BRIEFING

MEDICAL LAW

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INTRODUCTION

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Welcome to the December edition of the Medical Law Briefing.

To round off what has been a rather odd 2020, we bring you the Medical Law annual legal update, courtesy of Ella Davis and David Thomson. It has been a busy year for reported cases in this area and so we hope you find this briefing useful.

We look forward to working with you all in 2021, when hopefully some normality begins to gradually return to life and work. Wishing you all a Merry Christmas and a Happy New Year.

I hope it is as hectic/ restful / 'Quality Street' laden as you choose it to be!

2020 HINDSIGHT

ELLA DAVIS

STANDARD OF CARE

NO REQUIREMENT EXPRESSLY TO REFER TO BOLAM/BOLITHO

Morrison v Liverpool Women's NHS Foundation Trust [2020] EWHC 91 (QB) was an appeal to Turner J in a case involving a serious maternal injury at birth. The Defendant, who had lost the case at first instance, advanced a number of grounds of appeal. The first was a criticism of the structure of the Recorder's judgment, and others amounted to attempt to overturn findings which Turner J held were open to the Recorder. The second, however, was of wider potential interest. In this ground, the Defendant complained that the Recorder made no express reference to the Bolam/Bolitho test.

The Claimant was pregnant with her fourth child. Due to a previous tear to her womb her pregnancy was recognised as high risk and her treatment plan included *"elective CS…emergency CS during labour"*. She presented to hospital at 2:30 am, four and a half hours ahead of her scheduled elective caesarean. At that stage she was in 'latent' rather than 'established' labour, meaning that she was less than 4cm dilated. It was her case that when she was examined a second time at 4:10 am, the decision should have been taken to proceed to a caesarean section. This decision was not made until she was examined a fourth time at 7:05 am. When she gave birth she was found to have sustained damage to the posterior wall of her uterus which was not susceptible to repair. In consequence, a hysterectomy was performed.

The Claimant's expert concluded that no reasonable body of medical opinion could support the decision not to proceed to a caesarean section following the appraisal at 4:10 am. The Defendant's expert concluded that a caesarean section was not mandated at this time.

Turner J accepted that it would have been preferable for the Recorder to have made an express reference to the Bolam/Bolitho test. However, he was satisfied that this was in fact the test which the Recorder had applied. The Recorder had noted the competing view of the Claimant's expert that *"No reasonably competent obstetrician would have failed to make the decision to deliver by 4:10…"* and of the Defendant's expert that "*He felt that a reasonable body of opinion would have gone ahead with a CS at 4:00 am and alternatively a reasonable body would have left it.*" Turner J was satisfied that, in preferring the Claimant's expert evidence to that of the Defendant, the Recorder had by necessary implication applied the same test as the Claimant's expert which was the correct legal test.

The Defendant further argued that the Claimant's expert was unable to point to literature or guidance directly in support of his criticisms. The Defendant's expert had equally been unable to identify any significant guidance or literature in unequivocal support of his approach. Turner J held that while in many cases there exists a substantial body of literature and guidance, it would be unduly mechanistic to conclude that the absence of such material is, of itself, an insurmountable barrier to a finding of breach of duty. Not all circumstances which arise in clinical practice could be expected to be directly covered in guidance or literature.

Accordingly, the Defendant's second ground, and the appeal, were dismissed.

A further observation of Turner J, albeit probably obiter, may be of interest to practitioners dealing with claims relating to a failure to provide timely care during the Covid-19 pandemic. The Defendant alleged that the Recorder had wrongly excluded from consideration issues of what was practicable leading to an unfairly favourable adjudication upon the Claimant's position in a vacuum of context. Turner J accepted that if this had been the approach of the Recorder, it was flawed. At paragraph 24 he said:

"Of course, in the clinical context a balance has to be struck between the needs of any given patient and any

other competing professional demands placed upon the clinicians involved. Sometimes, the seriousness and urgency of a patient's presentation and the absence of any conflicting factors will mandate a swift and decisive response. On other occasions, it is equally obvious that the needs of the patient must be deprioritised to allow the clinicians to attend other demands on their time as a matter of priority."

Those comments were made in relation to the demands of managing a labour ward and competing needs for caesarean sections. However, the recognition that the context in which clinical decisions are taken is important, and that a balance has to be struck between the needs of any given patient and any other competing professional demands placed upon the clinicians involved, may be of wider application.

BREACH OF DUTY IN 'PURE DIAGNOSIS' CASES

In Brady v Southend University Hospital NHS Foundation Trust [2020] EWHC 158 (QB), Andrew Lewis QC considered the correct approach to the standard of care in 'pure diagnosis' cases.

The Claimant alleged that her actinomycosis infection had been negligently misdiagnosed by two consultant radiologists ("CR1" and "CR2"), and a surgeon. CR1 reported a CT scan on 5 August 2013 as follows *"There is a mass in the right upper quadrant…The appearances would be consistent with omental infarction rather than a primary mesenteric/omental neoplasm…After clinical discussion with the Surgical SPR, I gather she has had a recent laparoscopic appendectomy which makes the diagnosis of omental infarction most likely."* On 20 September 2013, CR2 reported a second CT scan as follows "*…There is a large mass which is vascular grossly related to the posterior aspect of the right abdominal wall. This requires for the urgent evaluation. This is causing gastric outlet obstruction. Also encasement of the right transverse colon. There is nodularity in the entire abdomen. And this requires further urgent evaluation. This case has been discussed with the referring consultant.*" A Specialist Upper GI Surgeon at the Royal London Hospital then reviewed the scans and advised that it *"looks like omental infarction"*. Accordingly the treating surgeon recommended conservative management.

In February 2014, a further CT scan showed a psoas abscess which was drained. Microbiological analysis confirmed the infecting organism as actinomyces. The Claimant underwent a number of further surgical procedures under general anaesthetic.

The Claimant's cases was that the mass observed on the first and second CT scans was an actinomycosis infection and not an omental infarction. If that omental mass was an infection, it was agreed that it could have been treated with antibiotics and the Claimant would have avoided the deterioration and surgical treatment which she underwent in February 2014. It was the Defendant's case that the Claimant suffered an omental infarction and then actinomycosis. Alternatively, the clinicians acted reasonably in concluding that the mass was an omental infarction and treating it conservatively.

