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Judgment: approved by the Court for handing down

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*(subject to editorial corrections)**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

QUEEN'S BENCH DIVISION

BETWEEN:

KATHLEEN SHAW

Plaintiff;

And

DOCTOR DIARMUID DE BURCA

Defendant.

GILLEN J

[1] The plaintiff in this action suffered a sub-arachnoid haemorrhage ("SAH") on 21 October 1999. As a result of this brain haemorrhage she has become significantly disabled. On 18 October 1999, she had consulted the defendant Dr Diarmuid de Burca, a registered general medical practitioner, complaining of certain symptoms and the action now before me has arisen out of that consultation.

[2] The plaintiff has issued proceedings against the defendant for personal injuries, loss and damage sustained by her by reason of the alleged negligence of the defendant in and about the provision of medical care and advices for her. The defendant was at all material times to this action a doctor at "Roedoc" which is a centre for general practitioners in the Limavady area to provide out of hours service to patients.

Factual background

[3] Many of the primary facts in this case are not in dispute and permit of brief description.

[4] It is common case that prior to 18 October 1999 when the plaintiff saw Dr de Burca, she had suffered a sentinel bleed in her head albeit a minor one. No expert in this case took the view she had suffered a major SAH on or before 18 October 1999.

[5] The symptoms that she did present to Dr de Burca on 18 October 1999 are in dispute however. Resolution as to what they were is absolutely crucial in this case.

[6] It will be helpful therefore if I set out initially the various accounts of her complaints which had emerged prior to the evidence before me. I observe initially that in light of the plaintiff's condition, she is unable to remember any of the symptoms herself and thus reliance has been placed on the recollection of her husband Mr Shaw.

[7] According to a statement of Mr Shaw taken on 23 June 2000 by his solicitor, "matters started on Sunday night 17 October (1999)". That statement records the following:

> "Matters started on Sunday night 17 October. That night she began to have sharp stabbing pains down the back of her neck from the back of her head, down her back to just at the top of the space between her shoulder blades. She took some pain killers for them.
>
> On Monday 18 October she started having severe head aches as well as the pains I have described. By the evening of 18 October she was being sick. She could not keep her food down.
>
> She continued to feel the same way on Tuesday 19 October. She had the same pains and severe headaches. She was still being sick although she was trying to eat regularly.
>
> I came home from work about 6.30 pm on the evening of Tuesday 19 October . . . about 8.30 pm Kate took a funny turn. She said she was dizzy and she was very confused. She was confused about where she was. I did not notice anything peculiar about her eyes.
>
> Because of this deterioration I drove her down to the emergency doctor at the Scroggy Road Medical Centre. I think there is an on call service of some kind. I had not made contact with him because Lisa

had phoned up the doctor to find out where to go. That was where we were told to go.

I took her to this doctor there. I do not recall his name. We had to wait about 45 minutes.

I went in with Kate and I spoke to the doctor. I told him she had severe headaches, had pains down her neck to the top of her shoulder blades, was constantly vomiting and now had this dizzy spell and was confused. I do not recall Kate saying anything to him.

This doctor looked into her eyes but did not use any equipment to do so. He then took her blood pressure and checked her pulse. He then checked into her ears with a piece of equipment.

He asked about whether Kate had any other medical conditions. I told him she had none. He then asked if there were any serious illnesses or conditions running through the family. I told him as far as I knew there were none.

One thing he did not ask about and of this I am certain is that he did not ask if Kate had had any previous anxiety or panic attacks. I would have answered that she had not because she had had none.

The doctor then said, "I think she has had a case of an anxiety attack". He then gave her two tablets to take which he said would bring her blood pressure down. He did not give her a prescription for anything else. We accepted what he said to us and started to make our way home.

Unfortunately Kate then vomited up the pills before we actually arrived home.

She vomited some more that night at home."

[8] I pause to observe that it is now common case that Mr Shaw is incorrect in stating that he visited Dr de Burca on 19 October 1999. It is agreed that it was 18 October 1999.

