abnormalities.
Normal coordination in right upper limb	No	The stroke team recorded a slight decrease in coordination on the right but this was not present on Dr C's examination.

104. The first point to note is that neither party says that the signs and symptoms all pointed one way one only; indeed the signs and symptoms were a long way from being specific, or clear or unequivocal. To the contrary Ms Longstaff and Dr Campbell-Hewson agreed in their joint statement that there were "*confusing*" bilateral

signs. Ms Longstaff also agreed that the symptoms were not "*text book*". And these conclusions must be placed in the context of the fact that the specialist stroke team had already ruled out a TIA or CVA which was, otherwise, the most likely neurological explanation for some of those symptoms. Dr Chong was hence confronted with confusing, non text-book signs and symptoms which (she was entitled to conclude) were not caused by a TIA or CVA. But since there is also no suggestion that Dr Chong should have diagnosed a brain tumour the context to the assessment is one where Dr Chong was confronted with, confused, non text-book signs and symptoms which did not signify a TIA, CVA or tumour.

105. Secondly, some of the symptoms could reasonably be linked to regular cannabis use. Medical literature, of recent vintage, shows that there is evidence that long term marijuana use can lead users to present with a variety of symptoms which include (*inter alia*): anxiety and depression; schizophrenia and psychosis, inflammation of the large airways, bronchitis, vascular conditions increasing the risk of myocardial infarction, stroke or TIA: See, e.g., "*Adverse Health Effects of Marijuana Use", Volkow, Baler, Compton and Weiss, The New England Journal of Medicine* (5 June 2014). Much of the work on the medical effects of cannabis use has followed in the wake of increased legalisation of usage. The position was not as well researched, and hence known, in 2010 when Dr Chong assessed the Claimant. However, in evidence, Dr Chong explained that she did understand cannabis use to be causative of some of the symptoms which Mr Mulholland exhibited. As such her conclusion not to rule out drugs as a possible attribution was one which a reasonable A&E doctor was entitled to form.

106. Thirdly, the experts agreed that drug use was capable of masking other symptoms and signs. This also puts into context (and supports) Dr Chong's conclusion that drugs might have been causative and that therefore a care pathway that sought to exclude drugs as a cause was sensible.

107. Fourthly, it is relevant that no one else, including Dr Boachie and the stroke specialists, formed a view inconsistent with that of Dr Chong and the Claimant accepts that those other professionals acted reasonably when they also excluded TIA/CVA and concluded that illicit drugs might be the (or at least "a") problem based upon this mix of signs and symptoms. Quite apart from the question of the reasonableness of Dr Chong's *reliance* upon the views of those individuals the simple fact that other equally competent professionals acting reasonably came to the *same* conclusion on the same body of signs and symptoms is strongly indicative that a body of reasonable professionals might form the same conclusion as Dr Chong. I am reinforced in this view by the (after the fact) evidence of the GPs who saw Mr Mulholland after 12th January 2010 who for a long period also formed the view that the symptoms were drug related. Mr Grundy submitted that the views of GPs should not be given weight because they were contaminated by the enduring "stigma" that was attached to Mr Mulholland after being diagnosed in A&E as a habitual drug user. But I do not think this is fair since it is assumes that a series of different GPS all declined to exercise independent judgment and there is no evidence to support this.

108. In these circumstances it is my judgment that Dr Chong's assessment of this mix of symptoms and signs was reasonable.

(iv) A&E and illicit drug taking: What level of knowledge is to be expected of an A&E doctor?

109. I turn now to consider a further central component of the Claimant's case. It concerns the question – what is the nature and extent of the enquiries that a doctor in A&E should perform concerning a patient's drug history (a) generally and (b) specifically in a case where drugs might mask symptoms and signs?

110. Mr Grundy, in his written closing submissions, which were elaborated upon orally, submitted as follows:

> "9. Dr Chong, as an A&E doctor, would be better placed than most medical disciplines to understand the issues surrounding drug supply, strength of the cannabis and potential symptoms. A diagnosis related to cannabis use should be one of exclusion; namely other more serious conditions should be considered initially including stroke/TIA and other neurological problems before the possibility of cannabis. Once cannabis is the only remaining possibility/option then appropriate and careful questioning would be undertaken by any reasonable A&E doctor before attribution.
>
> 10. The Claimant's discharge from hospital with advice to attend his GP should not have happened as no reasonable A&E doctor could have attributed the neurological symptoms/signs to drugs. It was not and could never be viewed as a "safety net". In fact because of the drugs "stigma" the Claimant's GP simply repeated the attribution of his symptoms/signs to drugs whilst assuring him that he had not had a stroke. The GP was falsely reassured by Dr Chong's negligence despite continuing neurological symptoms. Any subsequent abnormal behaviour pattern or symptoms were not given proper consideration because of the cannabis diagnosis".