The parties disagreed on the appropriate standard of care to be applied, particularly to the radiological reporting. The judge noted that *Bolam*, and many of the cases endorsing the *Bolam* test, were 'treatment cases'. In such cases a doctor, in recommending or undertaking treatment, has choices and options available and risks and benefits that need to be considered. In fields such as radiology or histopathology by contrast, there is limited scope for any genuine difference of opinion. A diagnosis based on a scan is generally right or wrong. However, the judge noted that he was bound by the Court of Appeal's decision in *Penny v East Kent HA [2000] Lloyds Rep Med 41*. That case concerned the incorrect reporting of cervical smear slides by primary cyto-screening as negative. The Court of Appeal held that the screeners were exercising skill and judgment in determining what report they should make and in that respect the *Bolam* test was generally applicable. However, the *Bolam* test has no application where that the judge is required to do is make findings of fact, even where those findings of fact are the subject of conflicting evidence. The judge in that case therefore had to answer three questions:

"(i) What was to be seen on the slides?

(ii) At the relevant time could a screener exercising reasonable care fail to see what was on the slide?

(iii) Could a reasonably competent screener, aware of what a screener exercising reasonable care would observe on the slide, treat the slide as negative?

" 28. Thus, logically the starting point for the experts' reasoning was what was on the slides. ... In so far as they were not in agreement, the judge had the unenviable task of deciding as a matter of fact which of the experts were correct as to what the slides showed. This was a task which required expert evidence. However the evidence having been given, the judge had to make his own finding on the balance of probabilities on this issue of fact in order to proceed to the next step in answering the question of negligence or no negligence. Having come to his own conclusion as to what the slides showed, the judge had, therefore, then to answer the 2nd and 3rd questions in order to decide whether the screener was in breach of duty in giving a negative report. Whether the screener was in breach of duty would depend on the training and the amount of knowledge a screener should have had in order to properly perform his or her task at that time and how easy it was to discern what the judge had found was on the slide. These issues involved both questions of fact and questions of opinion as to the standards of care which the screeners should have exercised. As already indicated, there was virtually no evidence of the actual training provided to the primary screeners. The approach of the experts was to give their opinion, based on their respective interpretations of what was on the slide, on the general question of whether a reasonably competent screener, exercising the appropriate standard of care, could treat the slide as negative."

The judge in *Brady*, also noted that Kerr J in *Muller v Kings College Hospital NHS Foundation Trust [2017] EWHC 218* had shown reluctance to accept that *Penny* was a correct statement of the law, but nonetheless also considered himself bound by it. The judge applied the law in *Brady*, concluding [27]:

"It follows that determining what the CT scans show (e.g. (i) omental infarction or infection, (ii) whether the mass involved the lesser omentum, (iii) whether the mass was infiltrating the transverse colon), are essentially questions of fact for the Court to determine on the balance of probabilities, with the assistance of the witness and expert evidence provided. It is a separate question as to whether [CR1's] or [CR2's] assessments, even if conflicting with the Court's findings of fact, were negligent or not negligent. In that respect, I judge their work in accordance with Penny by invocation of the Bolitho exception. Insofar as I am required to assess their views on advancing differential diagnoses or recommending further investigation or treatment, as well assessing Mr Wright's conduct, there can be no question but that the Bolam test, with the Bolitho qualification, applies."

The judge found as a fact that the omental mass seen in 2013 was probably not an infarction but, on reflection, an infection. Nevertheless he did not accept that CR1's negligent of CR2 to fail to state that omental infarction was not a likely diagnosis or to fail to provide a differential diagnosis. CR2 did not identify what the mass was or could be, but clearly reported the appearances seen on the second CT scan. She was wholly uncertain and unwilling to identify a diagnosis in her written report. She did inform the surgeon of the possibilities of omental infarction, infection and even malignancy. She also recommended further urgent evaluation. The judge therefore found that although her report was sub-optimal and did not identify the differential diagnoses, it did provide a clear view from a radiological perspective of where to go in the further investigation of the case.

The case is a useful reminder both of the correct approach to the question of the standard of care to be applied where a diagnosis is either right or wrong, but also of the differing role of experts in assisting the court to make findings of fact and to determine the standard of care.

FAILURE TO SUPPORT CLAIMS AGAINST A PROFESSIONAL WITH EXPERT EVIDENCE

Two decisions of Yip J from the last twelve months address the requirement to support allegations against a professional person with expert evidence.

Bot v Barnick [2019] EWHC 3704 (QB) was a claim arising out the Claimant's care at the Portland Hospital following the birth of her second child in 2011. Her case against the First Defendant, a consultant obstetrician and gynaecologist, was that he failed to

recognise her mental illness and failed to diagnose and treat an infected haematoma. The Second Defendant was a consultant psychiatrist who was alleged to have failed to recognise her mental illness.

The claim was issued in December 2016 and directions were given in January 2018. The trial was listed in the window from 24 February to 4 March 2020. At the time of the hearing before Yip J on 17 December 2019, the Claimant had not served any liability evidence from an obstetrician. Further, the Defendant had been unable to serve condition and prognosis evidence due to the Claimant's failure to attend an examination.

The Defendants applied for the striking out of the claim against the First Defendant as having no reasonable prospects of success, a stay pending the Claimant's attendance at a psychiatric examination and adjournment of the trial in view of the lack of compliance with the directions.

Yip J observed that it was in the Claimant's interests, as well as that of the Defendants and other court users that the case be heard promptly. She also stressed that the Defendants' representatives had been reasonable and understanding of the Claimant's position. Further the claim was against two professional men with allegations of professional negligence hanging over them. This could not be overlooked when making allowances for the Claimant's vulnerability.