[9] Mr Shaw made a further statement to his solicitor which was taken on 18 December 2002. In that statement he recorded –

> "I said in my original statement of 23 June 2000 that on Tuesday 19 October 1999 my wife, Kate, took a funny turn and said she was dizzy and very confused.
>
> Those were more or less her exact words when she took the funny turn. She kept telling me she was very confused. Her voice was also noticeably slower as if she was thinking hard about what she was trying to say. She was not slurring her words as far as I can recall.
>
> I was quite alarmed at this and asked her some questions.
>
> I asked her "Where are we?" She replied we were at home.
>
> I then asked her what country we were in and she replied slowly "Northern Ireland".
>
> I then asked her what the date was and she got it completely wrong. She was way out and mentioned a date and a month in the Spring-time. With that I asked my stepdaughter Lisa to phone for a doctor. As Lisa was doing this I took Kate by the arm and sat her down. This was harder than normal as she was clearly dizzy. Her balance was not great. I then proceeded to reassure her whilst Lisa was phoning.
>
> As soon as Lisa came off the phone and told us we had to go to the Scroggy Road Medical Centre to the out of hours service I helped Kate out of the chair physically and helped her into my car. Her balance was still not good and she was clearly still dizzy. She was speaking the same slow way."

Mr Shaw goes on to say in the course of his statement –

> "The doctor examined her as I have stated. He did not ask her any questions and as I recall it hardly spoke. It was obvious to me that Kate was not with it at all. You trust the doctors to do a proper examination and ask the right questions. I was not all

> convinced by his diagnosis that she had had an anxiety attack."

[10] Later in this judgment I shall set out his account given in evidence before me.

[11] There were before me records of Mrs Shaw's attendance at Roedoc out of hours centre dated 18 October 1999.

[12] The initial telephone message received by the receptionist at Roedoc on the evening of the 18 10 1999 reads –

> "Pains in head – back – trouble seeing – hyperventilating".

It is common case that this information was given to the receptionist by Mr Shaw's 16 year old stepdaughter Lisa on the night of the 18 October 1999 There is no note of the time Mrs Shaw arrived at the medical centre nor how long the consultation with Dr de Burca lasted.

[13] Dr de Burca's handwritten note, made on the night in question, reads –

> "Extremely anxious, tremulous ++. Headache around head – neck. BP: 170/110 HR 90/Min. Throat sl red. Neck good ROM (*range of movement*). Tender l sided cervical. No focal neurology. PERL (*pupils equal, reacting to light)*. Imp (*ression*) acute anxiety attack."

[14] Therapy given was recorded as "diazepam 5 mg stat script issued – no. Persistent quite severe headache. If doesn't settle Solpadol 6 hy prn 4 tabs". No review arrangement was suggested.

[15] It is common case now that on 20 October 1999 Mr & Mrs Shaw returned to the surgery and there saw Dr Devlin. The record of Mr Shaw's consultation with Dr de Burca at Roedoc was faxed to Dr Devlin's practice on 27 October 1999, a second copy being dated as having been received at the practice on 2 November 1999. Neither copy would therefore have been available to Dr Devlin when he saw Mrs Shaw on 20 October 1999.

[16] Dr Devlin recorded his consultation with Mrs Shaw on 20 October 1999 as follows –

> "a(attendance) headache, vomiting, visual disturbance on Monday night. Saw ROEDOC. BP?
>
> Still frontal headache.

> Nausea but no vomiting.
>
> Vision OK.
>
> Admits to anxiety ++ headache o/e. Tender over forehead and occiput.
>
> Mem°ingism. Cranial nerves✓ fundi✓✓ (retinae seen with ophthalmosphe). BP 140/100. Check U+E (urea and electrolytes blood tests of kidney function) esr (erythrocyte sedimentation rate, a marker for inflammation) TFT (blood thyroid function test) 24 hour urine for catecholamines.
>
> Anxiety tension headache."

The reference to"still frontal headache" was significant.

[17] Altnagelvin Hospital clinical notes dated 22 October 1999 record that Mrs Shaw was admitted by ambulance at 00.14 am having been found unconscious on the bed at home by her husband. In the course of his statement of 23 June 2000 Mr Shaw describes his wife in bed watching television at about 10.30 pm on 22 10 1999. He goes on to say –

> "She suddenly sat up, listed to her left and I saw that her eyes were rolling in the back of her head. She was breathing very funnily. I went and phoned for an ambulance which arrived about 10 minutes later and took her to hospital."