111. In oral submission (following a line of cross examination) Mr Grundy submitted that Dr Chong was negligent in not delving deeper into Mr Mulholland's drug taking and as to the details of "supply" to him. He submitted that had she done so she would have come to the conclusion that Mr Mulholland was a long term user who was habituated to cannabis and would not, as such, exhibit adverse symptoms. He submitted that had a full "drugs history" been taken Dr Chong should have been able to exclude drugs as a possible attribution and this would then have forced her to consider other – neurological – explanations. I do not accept this analysis. This is for the following reasons.

112. First, it is apparent that Dr Chong was aware of a number of facts and matters concerning Mr Mulholland's drug usage which related to: habituation, frequency of use, strength, and most recent usage. She was aware that he smoked "*strong weed*", that he regularly smoked three joints in an evening, that he was a long term user, and that he had smoked cannabis within the previous 24-36 hours. Every professional who assessed Mr Mulholland considered these facts to be relevant. No one considered that

more information, including as to "*supply*", was necessary or that the fact that Mr Mulholland was habituated meant that drug attribution could or should be excluded.

113. Secondly, I reject the suggestion, reflected in paragraph 9 of the Claimant's written submissions (*supra*) that "*as an A&E doctor*" she would be "*better placed than most medical disciplines to understand the issues surrounding drug supply*". This, in my view, is unrealistic. There was no evidence adduced in the course of the trial as to Dr Chong's personal knowledge relating to drug "supply", or as to the training that is given to A&E doctors as to local drug supply conditions and no suggestion that in actual fact Dr Chong had been trained in such matters or even that she should have been. Furthermore (as any QBD judge sitting in crime knows) the characteristics of different drug supply chains (even for the same drug and in the same town) can vary enormously. The composition, purity and strength of drugs supplied can vary over time, as can the identity of the supplier. A&E doctors are not trained in the (murky) world of drug distribution and supply. And there was no evidence before me to suggest that an A&E doctor would be "*better placed*" than other medical professionals to understand issues surrounding such drug supply. Indeed, frequently, the purchasers of drugs themselves will not know, at least with any accuracy, the details of those who are supplying them for the obvious reason that suppliers are rarely (if ever) inclined to disclose such details to their customers. In any event, suppliers are well known to misrepresent the purity and/or strength of the drugs being supplied and information, therefore, communicated from a supplier to a purchaser which would then (on the Claimant's hypothesis) be relayed to an A&E doctor may very well be misleading and inaccurate.

114. In conclusion, I do not accept that an A&E doctor is required to investigate drug or drug supply issues to any greater degree than did Dr Chong in order to justify a conclusion that the symptoms and signs as presented might be drug attributed. Dr Chong was aware in general terms of the facts and matters referred to in paragraph [112] above. In my judgment that was ample to enable her to form a view of possible causes, certainly in the time available to her. I would view any requirement over and above this as imposing a near-impossible task and not one which should be required of a reasonable doctor within an A&E environment.

(v) Diagnosis: Provisional or definitive?

115. Finally, I turn to the criticism that Dr Chong failed <u>immediately</u> to either refer the Claimant to a specialist neurological clinic or <u>immediately</u> to direct a CT scan. I do not accept this criticism. The diagnosis that Dr Chong arrived at was, in substance, a provisional diagnosis. She was of the "*impression*" that the signs and symptoms might be cannabis related. But she did not definitively arrive at this conclusion. She adopted a course of action which she considered was capable of excluding a drug attribution and which was endorsed by the Registrar. This was that Mr Mulholland should stay off cannabis for three days and then see his GP. If the symptoms persisted beyond the three days (when the effects of cannabis should, ordinarily, have worn off) an attribution to cannabis or drug use could be ruled out and this would then assist in narrowing down the causes to something else including, possibly, a neurological condition. For this decision to be so unreasonable as to amount to a breach of duty it seems to me that the facts would have to have been very different indeed from those which actually pertained. The evidence would have to be very strong indeed that the cause of the symptoms (a) were *clearly* not illicit drug related; <u>and</u> (b) were *clearly*

neurological; and (c) were such that the patient required urgent treatment which could *not* await a GP referral made even a few days hence. If these circumstances had all existed then there would be greater force in the submission that an immediate and urgent referral to address a possible neurological condition might have been required. But these conditions did not exist:

a) Clearly not drugs – Dr Chong highlighted anxiety, hallucinations and spasms as symptoms and signs possibly caused by drug use. The literature indicates that these may flow from frequent cannabis use. It is common ground that the signs and symptoms were "confusing" and not "text book" and that illicit drug use can mask symptoms. The signs and symptoms as a whole were thus mixed and confusing and Dr Chong acted reasonably in not clearly excluding drug use as a possible cause.