Yip J held that the Claimant had not been prosecuting her claim expeditiously. Three years after issue she had not served any supportive expert evidence in relation to the claim against the First Defendant. The parties had agreed numerous extensions of time. The Claimant, who had not given full instructions ahead of the hearing and had indicated a desire to change solicitor, had not put anything before the court to suggest that evidence to support the claim against the First Defendant was forthcoming. Yip J noted that it is well known that claims against professional people should not be maintained in the absence of supportive expert evidence. It was inappropriate for the Claimant to maintain her claim in such circumstances. Even taking account of the absence of any unless order in relation to the service of the expert evidence, the Claimant had failed to comply with a final extension by consent, and accordingly her claim against the First Defendant was struck out pursuant to rule 3.4(2)(c).

In relation to the Defendant's condition and prognosis evidence, Yip J noted that the Defendant's expert had proposed four dates on which he could visit the Claimant in her home. Yip J proposed a short period of time in which the Claimant should confirm which dates she could attend, or to set out very good reason why she could not attend on any of those dates. She proposed that that order should be made as an unless order, and that there should also be an unless order relating to the Claimant's attendance on examination, providing that her claim will be struck out unless she attends or, within 48 hours of the appointment, provides a full written explanation and subsequently make an application. In this respect the court went further than the perhaps more usual order which the Defendants were seeking that the claim be stayed pending examination.

Magee v Willmott [2020] EWHC 1378 (QB) was an appeal against a Recorder's decision to grant a Claimant relief from sanctions after her solicitors had sought to rely on additional expert evidence at a very late stage, causing the trial to be vacated. The expert evidence on which she did have permission to rely supported only some of her pleaded case.

Yip J overturned the decision refusing relief from sanctions and therefore permission to rely on the late expert evidence. Further, she struck out parts of the claim which were not supported by expert evidence under both CPR 3.4(2)(a) and 3.4(2)(b), agreeing that it was an abuse of process to put forward a claim for professional negligence that was not founded on appropriate expert evidence *(Pantelli Associates Ltd v Corporate City Developments Number Two Ltd [2010] EWHC 3189 (TCC))*. However, it was not appropriate to strike out the rest of the claim, notwithstanding the Claimant's acceptance that without the late expert evidence the claim could not succeed. The Defendant was not willing to accept a discontinuance but wanted the claim struck out in order that a QOCS exemption would apply. Yip J accepted that on balance the expert evidence which the Claimant had was just sufficient to

mount a claim. It was not a case where there was no expert support for the claimed breach of duty. This decision left the way open either for the Claimant to discontinue without facing an enforceable cost order, or for the Defendant to make an application for summary judgment, the Claimant having conceded that the claim no longer had any realistic prospect of success.

These two decisions within the last twelve months are an important reminder to practitioners to carefully check that all allegations pleaded against a professional are supported by expert evidence.

2020 HINDSIGHT

DAVID THOMSON

Cauda Equina Syndrome – Again, but the first one before the Court of Appeal!

BARRY HEWES v (1) WEST HERTFORDSHIRE HOSPITALS NHS TRUST (2) EAST OF ENGLAND AMBULANCE SERVICE NHS TRUST (3) PANKAJ TANNA [2020] EWCA Civ 1523

Court of Appeal 18/11/2020 Davis LJ, Nugee LJ, Elisabeth Laing LJ.

The judgment is important because it considers – in the progress of the proceedings from Queens Bench Master to QB judge, on appeal of striking out, and then from the QB substantive judge to the Court of Appeal - the issues of striking out or not of the claim in a clinical negligence case against the Third Defendant, a GP, and the approach to be taken by the Court to applying the law from *Bolam* (Bolam v Friern Hospital Management Committee [1957]) and *Bolitho* (Bolitho (Deceased) v City and Hackney HA [1993]) concerning breach of duty.

The proceedings were concerned the diagnosis and treatment of Cauda Equina Syndrome ('CES') in a 50 year old man in 2012. The basics concerning CES were set out by Elizabeth Laing LJ: 'CES' is commonly caused by the prolapse of a large disc in the spinal canal. This compresses a bundle of nerves which transmit messages to and from the bladder, bowel, genitals and saddle area, interfering with sensation and movement. Once it has been diagnosed, it is seen as an emergency, because unless the pressure on the nerves is released quickly, they can be damaged permanently. A clinical diagnosis of CES is confirmed by an MRI scan.

There is a group of symptoms, described as 'red flags', the presence of which may lead a clinician to suspect CES. Often, as in this case, a patient has severe pain in his lower back, and sciatica. The red flags include numbness (or hypoaesthesia) in the saddle/peri-anal, or genital area, or in the urethra. Most patients who go to an accident and emergency department with suspected CES are not, in fact, suffering from it.

There are different types of CES, depending on the extent of nerve damage. These include CES Incomplete ('CESI') and CES Complete, or Retention CES ('CESR'). All patients with CES experience a continuous deterioration, but the rate of deterioration varies between patients. Sometimes the deterioration is complete within hours. Other patients' CESI never reaches CESR. It was agreed that, in general, on balance of probability, the outcome of surgery for patients with CESI tends to be good, whereas it tends to be poor for patients with CESR.

It is therefore vital, once a clinician *suspects* CES [*my emphasis*], that an MRI scan is done as soon as possible (or as soon as is reasonably possible), and that, if CES is found, the patient has decompression surgery as soon as possible (or as soon as is reasonably possible).

The Claimant was 50. He had a history of pain in his lower back. An MRI scan taken in January 2012 showed bulges in two discs (L4/5 and L5/S1). He was given a caudal epidural on 22 February 2012 for pain relief. On 11 March 2012, he went to an Urgent Care Centre ('UCC') in Hemel Hempstead with worsening

back pain. He was seen by an out-of-hours GP and given a prescription. He was told to consult his GP if he became worse, and that, if he became numb, that would show that he needed immediate hospital treatment.

He went to bed at 0100 on Monday 12 March. He had urinated just before he went to bed. He woke at about 0500 in pain. His groin had become numb. His wife called the UCC at 0543. She called an ambulance at 0602. She spoke to one of ambulance Trust 2's operators.