[18] It is common case between the experts that the major bleed of the SAH occurred on 21 October 1999 when she went into a coma on that evening.

[19] The ambulance notes of 21 October 1999 record –

> "History – patient suffering constant severe headaches since Tuesday (*this would be 19 October 1999)"*. The nature of her treatment was then outlined.

Mr Horner QC, who appeared on behalf of the defendant with Ms Simpson drew attention to the fact that in this note there was no mention of vomiting, nausea, dizziness or visual disturbance in the history.

[20] The Accident and Emergency record (A&E) of 22 October 1999 at 00.14 recorded –

> "4 (*days*) ago – headache – quiet and pale with associated vomiting. Headache for past 3 days over whole head. Pain in neck for past 3 days. Headache (*decreasing)* severity".

[21] The Accident and Emergency records at 12.30 am on 22 October recorded that the history was given from her husband; headache 4 days, had been settling, tonight stated "Its starting again" and "lost consciousness".

[22] The clinical notes at 1.00 am on 22 October 1999, again recorded according to her husband, noted "headache – 3 days – severe headache all over the head, associated with vomiting for the past 2 days".
Mr Horner relied heavily on the reference to vomiting only 2 days before.

[23] The intensive care unit record of 22 October 1999 at 0200 recorded –

> "3 days history of increasing headache. Got suddenly worse this pm. Patient went unconscious. Fitted at home."

[24] I pause to observe that while counsel was perfectly entitled to draw attention to the failure to note any symptoms, nausea, dizziness or visual disturbance in the records at the hospital on the evening/morning of 21 and 22 October 1999, I did bear in mind the assertion of Dr Judith Chapman a general practitioner expert retained on behalf of the plaintiff, that caution is required with any assessment of the history given by a man such as the plaintiff's husband who is under stress with his wife unconscious and in circumstances where junior doctors are recording histories which sometimes are simply a transcript of what they have been told by somebody else. Her experience is that there is a variation in the reliability of history given in such circumstances.

The Law

[25] There was no dispute between the parties as to the applicable law in this case. The test set out by McNair J in Bolam v Friern Hospital Management Committee (1957) 1 WLR 582 at 586 has stood the test of time and is so well known that it does not require detailed recitation by me. Suffice to say that the test in this case is the standard of the ordinary skilled man exercising and professing to have the skill of a general practitioner. He must act in accordance with the practice accepted at the relevant time as proffered by a responsible body of medical opinion; see also Sidaway v Bethlem Royal Hospital Governors (1985) 1 All ER 643 at 649.

[26] In short the test is whether the defendant in this case has been proved to be guilty of such failure of care as no doctor of ordinary skill and

competence would be guilty of if acting with ordinary care; see Hunter v Hanna (1955) SC200, per Lord President Clyde at 206.

[27] The standard of care must reflect clinical practice which stands up to analysis and is not unreasonable. It is for the court, after considering the expert medical evidence, to decide whether the defendant's assertions as to the standard of care in fact put the patient at risk.

[28] Given the division of expert opinion in this case, it is appropriate to draw attention to the views expressed by Lord Scarman in Maynard v West Midlands Regional Health Authority (1984) 1 WL 634 where he said:

> "It is not enough to show that there is a body of competent professional opinion which considers that there was the wrong decision, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances … differences of opinion in practice exist, and will always exist in the medical as in other professions. There is seldom any 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."

[29] Accordingly, applying the appropriate test of the standard of care in this case the issue is whether the general practitioner defendant, acting with ordinary care and skill, has failed to either diagnose SAH, or, perhaps more pertinently, has failed to consider SAH as a possible/differential diagnosis and in the circumstances before him therefore ought to have proceeded to a referral to hospital. Should he have cast his generalist diagnostic net sufficiently wide to have included within the full range of diagnostic possibilities the risk of SAH and to have sought more expert opinion than his own?