b) Clearly was neurological – I have already addressed the question of the assessment formed by the specialist stroke services. They conduct a full neurological assessment going beyond a FAST test and did not diagnose TIA or CVA. And no one suggests that Dr Chong should have diagnosed the actual tumour. Dr Chong accepted that it was fair to describe *some* of Mr Mulholland's signs and symptoms as "neurological" and that they were present before her when she assessed Mr Mulholland. However, she said that when all signs and symptoms were taken into account, and bearing in mind the prior conclusions of the specialist stroke services, she was not of the "impression" the cause was neurological. The symptoms were simply not specific enough. In my view Dr Chong acted reasonably in not concluding that the signs were clearly neurological.

c) No time to await a possible GP referral for a CT scan in the near future / urgency – It is important that the course of action adopted by Dr Chong did not rule out a non-drug (neurological) attribution. She adopted a course of conduct which could, if drugs were ruled out, have led to a diagnosis of a neurological condition within a reasonably short period of time. As such the decision contemplated the possibility of a CT scan for Mr Mulholland but in the future and not by a reference from a doctor in A&E. Dr Campbell-Hewson made the point in his oral evidence that referrals for CT scans were normally made by GPs or specialist stroke services, and not by A&E doctors. He accepted that a doctor within A&E could refer a patient for a CT scan but it was his view that, normally, this would arise, as observed, from a specialist stroke unit or from a GP. Ms Longstaff accepted that it was reasonable not to make an immediate reference for a CT scan but, instead, to make a reference to a specialist stroke clinic for an assessment and a (possible) scan within 7 days (see para [98] above). But this is not that far from what Dr Chong actually did, i.e. refer on with the possibility of a future CT scan. In all such circumstances, I cannot conclude that the case as presented was so extremely urgent that an immediate or near immediate referral to specialist neurologists or for a CT scan was called for and that anything less was negligent.

116. In short, Dr Chong's provisional conclusion linked to a solution designed to exclude cannabis as a cause was in my judgment a reasonable one to adopt.

I. Other matters: Causation and quantum

117. For all the above reasons Dr Chong was not negligent. Given my conclusion on breach of duty it is not strictly necessary to proceed to consider causation and/or quantum. However, I heard evidence and submissions on these matters and in the circumstances I will set out shortly my principal conclusions relating to these issues.

118. First, I address the submission that had Mr Mulholland been diagnosed with a brain tumour in January 2010 he would have been saved the stress, anxiety and uncertainty of not knowing what was wrong with him and that therefore he is entitled to some compensation from January 2010 onwards to reflect this. As to this I have real difficulty when comparing what actually happened with what the Claimant says should have happened. I cannot, at least upon the evidence before me, identify anything tangible to compensate Mr Mulholland for. Had he known of the true diagnosis in January 2010 he would have substituted uncertainty as to whether he had any condition *at all* for a certainty that he had a brain tumour. If I were to compensate for this I would have had to be satisfied that knowing, in such circumstances, was better than not knowing. This is far from evident. There may be more comfort in uncertainty than there is in the dread of knowing; not knowing might be a distinct blessing in disguise and ignorance might, quite possibly, be bliss. In the absence of some clear evidence on this I am not able to say which is the lesser of the two evils and, in consequence, to conclude that there is anything to compensate for.

119. Secondly, in relation to the benefits of having been operated upon in May 2010 rather than in August 2010, upon the evidence before me, had I found breach I would have concluded that there was some medical advantage or benefit lost to Mr Mulholland attributable to the breach for which compensation should be paid. I would not have awarded damages for the full amount sought by the Claimant but, equally, I would not have awarded the near nominal sums being suggested by the Defendant as appropriate.

120. Thirdly, in relation to the alleged post-surgery memory deficits and other adverse symptoms said to be attributable to the delay in surgery had I found breach I would not have found that any such symptoms and effects following surgery were in fact due to the delay in treatment. The documentary evidence recording Mr Mulholland's symptoms over the period from August 2010 onwards reflects the normal post-operative symptoms that would be expected to flow from the operation itself, from the thirty sessions of radiotherapy which ensued, and from the anti-convulsant drugs. There is no real evidence to suggest that there is any difference, in this specific regard, between being operated upon in August 2010 as opposed to May 2010.

J. Conclusion

121. At a personal level I have real sympathy for the Claimant and for his wife. I have accepted as a matter of evidence that Mr Mulholland experienced real and distressing symptoms for a lengthy period of time. I also have accepted that this impacted adversely upon him, his wife and his family. It goes without saying that the Court wishes him and his family the very best in the future.

122. However, I am required to decide this case upon the law and upon the facts and I am quite clear that applying that law Dr Chong did not act unreasonably in all the circumstances. Accordingly, the claim necessarily must fail.