At 0604, the GP, who was an out-of-hours GP, spoke to the Claimant on the telephone for about five minutes. Out-of-hours is a very busy service generally. There was probably a queue behind the Claimant of between 10 and 20 calls. At the start of the call, the Claimant said that in the last hour he had 'developed numbness in my bum and leg'. The numbness went down his left leg to his calf and he had pins and needles in his foot. He was asked whether he had had any difficulty, or accidents, in urinating or in opening his bowels. He said that he had not. He had not, however, urinated that morning, and it was painful to sit on the toilet.

The GP asked the Claimant where exactly the numbness in his bum was. The Claimant said that it was in his left buttock and all the way down his leg. The Claimant said that his testicles felt numb. The GP recommended that he go to Watford General Hospital ('the Hospital') immediately as that was where the A and E department was. They would organise an urgent scan there, and get him to see an orthopaedic doctor.

The GP specifically told the Claimant that it would not be helpful to go to the UCC. The Claimant told the GP that he would go to the A and E department at the Hospital.

The GP explained that there were important nerves which could get pinched. The GP's notes recorded that he considered that this was potentially a case of "CES ??" and that he had advised the Claimant to go to the A and E department at the Hospital for an urgent review. He also recorded that the Claimant had "no abdo pain, no urinary/bowels sx [symptoms], no numbness in perianal area, reports developed numbness under genitals/saddle area in the past 1hr, and pain increasing ++"

The Claimant's wife spoke to Trust 2's clinician at 0632. The clinician arranged for an ambulance to be sent under normal road conditions. It arrived at the Claimant's home at 0721, left at 0738, and arrived at the Hospital at 0819. He was handed over to Trust 1's A&E care at 0827. Trust 2's handover sheet recorded numbness in the Claimant's left buttock, leg and foot.

The Claimant was seen by Dr Roffey, an FY2 A & E (a junior hospital doctor who was in his second year of his foundation training) at 0920 in the 'Majors' area of A & E. He noted the report of saddle numbness and that there had been no obvious disturbance of the Claimant's bowel or bladder. On examination, he found "good anal tone". He did not diagnose CES, but referred the Claimant for orthopaedic assessment in the light of "new neurology". His treatment plan included pain relief and admission for a further scan. His notes record that the Claimant was 'accepted' in the orthopaedic department at 1040.

No allegation of negligence was made against Dr Roffey.

The Claimant was next seen by Dr Kirkby, FY1 (in the first year of her foundation Training), and who was an on-call orthopaedic doctor. There was an issue about when Dr Kirkby assessed the Claimant. The Claimant believed it was at about 1000, whereas Dr Kirkby thought that it was nearer 1040. Dr Kirkby examined the Claimant. She noted that the Claimant's groin was numb and that he had not opened his bowels or urinated since the previous evening. She noted that the Claimant's perianal area was not numb and that his anal tone was normal. The Claimant's wife could remember Dr Kirkby examining the Claimant's rectum, but she remembered that, when asked, he had said that he could not feel that examination.

Dr Kirkby noted he was under the care of an orthopaedic consultant, Mr Dyson (a member of Trust 1's orthopaedic team). Her note described what had

happened when the Claimant had gone to the UCC the day before. Under the heading 'Problems and Diagnosis' she wrote 'L5/S1' bulging and L5/SI protrusion,? Cauda equina'. She discussed her management plan with Dr McKenzie, orthopaedic Registrar. It included an MRI scan, x-rays, pain relief, 'Bladder scan-? Retention' and 'nil by mouth' in case surgery was needed, and a discussion with the Registrar 're cauda equina'.

Dr Roffey filled in forms asking for an x-ray and MRI scan 'probably on instruction'. The Claimant was given a spinal x-ray at 1123. At 1159 a form asking for an MRI scan was put into the Computerised Radiological Information System ('CRIS'). That form did not refer to a diagnosis of CES or possible CES and was not marked urgent. The Claimant alleged that that was negligent.

The Claimant had a bladder scan at 1203. The volume of his bladder was recorded as 621 ml. The Claimant was advised by a nurse to try to urinate, but he could not.

The Claimant's details were put into the CRIS at 1326. He had an MRI scan between starting 1333, about 90 minutes after the MRI request was put into the system.

At 1445, a urinary catheter was inserted. The Claimant could not feel it. The residual volume was 625 ml.

Dr McKenzie review at 1500 described the Claimant's 'Painless urinary retention' and said 'neurology worsening'. The plan was that there should be an urgent discussion with Mr Langdon (the orthopaedic consultant) 'for theatre today...Impression: cauda equina'.

The MRI of the lumbar spine showed a 'massive L5/S1disc herniation which occupied 'most of the central canal'.

A further note at 1500 recorded a discussion with the National Hospital for Neurology and Neurosurgery in Queen Square, London ('QSH'). QSH would review the scans and arrange for the Claimant's transfer, if necessary.

A nursing note at 1800 recorded that CES had been confirmed and that the Claimant was to be transferred urgently to QSH. An ambulance arrived at the Hospital at 1835, left at 1935 and arrived at QSH at 2009. The Claimant was admitted at 2034 and taken to theatre at 2230. Surgery started at 2300.

The Judge observed, 'some 17 hours or so had passed' between the points when the GP suspected CES and when the Claimant had the necessary surgery.'

There was (and is) no relevant local or national policy for CES which applied to referrals from primary to secondary care. The Society of British Neurological Surgeons had published 'Standards of Care for Established and Suspected [CES]' ('the Standards'). It noted that the clinical assessment of patients with suspected CES is difficult. It provided that all cases of suspected CES should be referred to and assessed at the local A & E department or orthopaedic/neurological service 'depending on local facilities and arrangements'.

Further all emergency departments receiving such patients should have an agreed protocol with their spinal service for the assessment, imaging and referral of such cases. Whether an MRI scan was needed should be established. MRI scans should be done locally if possible. Patients with suspected CES must have access to a 24-hour MRI service. If CES compression is confirmed by an MRI scan, the local specialist unit must be told immediately, and the scans made available. The patient should be directly transferred to the unit with the images and documents. If the clinical and radiological assessment indicates that surgery might reduce long-term damage, it should be done immediately.