[30] It is the plaintiff's case that the defendant was given sufficient symptoms relating to Mrs Shaw so that SAH should have been raised in his mind as a diagnostic possibility with a result that she should have been referred for immediate hospital opinion or treatment. Mr McNulty QC who appeared on behalf of the plaintiff with Mr Hamill, submitted that the risks inherent in SAH were so great that the diagnostic bar should have been set very low in these circumstances before he should have contemplated dismissing the possibility. In terms SAH is such a serious condition, that the plaintiff ought to have been referred to more specialist opinion or treatment at the hospital where doctors would have been more capable of making a diagnosis. It is Mr McNulty's case that if the defendant was unable to

diagnose or treat the plaintiff, he was under a duty to seek advice from an appropriate specialist or refer the plaintiff to more specialist treatment at the hospital.

[31] The defendant's case is that the plaintiff's presentation was very different from that asserted by her husband. On the symptoms presented to Dr de Burca , the diagnosis of acute anxiety headache was a reasonable one and the decision not to refer her on for further assessment was appropriate. The history, symptoms and signs presented by the plaintiff were far from typical of SAH and in the circumstances presented to him, did not justify him concluding that further referral was required.

The witnesses

[32] It is necessary for me to briefly rehearse some of the salient evidence arising from the witnesses who gave evidence before me. In doing so I do not intend to set out the entirety of their evidence but simply to indicate some of the salient points in their evidence.

Dr Judith Chapman

[33] This witness, called on behalf of the plaintiff, was a distinguished clinician who had passed her MRCGP examination with distinction in 1977 and was elected a fellow of the RCGP in 1996. She was an experienced professional witness before the courts. Dr Chapman was a trainer since 1994 who was thus required to know what constitutes good practice and acceptable standards of care for general medical practitioners and to teach this to young doctors.

[34] She asserted that the context of this examination was important. Dr de Burca was acting as a locum with a remit to deal with emergencies. Whilst she recognised that it was neither his responsibility to initiate more detailed investigations nor to go into great detail in advising further management of the anxiety state if that was the plaintiff's diagnosis, nonetheless he did have a duty to consider matters such as whether Mrs Shaw required emergency hospital admission, did she need an arrangement for further investigation or should she be advised to consult her own GP for further examination or assessment. However she did recognise that SAH was a rare condition and to see only 6 potential cases in 30 years was not unusual.

[35] Key to Dr Chapman's evidence however was her assertion that there were features that suggested a serious physical cause of the plaintiff's symptoms including severe headache of recent onset, disturbance of vision, confusion, and nausea. She frankly accepted that there was clearly some doubt as to whether or not the symptoms of vomiting had been given to Dr de Burca. In her opinion Dr de Burca, by virtue of the defects in the notes he

had made, did not put himself in a position to make a clear decision as to whether these were sufficiently alarming as to require urgent investigation i.e. he did not clarify the nature of onset of the headache, the visual disturbance or confusion. He should have considered the possibility that this represented significant physical disorder. It was her contention that on the basis of these "alarm" symptoms, no GP acting with an ordinary degree of skill and care would have failed to either admit Mrs Shaw to hospital as an emergency or else to consult a physician by telephone to arrange urgent investigation.

[36] Her opinion was therefore predicated on Mrs Shaw or someone on her behalf having given a clear history of sudden onset severe headache, associated with a brief episode of confusion, visual disturbance and nausea. I agree with Dr Chapman that had that been the presentation, no ordinary GP acting with a normal degree of skill and care should have failed to recognise the need for immediate admission or for urgent investigation. The difficulty for the plaintiff in this case was that there was a fundamental factual dispute as to whether or not Mr Shaw/Mrs Shaw had given such a history. In the absence of the court being satisfied on the balance of probabilities that such a factual matrix was before the defendant. Dr Chapman's contention fell away

[37] In answer to me Dr Chapman accepted that if the only significant history given in this context to the defendant was of gradual onset of headache with no mention made of vomiting, confusion or visual disturbance, then it would not have been negligent on the part of a GP not to refer the matter to the hospital.

[38] It bears mentioning at this stage that most witnesses accepted in this case that headaches, particularly in women, do form a very substantial part of cases seen by general practitioners. In the vast majority of cases this is accounted for by a diagnosis of simple headache/migraine etc. It is only in rare cases where a more serious condition is found.