The Hospital had a policy dealing with admission to hospital for patients with back pain, including CES. It was aimed at doctors in their Foundation years, senior house officers and specialist registrars, orthopaedic surgeons on the on-call rota and orthopaedic surgeons with an interest in spinal surgery (which would include Mr Langdon).

The evidence of Dr Roffey and Dr Kirkby was that they did not know about this policy. Mr Langdon said that

the judge decided that, on the balance of probability, the Claimant was in CESR by 1203, when he had the bladder scan. She accepted evidence that bladder function was the most reliable means of distinguishing between CESR and CESI.

From Paragraph 60 Elizabeth Laing LJ explained: The question for the court on this appeal is whether the decision of the Judge is wrong. Nevertheless, an appellant in an appeal such as this is not free to invite this court to re-visit the whole case, and to stand in the shoes of the first instance judge.

The Respondents referred to the judgment of the Supreme Court in Perry v Raleys Solicitors [2019] UKSC 19 in which the issue for the Supreme Court was whether the judge at first instance had gone wrong in his decision on the facts to an extent which enabled the Court of Appeal to intervene. At paragraph 52, Lord Briggs said that the test is whether there is no evidence to support a challenged finding of fact, or that the finding was one which no reasonable trial judge could reach.

The Court explained that the appeal is 'not a wholesale opportunity to revisit, in detail, her findings of fact, her evaluative assessments, or her mixed findings of fact and law. To use Lewison LJ's vivid metaphor in Fage UK Limited v Chobani UK Limited [2014] ETMR 26, at paragraph 114, 'In making [her] decisions the trial judge will have regard to the whole sea of evidence presented to him, whereas an appellate court will only be island hopping'.

…. The Claimant has to persuade the court that the only possible view was that advocated by the Claimant at first instance….It is inconceivable that the Judge, having referred expressly to Bolam and Bolitho, did not have the test well in mind throughout her process of reasoning. That is supported by her use of the words 'reasonable', 'reasonably' and 'logical' at various points in the judgment. She recorded, in paragraph 36, that the parties had agreed what test she should apply. The Claimant objects that paragraph 36 does not accurately reflect the Claimant's position, because his position was that in an emergency, each step must be taken as soon as practicably possible. Whether or not the Judge accurately recorded her understanding of what the parties agreed, the test she described is legally accurate. To introduce a gloss such as the Claimant now suggests, if it had led to a decision adverse to the Respondents, would, rightly, have prompted an appeal from them. The Judge was right to use reasonableness as a touchstone, while making it clear that what was reasonable depended on the context, and that part of the context was that, on his case, the Claimant was an emergency. The other part of the context is the relatively limited resources of a District General Hospital in a busy public health service with many urgent cases competing for attention.

…I do not consider that there is anything to criticise in the conduct of this busy out-of-hours GP. In a short telephone call he took an accurate history from the Claimant, skilfully elicited a red flag for CES, diagnosed suspected CES, and gave the Claimant sensible and reasonable advice, which was to go to the A & E department at the Hospital where an urgent scan could be organised and he could be referred to an orthopaedic doctor.

…The conclusion that there was no unreasonable delay between Dr Kirkby's examination and the point when images were available.

The Judge's finding that the Claimant had lost bladder function by 1203 was sound.

All so far is clear, but there were Interesting hearings prior to the Court of Appeal:

Master Cook on 5/6/2018 – [2018] EWHC 1345 (QB) – an application by the GP for summary judgment.

T applied for summary judgment against the Claimant. in order to establish that the Claimant's actions amounted to a breach of duty, the Claimant would have to prove that in referring him to A&E, the GP had failed to act in accordance with a responsible body of GPs; or, put the other way around, that no responsible body of GPS would have referred the claimant to A&E following Bolam he had failed to do so. Despite having had ample time to do so, he had not served his final GP expert's report, but merely a statement from him that he

remained supportive of the claim having read the pleadings. That statement was inadequate. It failed to identify and address the central issue. The court could not accept that the Claimant's 'supportive' expert evidence when served would raise a realistic Bolitho issue, T had adduced logical and credible evidence from an appropriately qualified expert and that evidence was sufficient to raise the evidential burden requiring the claimant to prove some real prospect of success or some other reason for a trial.

None of the material submitted by the Claimant contraindicated a referral to A&E in a case of suspected CES or raised realistic or credible grounds to undermine T's expert opinion. The Claimant had no real prospect of showing that a general practitioner, who had referred him to accident and emergency having spoken to him on the telephone and suspected cauda equina syndrome, had failed to act in accordance with a responsible body of general practitioners.

The Claimant made an appeal to Foskett J [2018] EWHC 2715 (QB) who decided on 18/10/2018 that there would be few cases where an application for summary judgment could properly be contemplated before the exchange of the experts' reports and, in most cases, until after the experts had discussed the case and produced a joint statement.

He explained that the master's view - that the GP expert evidence at trial would not be a sufficient response to the doctor's expert's view and that, accordingly, the Claimant would not be able to establish his case against the doctor - was unjustified. The Claimant's advisers' reluctance to permit their expert to tie himself to the terms of a rapidly-produced short response was understandable. Any omission or infelicitously expressed observation would doubtless be seized upon in cross-examination at trial, as would any failure to mention some relevant document, piece of research or guidance note. There were also costs implications: the budgets were agreed against the background of what an expert could be expected to do within a particular timescale. Any alteration therefore had potential costs consequences. Even without evidence concerning the difficulties of producing a suitable response to the doctor's expert, it was unreasonable to expect that the Claimant's expert should produce even brief reasons in response.

This was not a view accorded with by the Court of Appeal – read on…

Back to the Court of Appeal, with Davis LJ at Paragraph 96 onwards:

"…We were told that, so far as is known, this was the first case directly relating to the treatment of CES which has come before the Court of Appeal. But that does not mean that it raises issues of principle of general application. In fact an appellate court, a court of law, often may need to be careful to avoid making generalised pronouncements on the obligations of doctors in medical situations. What is ordinarily required, in each case, is consideration of whether the responses and procedures actually undertaken in a given medical situation fall out with the range of reasonable and logically justifiable responses and procedures, applying the Bolam/Bolitho principles, on the facts of the individual case.