Dr Peter Thornton

[39] Dr Thornton FRCGP was another expert on behalf of the plaintiff with distinguished qualifications which included FRCGP. Since 1999 he had provided over 200 expert opinions in cases of alleged negligence by general medical practitioners. He had also given evidence as a general practitioner expert to the General Medical Council in the Court of Session and to fatal accident inquiries.

[40] Dr Thornton made what I considered to be a number of reasonable criticisms of Dr De Burca's note taking in this matter and to which I will return later in this judgment.

[41] However once again his conclusions as to the negligence of the defendant depended largely on which symptoms had been given to Dr de Burca. It was Dr Thornton's view that if vomiting had been part of Mrs Shaw's presenting history, the combination of these features with new onset severe headache radiating down to between the shoulder blades and visual disturbance should have been enough to make an ordinarily competent general practitioner, acting with ordinary care and skill, suspect an organic cause. Whilst he accepted that not all such practitioners would necessarily suspect that the symptoms were those of impending SAH, they would feel that a neurological emergency was sufficiently likely that they would have arranged immediate referral for specialist treatment. The strength of his evidence in the plaintiff's favour hinged largely on my finding of fact as to what symptoms had been disclosed to the defendant or what inquiries he ought to have made based on the information he had before him.

Mr L A McKinney FRCS

[42] Mr McKinney was a consultant in accident and emergency medicine called on behalf of the plaintiff. He outlined SAH as typically resulting in a sudden onset severe headache, often depicted as having the effect of a thunderclap, and which may result in abnormal neurological signs. The headache he said signalled irritation of the meninges by leakage of blood usually from an aneurism of the basal circle of the arteries.

[43] He recognised that where a headache was not described as severe or as of sudden onset, SAH is very difficult to diagnose. To do so, it is necessary for other "red flag" symptoms to be present. He accepted that if the headache was of gradual onset, bifrontal, starting with neck pains, then this was atypical of SAH.

[44] Mr McKinney and Mr Illingworth, to whom I shall shortly turn, referred to a report by Mr Davenport which suggested that headaches, where the onset was gradual and developing over longer than 5-10 minutes were not likely to be associated with SAH.

[45] The witness recorded that tension headaches are the most common cause of headache and can present either as a common headache or less frequently as a severe headache associated with anxiety, pallor, neck stiffness and photophobia-- symptoms which of course may also occur in SAH. He indicated that although anxiety could have provoked an acute tension headache, persistence after the anxiety had been relieved would cast doubt on this diagnosis. Of course one must bear in mind in this context that Dr de Burca was the first person to see the plaintiff in terms of medical treatment and he was not the doctor who therefore would have been in a position to know that the headache had persisted after treatment. It was Dr Devlin who was faced with a more chronic headache of several days duration.

[46] Mr McKinney indicated that had the plaintiff been referred to Altnagelvin requesting admission, that request was likely to have resulted in admission. The question is whether or not she should have been referred. Dr McKinney who apparently had had experience of a previous negligence suit involving the hospital , indicated that in Altnagelvin Hospital there is now a protocol which recommends admission to the hospital if a plaintiff attends with a symptom of acute severe headache. Where SAH is suspected or cannot be eliminated an emergency CT scan will be requested and likely to carried out .However this would only be where the complaint was an acute severe headache. I do not consider that Dr McKinney was asserting that every case of gradual onset headache as described by Mr Shaw would be the subject to admission/CT scan, etc unless at least some of the other indicia of SAH were present.

[47] Mr McKinney said that a complaint of headaches gradually evolving over a period of time is unusual in a diagnosis of SAH and indeed he had never come across it. The classic symptom is described as "like a kick in the back of the head" with sudden onset persisting together with symptoms such as vomiting and stiffness. The headaches should start suddenly.

Mr Kenneth Lindsay FRCS

[48] This witness was a consultant neurosurgeon from Glasgow called by the plaintiff . Essentially his evidence dealt with the question of causation. It was his view, which I accepted, that as a result of the failure to diagnose the occurrence of the SAH on 18 October 1999, on the balance of probabilities, Mrs Shaw had sustained cognitive disabilities significantly more severe than she might have sustained if a diagnosis of SAH had been considered on that date. This of course was to beg the primary question as to whether or not such a diagnosis ought to have been made or a referral instituted.

Dr Devlin

[49] Dr Devlin was the plaintiff's general practitioner who had treated her since 1994.He had been a second defendant in this action until the first day of trial when the case against him was ,by consent ,dismissed . When he saw her on 20 October 1999, he did not have the notes of Dr de Burca concerning his examination and conclusion of the 18 October 1999. He therefore had no information why she was coming to see him. Mrs Shaw told him she was complaining of headache, vomiting and visual distress from the previous Monday. She still had a frontal headache with nausea and anxiety. He made a note that there was no vomiting at that time and there was no mention of confusion or dizziness. She said she was very nervous adding, "I know probably I am very anxious". He was not 100% certain but he thought she said that she had been having some marital problems.

[50] Dr Devlin's evidence was that he tried to eliminate as many causes of headache as possible including tension headache, migraine, cluster headaches and rarer things such as SAH, brain tumour, etc.

[51] He found tenderness over her forehead, back of head and back of neck. He did a test for meninges and found it negative. He also tested her cranial nerves and her visual fields. He then carried out tests on her blood pressure, kidney function , thyroid and urine.

[52] The witness said that he felt his attention was drawn to SAH as he specifically tested for meningism and he felt it could be safely excluded . Even though he had not recorded this, he said that he would have undoubtedly have asked questions about the nature of the headache together with the onset.

[53] Dr Devlin said that he has diagnosed SAH on one other occasion in his career and has referred four to five patients to the hospital although they proved not to have the condition. He described the symptoms in those cases as being the classic signs of sudden onset headache at the back of the head, confusion, etc.

[54] He arrived at precisely the same diagnosis as Dr De Burca namely tension headache even though he did not have any indication that this was what Dr de Burca had diagnosed.

[55] In terms of the notes, he did not record a number of normal findings including what the patient said about her anxiety.

[56] Finally Dr Devlin said that even if he had the information from Dr De Burca, it would not have altered his conclusion.

Dr Robin Illingworth FRCP

[57] This witness was a consultant in accident and emergency medicine called on behalf of the defendant .He was employed at St James University Hospital, Leeds, and West Yorkshire. He was co-author and co-editor of the books "Accident and Emergency" and "Oxford Handbook of Accident and Emergency Medicine" 2nd Edition 2005.

[58] This witness similarly described headache as being a relatively common reason for attending Accident and Emergency (A&E).In his experience only a small proportion of patients with headaches have serious or life threatening problems such as SAH.

[59] He emphasised that the history is of crucial importance in the assessment of a headache especially the severity and speed of onset. He described SAH as typically presenting with a sudden onset of very severe headache, classically described as a blow to the back of the head, although some patients have a much less dramatic onset. Some SAH patients have had various warning headaches but these are usually only diagnosed in retrospect. Some patients with SAH have no neck stiffness and no abnormality on examination when seen in A&E. It was his view that in order to avoid missing such cases one should admit and investigate all patients with sudden severe headache suggestive of SAH even if there are no abnormal signs.

[60] However, significantly, it was his evidence that if the plaintiff had attended A&E and only had the symptoms and signs as outlined by Dr de Burca, he thought that it was unlikely she would have been admitted to hospital. The signs and symptoms recorded by Dr de Burca were not in his view typical of SAH and so he would not have expected a CT scan or lumbar puncture to have been arranged. If the headache had been very sudden and severe she would have been admitted but not on the basis of the symptoms alleged by Dr de Burca. It was his view that in retrospect the headache which started on 18 October 1999 was a warning headache, probably from a small bleed from the aneurysm. However this case demonstrates in his view the great difficulty in distinguishing this headache from much more common headaches due to other causes which are far less serious than SAH.

[61] He agreed with the conclusions of the Davenport Report namely where the onset of a headache was longer than 5-10 minutes it was not likely to be associated with SAH.