The present grounds of appeal are directed at the judge's primary findings of fact and her evaluation of the facts. Regrettably, they in my view fall foul of virtually all the warnings and prohibitions contained in the various recent authorities, as most recently summarised in Perry. The selected quotations and citations from the evidence and literature advanced in his most careful and thorough submissions by Mr Booth QC, for example, thus in turn were matched – more than matched – by the counter quotations and citations in their no less careful and thorough submissions by Mr Antelme QC and Mr Hutton QC.

In fact the overall impression conveyed to me, from the arguments, of island hopping in the whole sea of evidence caused me at stages also to wonder (changing the geographical allusion) if Mr Booth was sailing in the Pacific Ocean while Mr Antelme and Mr Hutton were sailing a parallel course in the Atlantic Ocean.

As I see it, the judge is to be commended for getting closely to grips with the totality of the evidence and in making, in her careful reserved judgment, a thoroughly

rational and cogent appraisal of the evidence. The criticisms of her judgment in the Grounds of Appeal and supporting arguments demonstrably are not made out: indeed some of the criticisms in my view should never have been made in the first place (although in fairness Mr Booth himself, who had not appeared below, wisely moderated at least some of them).

It rather troubled me that the appellant's submissions at stages seemed to come close to advocating an approach in effect requiring a counsel of perfection, bordering on strict liability: a long way away from the yardstick of reasonableness.

I am, speaking for myself, most surprised, given the circumstances, that the claim against the GP was pursued at all. (I say this irrespective of the, in itself conclusive, causation finding of the judge, having regard to the evidence of Mr Langdon.) As to the claim against Trust 1, the judge's findings both on liability and on causation, on her appraisal and evaluation of the evidence and which appraisal and evaluation were properly and reasonably open to her, are unassailable in the appellate court.

Obviously the overall outcome here is very unfortunate for the claimant. But sympathy cannot determine the proper outcome for this legal case…"

The Appeal was dismissed.

So the door is open for strike out applications. And the application of the Bolam and Bolitho principle should be realistic and pragmatic.

SPIRE HEALTHCARE V ROYAL & SUN ALLIANCE [2020] EWHC 3299 (Comm)

This case was an interesting aside to routine clinical negligence litigation but flowed from the litigation concerning the surgery of Mr Ian Paterson. The ultimate issue was who paid the bills for the successful multiple claims against Mr Paterson. HH Judge Pelling QC:

Introduction
1. This is the trial of a claim by the Claimant ("Spire") against the Defendant ("RSA") under a policy of insurance underwritten by RSA by which RSA insured Spire in respect of its predecessor's liabilities for the acts and omissions of those employed or providing medical or surgical services at hospitals operated by Spire ("Policy").
2. This claim is essentially an aggregation dispute in which Spire maintains that the claims in respect of which it is entitled to cover under the Policy were consequent on or attributable to two separate original causes and RSA maintains that they are all attributable to a single source or cause. If Spire is correct it is entitled to recover up to £20 million whereas if RSA is correct then it is only liable to pay Spire £10 million. There are other issues that arise or arose at the start of the trial though they were later conceded. By the time closing submissions were delivered, only Issues 1,2,3 and 9 as set out in the Agreed List of Issues remained to be decided. I refer to those issues in detail below, having set out the relevant background so as to make them intelligible.

Background
3. The claims, the subject of this dispute, arise from surgery carried out on private patients at two hospitals operated by Spire - known respectively as "Little Aston" and "Parkway" - by Mr Ian Paterson, who at the time was a Consultant Breast Surgeon employed by the Heart of England NHS Foundation Trust ("HEFT"). Mr Paterson was suspended from practice in 2011 by the General Medical Council ("GMC") over concerns about the manner in which he had performed mastectomy procedures on patients suffering from breast cancer.
4. It is not necessary in this judgment to explore the technical issues relating to mastectomy procedures in any detail. It is sufficient to note that it was universally accepted by all professionals in the relevant field at the relevant time that if a mastectomy was clinically indicated (because a diagnosis of breast cancer had been made) all breast tissue should be removed in order to eliminate or reduce the risk of a recurrence of breast cancer and the consequent risk that it would metastasise through the blood or lymphatic system to form tumours in other parts of the body.
5. Notwithstanding the universal practice being as I have described, Mr Paterson developed the practice of performing sub-total mastectomies ("STM") (which he described as "cleavage sparing" mastectomies), which involved leaving some breast tissue behind. It is

common ground that to perform such procedures was negligent. In most if not all cases where Mr Paterson performed this procedure he failed to obtain informed consent from the patient either by not explaining what he planned to do or failing to explain the risks associated with what he planned to do. Why he developed this practice has never been adequately explained. The two possibilities identified in the evidence were either that which he identified (an improved cosmetic appearance) or because the procedures were rushed and the presence of unremoved tissue went unnoticed. Mr Paterson adopted this practice both in his NHS and private practices.

6. This method of proceeding had first been detected in 2007 by NHS officials at HEFT. Those NHS officials sought and received from Mr Paterson an assurance that he would stop performing STMs but by 2011 it had become apparent that he had continued to perform such procedures. The GMC placed restrictions on Mr Paterson's practice in consequence and, in August 2011, Spire suspended all Mr Paterson's practising privileges at its hospitals. The GMC thereafter suspended Mr Paterson from practice.

7. Following his suspension, in October 2011, it was discovered that Mr Paterson had also engaged in what Spire characterises (correctly) as "… a quite different, and utterly abhorrent strand of conduct, carrying out unnecessary surgical procedures – typically wide local excisions ("WLEs") – where there was no clinical indication for the surgical procedure undertaken." Mr Paterson's methodology was to falsely report pathology test results as indicating the presence or a risk of the presence of cancer, obtain consent for treatment on the basis of this falsely reported pathology and then perform unnecessary surgery and follow up treatment for which necessarily no informed consent had been obtained. This course of misconduct occurred almost exclusively in relation to private patients, for which Mr Paterson claimed fees either from the patients themselves or their insurers.