Mr John Gray FRCS

[62] Mr Gray was a consultant neurosurgeon attached to the Royal Victoria Hospital, Belfast in 1989 called on behalf of the defendant. He has a special interest in the condition of SAH. During his training and in his consultant career he has treated over 500 patients with SAH.

[63] In his experience there are two common presentations of SAH. First, sudden onset of a very severe headache associated with photophobia, nausea, and vomiting and neck stiffness. The onset of headache is so sudden that patients can often remember exactly what time it started. Secondly, sudden collapse with coma and seizures.

[64] However not all patients present in one of these two manners. In some patients, if there is a small bleed, as was the case with the plaintiff, the symptoms can be much milder and may not follow the classical presentation. Headache may not be of abrupt onset. There may be no vomiting. Neck

stiffness can be absent. Consciousness is not usually affected and seizures are rare. However Mr Gray went on to say that in this situation the diagnosis can be very difficult and it may require a doctor who has a great deal of experience to make such a diagnosis.

[65] Importantly he recorded that the average GP will rarely make the diagnosis of SAH. The incidence of SAH is about 200 cases in Northern Ireland each year. The average GP will look after less than 2000 patients so he will have on average one patient with an SAH every 4-5 years. In most of these patients the onset of haemorrhage will be fairly dramatic and that diagnosis will be straightforward. Only a minority of patients will present with a small bleed and therefore the average GP may only see one or two such patients in their entire working career. This experience coincided with the evidence of all the general practitioners in this case.

[66] Significantly, Mr Gray recorded that in his view if the plaintiff had attended hospital with the symptoms recorded by Dr de Burca, she would probably not have been admitted. Indeed he went as far as to say that he would not have admitted her. Had she attended at hospital she probably would have been examined by a relatively junior doctor. The absence of neck stiffness, focal neurology or other features which occur in the classical SAH coupled with the history of gradual onset of the headache would probably have been sufficient to prevent acute hospital admission. In his experience, most patients who have a small bleed and then have a more severe haemorrhage later are rarely admitted to hospital at the time of the first bleed.

Dr Steele MD FRCGP

[67] This witness was a senior lecturer in general practice. He performs 20 hours teaching with post graduates and 20 hours with patients. He has a special interest in educating under graduates and post graduates.

[68] Asked about the note taking of the defendant in this instance he said that in teaching young doctors, recommendation is made that they record as much as possible although pressure of time means that it is not always done. There is an acceptable body of GPs who do not record everything but it is good practice to record all relevant matter. He considered that Dr De Burca had made a reasonably good note ("I have seen a lot worse") with some good detail.

[69] Dr Steele indicated that 86% of women suffer from tension headaches per year. There are many causes of headaches and it is the most common complaint that general practitioners see.

[70] In his opinion if the symptoms presented were of on set of headache over 1 hour, clear neurological tests, no vomiting, no photophobia, no

meningism, no nausea and no confusion then a diagnosis of SAH would be highly unlikely.

[71] The witness confirmed that the precipitant for anxiety is often difficult to ascertain although you usually can find out some cause.

[72] Dr Steele described tremor, nausea, sweating, shaking, palpitations, headache as all being symptoms of anxiety.

[73] He considered the record of events made by Dr De Burca- including the bi frontal headache, elevated blood pressure, absence of high temperature, heart rate slightly elevated, throat slightly red, good range of neck movement, muscular tenderness, no focal neurology, PERL-were typical symptoms of acute anxiety and pointed to such a diagnosis

[74] In cross examination by Mr McNulty this witness emphasised that the general practitioner is the gate keeper of the National Health Service. He cannot refer everyone with a headache to hospital and needs reasons to so refer.

Other witnesses

Mr Shaw

[75] I found Mr Shaw to be a decent man who was clearly bewildered by the turn of events that had damaged his wife's health in circumstances where two general practitioners had failed to diagnose her problem.

[76] Equally so however, the passage of time had not served him well and I found him confused and uncertain in his recollection of events that had occurred at the time that Dr de Burca were examining his wife. Mr Shaw's evidence before me in evidence in chief was that his wife on Sunday 17 October 1999 complained of pain from the crown of her head, down her shoulder blades and a headache. In particular he said that the headache came on slowly within the space of an hour. He was not aware of it improving and it was only getting worse. He described her shaking and being hesitant. Initially he told me that in the early hours of the morning of 18th she had vomited to the extent that it woke him up and he had stood and watched her vomiting.