8. This led to Mr Paterson being charged with offences under sections 18 and 20 of the Offences against the Person Act 1861 and tried in the Crown Court at Nottingham before Jeremy Baker J and a jury, where he was convicted of 17 counts under s.18 and 3 counts under s.20. He was sentenced to 15 years imprisonment, later increased on appeal by the Attorney General to the Criminal Division of the Court of Appeal ("CACD") to 20 years. In his sentencing remarks, Jeremy Baker J said:

> "57. Inevitably, the effect of carrying out the unnecessary procedures upon these individuals, has varied from one to another. However, it is clear both from listening to their accounts during the trial, and subsequently having considered their victim impact statements, that the physical, and particularly psychological effect upon each of them, has been profound.
>
> 58. All of them have suffered the pain and discomfort associated with surgery, whilst some have suffered the debilitating longer term effects of complications arising from the unnecessary procedures; especially those who have undergone mastectomies with immediate subcutaneous reconstruction.
>
> 59. All of them have been left feeling violated and vulnerable, whilst some have suffered prolonged psychological conditions, including post-traumatic stress disorder, anxiety and depression, which has required professional intervention and treatment.
>
> 60. All of them have been left with physical scarring to their bodies, and those who underwent mastectomies have had their breast tissues removed. The one man who was affected by this type of procedure has spoken eloquently of the effect that this procedure has had upon him, and it is probably difficult to overstate its psychological effect upon the women to whom it took place, which is best encapsulated by one of the victims, who puts it in these terms, "Now and probably for the rest of my life, when I look in the mirror I see a victim of Paterson, who took away part of being a woman."
>
> 61. In addition to economic losses caused to some of these individuals, either from the cost of the operations themselves, or the psychological impact on their employability, the other effect which is common to all these individuals has been their loss of trust in others, including the medical profession, and the reputational harm of your conduct may well extend beyond those immediately affected." As Hallett LJ observed in the course of delivering the judgment of the CACD: "The jury's verdicts mean

that they were satisfied that over a period of 14 years, in respect of ten patients (nine women and one man) the off ender deliberately misrepresented the contents of pathology, exaggerated the risk of cancer and advised and carried out unnecessary surgery including mastectomies."

9. About 750 former patients of Mr Paterson commenced proceedings, with the Lead Action being case number HQ15 P02152 between LG and 6 others v (1) Mr Paterson, (2) Spire and (3) HEFT ("Paterson Litigation"). The claims against Spire were by claimant patients who had either suffered negligently performed STMs or who had been the victims of unnecessary surgery as described by Jeremy Baker J and Hallett LJ or who have been the victim of both negligently performed STMs and unnecessary surgery. RSA accepts that Spire is entitled to an indemnity under Section 4 of the Policy in respect of its legal liabilities to the patient claimants and its defence costs.

In total, Spire contended that its outlay on damages, costs and its own defence costs amount to £37,239,007.81. It maintains that it has incurred a combined outlay in excess of £10m in respect of each of the groups of cases which it maintains are to be aggregated. RSA does not accept that this is so and puts Spire to proof on that issue…."

Two issues had to be determined by the Court – the Aggregation Issue and the Damages Issue.

The Aggregation Issue

This was the principal issue to be determined at trial. In summary, by clause 5(a) of the insurance policy, it was agreed between the parties that: "The total amount payable by the Company in respect of all damages costs and expenses arising out of all claims during any Period of Insurance consequent on or attributable to one source or original cause irrespective of the number of Persons Entitled to Indemnity having a claim under this Policy consequent on or attributable to that one source or original cause shall not exceed the Limit of Indemnity stated in the Schedule"

Spire maintained that there were two separate groups of claims being:

i) claims resulting from Mr Paterson negligently performing STMs where a mastectomy was clinically indicated, which Spire characterise as the "Group 1" claims; and

ii) claims resulting from the conduct summarised by Jeremy Baker J and Hallett LJ (as quoted above), where Mr Paterson had deliberately misrepresented the contents of pathology, exaggerated the risk of cancer and advised and carried out unnecessary surgery including mastectomies, which Spire characterised as the "Group 2" claims

On this basis Spire maintained that it is entitled to at least two Limits of Indemnity of £10 million (subject always to the aggregate limit of indemnity of £20 million) being one in respect of each of the two separate groups of claims because, it maintains, each group of claims was consequent upon or attributable to a different source or original cause. RSA maintained that the distinction that Spire draws between the two groups of cases was a false distinction and that on a proper construction of clause 5(a) of the Policy all the claims should be aggregated once because they are all consequent on or attributable to one source or original cause, namely Mr Paterson or Mr Paterson and his conduct. In relation to the alternative formulation, RSA's case as to what "his conduct" consisted of has varied. By the time this trial started the focus of attention was on an assertion that in both groups of cases the injuries and loss for which damage was claimed had been caused by Mr Paterson's negligence. This changed during the course of the trial to an assertion that the aggregating cause was that in both groups of cases the injuries and loss had resulted from deliberate misconduct on the part of Mr Paterson.

In relation to its case that the aggregating conduct in both groups was Mr Paterson's negligent and inappropriate clinical care, RSA relied on the fact that both types of claim were pleaded in the Paterson Litigation as having been caused by Mr Paterson's negligence and that Spire adopted a similar course when pleading its contribution claim against Mr Paterson. It also relied on the fact that the claimant patients who sent letters of claim relied exclusively on negligence, whether or not the claims were what Spire characterises as Group 1 or Group 2 claims. It relies on the fact that Mr Paterson conceded a breach of a duty of care in relation to the claims irrespective of whether

they were Group 1 or Group 2 claims and that the duty by reference to which the claims were advanced in correspondence, pleaded in the Paterson Litigation and conceded by or on behalf of Mr Paterson was a duty to prevent harm whether caused "accidentally or deliberately" – (RSA's opening written submissions).

In relation to RSA's alternative case that the single aggregating factor was Mr Paterson's deliberate misconduct, the focus changes to the fact that Mr Paterson continued to perform STM procedures notwithstanding his assurances to HEFT's officials that he would not do so and so was deliberate just as was the performance of unnecessary surgery on patients within Group 2.

In either event, RSA argued that Spire's approach was impermissible disaggregation and, in consequence, RSA maintained that Spire is entitled only to a single Limit of Indemnity of £10 million because all the Claims are consequent on or attributable to that one source or original cause being Mr Paterson and his conduct.

Spire's response was that neither of RSA's approaches constitutes permissible aggregation either as a matter of construction of Clause 5(a) of the Policy or as a matter of general law because it does not identify properly why each category of loss occurred or how they were each caused.

As to the Quantum Issue, RSA put in issue whether the damages interest and costs including defence costs paid out by Spire in respect of the Group 2 claims exceed £10 million. This issue was as being:

> "Did the quantum of the damages and interest paid to the Patients, the Patient's costs, and the Claimant's defence costs arising out of the second distinct group of Claims exceed £10 million? If not, what was the quantum of the damages, interest, costs and defence costs of Claims arising out of Mr Paterson's deliberate conduct?"

The Court found:

"…40. I find that Mr Paterson's motivations in respect of his decision to carry out STM procedures to patients with breast cancer were different from his motivations in respect of his decisions to carry out wholly unnecessary procedures either on patients who were not ill at all or who were ill in ways that did not necessitate such procedures.

41. I have already set out the cardinal differences. In substance however, the fundamental difference was that in the Group 1 cases the procedures were carried out on patients that required mastectomies in order to remove the breast tissue from a breast that had cancerous tumours within it whereas in the Group 2 cases the patients concerned were not suffering from any medical condition that necessitated the treatment undertaken. Whether the cause of action available to patients in each group is legally characterised as negligence or assault is immaterial. What matters is essentially a factual question – what factually was the original cause of each of the claims? As I have said, when analysed at that level, the original cause of the group 1 cases was not the original cause of the Group 2 cases.

42. If legal characterisation matters at all, I consider how in fact the claims were set up is immaterial. That the Group 2 cases should be characterised for these purposes as assaults is both obvious and apparent from the verdicts in the criminal proceedings against Mr Paterson referred to earlier. The cases considered in those proceedings were exclusively cases concerning unnecessary procedures on patients who were not ill in any relevant sense….The Group 1 cases were either the result of a mis-appreciation by Mr Paterson that an effective mastectomy could be carried out leaving some tissue behind for cosmetic reasons or because some breast tissue was left behind as a result of the procedure being carried out too hurriedly.

43. At a factual level the original cause of each group of cases was different. I find on the balance of probability that the Group 2 cases were motivated at least primarily and predominantly by financial greed. I infer that to be most likely to be the dominant motivation because the vast majority of the patients on whom unnecessary surgery was performed were private not NHS patients and from the fact that in a number of cases, procedures were misdescribed when Mr Paterson claimed payment so as to enhance further the payment he received for the unnecessary procedures. It is conceivable that a subsidiary motivation for carrying out the unnecessary procedures was psychological. There is some evidence for that to be derived from the fact that Mr Paterson carried out some albeit very few

wholly unnecessary procedures on NHS patients. Jeremy Baker J alluded to this in paragraph 62 of his sentencing remarks when he observed that he was satisfied that Mr Paterson was motivated in relation to the cases that were the subject of the prosecution (all Group 2 cases as I have noted) by "… your own self aggrandisement and the material rewards which it brought from your private practice…" However that is immaterial to the issue I am concerned with because there is no evidence either direct or inferential that suggests either of these factors played any part in his decision to carry out STM procedures on patients who required Mastectomies because they had breast cancer in the affected breast.

44. Returning to the analysis necessary to determine the aggregation issue, the terms of the aggregation clause agreed between the parties when construed correctly and in accordance with the authorities referred to earlier require that what has to be identified is the single source or originating cause of all the negligent acts and their consequences. It is obvious but in any event I find that Mr Paterson's motivations for carrying out unnecessary procedures were entirely different from his motivations for carrying out STM procedures on patients with cancer when he should have been carrying out conventional mastectomies. It follows from this that his motivations for carrying out unnecessary procedures could not and I find did not cause him to carry out any of the STM procedures on patients with a medically identifiable need for mastectomy procedures and likewise his motivation for carrying out STM procedures to such patients did not cause him to carry out any of the unnecessary procedures…."

The Court found that "there was a different source and originating cause for each of the groups of cases identified by Spire."

The Quantum issue

This was "Did the quantum of the damages and interest paid to the Patients, the Patient's costs, and the Claimant's defence costs arising out of the second distinct group of Claims exceed £10 million? If not, what was the quantum of the damages, interest, costs and defence costs of Claims arising out of Mr Paterson's deliberate conduct?"

RSA did not advance any positive case in relation to this issue but merely puts Spire to proof. Spire called evidence the group 2 cases did exceed £10 million. The evidence concerning the cases and their damages and costs was reviewed and heard by the Court. Whilst challenging to assess, in part because of issues concerning individual injured women's confidentiality, the Court found that the quantum did exceed £10million and found for Spire.

In the end RSA footed the multi-million pounds of bills.

We have produced a number of Briefings and case reports over the past few months, including on:

- Sanderson (by her litigation friend) v Guy's and Thomas' NHS Foundation
- Thimmaya v Lancashire NHS Foundation Trust v Jamil
- WM Morrison Supermarkets plc v Various
- Barclays Bank plc v Various Claimants
- Whittington Hospital NHS Trust v XX
- ABC v St George's Healthcare NHS Trust
- Dorrington v Basildon and Thurrock University Hospitals NHS Foundation Trust
- Paul & Another v Wolverhampton NHS Trust
- Younas v Okeahialam
- Bradfield-Kay v Cope
- SC (by her mother and litigation friend AC) v University Hospital Southampton NHS Foundation Trust
- Swift v Carpenter
- Marshall v Schembri
- Henderson v Dorset Healthcare University NHS Foundation Trust [2020]
- Tavistock v Bell

You can read about these at www.1chancerylane.com

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