[77] In cross examination however he accepted that his wife had not vomited in the early hours of the 18th morning and that his earlier assertion was as a result of him being nervous and confused. Sadly I came to the conclusion that much of his evidence was so affected. It echoed his earlier confusion about the day when she had attended the defendant.

[78] He left for work on the morning of the 18th – initially having said that the vomiting had not ceased at that stage – and returned in the evening to find her in the same way. The vomiting had increased he said and pain was intense. Her vision was blurred, she was dizzy and she had difficulty focusing her eyes. She was hyperventilating. He recalls her taking a "funny turn" that evening when she was dizzy and very confused. He asked her several questions such as where they were, what country they were in and what day it was. Some answers were correct and some were not. Therefore he asked his stepdaughter, aged 16, to telephone the out of hours service about 8.30 pm to get an emergency consultation. Thereafter he drove her down to the Roedoc Call Service at Scroggy Road Medical Centre.

[79] His recollection was that he accompanied his wife and spoke to the doctor. He said his wife tried to explain but was not giving full information because she was hyperventilating He said they told him she had severe headaches, pains down the back of her neck to the top of her shoulder blades, was constantly vomiting and now had a dizzy spell and was confused.

[80] I find it inconceivable that if she had been vomiting, that would not have been told to the call centre when the telephone call was made by his daughter, and that some record of this would not have been made by Dr de Burca. A factor which has underlined my conviction that he did not mention vomiting to Dr de Burca was that when he eventually saw the hospital doctors on 22 October 1999, the note records that the vomiting had only been present for two days. I consider that it is inconceivable that he would have said it was only present for two days if in fact it had been present for over four days. Whilst I am conscious of Dr Chapman's reservations about the reliability of hospital notes, this entry corroborates Dr de Burca's assertion that no such reference was made to him.

[81] Mr Shaw's recollection was that Dr de Burca looked in her eyes but did not use any equipment to do so, took her blood pressure, checked her pulse, checked her ears with a piece of equipment and confirmed with him that she did not have any other medical conditions. He said he was sure that he did not ask if his wife had any previous anxiety or panic attacks.

[82] Mr Shaw then said that the doctor said he felt she had had a case of anxiety attack, gave her two tablets to take which would bring her blood pressure down and did not give any other prescription.

[83] In cross examination it was his view that she had short stabbing pains on the 17th and the headaches were all over her head on the 18th. This tended to underline the case which he was making that the onset of the headache was gradual. I had to bear in mind that the pleadings in this case had suggested that the headaches "became constant" which also served to suggest a gradual

onset. Given that the classical onset of SAH is heralded by a sudden severe headache this became a very important piece of evidence in the case.

[84] Mr Shaw had also failed to make any mention of difficulty with eyesight or blurring in a statement he made on 23 June 2000. On 18 December 2002 in his statement he made no mention of vision. In a statement on 10 December 2006, six years thereafter, he said that vision was affected by dizziness.

[85] Understandably he had some difficulty remembering if Dr de Burca had asked about confusion or whether they told him about confusion. He could not remember if dizziness had been mentioned. He also had said in his statement of June 2000 that he did not recall his wife speaking at all. However now before me he did recall her speaking. He said that this recollection just came back to him over the years. I also found him uncertain in his recollection of what physical examination he said Dr de Burca had carried out. In particular he said he was unaware that Dr de Burca had recorded her heartbeat which was clearly indicated in his notes.

[86] I therefore came to the conclusion that this witness was fundamentally unsure about what had happened. The passage of time has caused him not only to become further confused about the events but perhaps even to conflate symptoms which occurred after he saw Dr de Burca with events that had occurred before he saw him.

Dr de Burca

[87] I found this man to be a genuine, straightforward and entirely credible witness who gave his evidence in the main in a compelling manner. It was clear to me that he was a witness who felt under great pressure as a result of the lengthy proceedings which had stretched out for years and the searching but fair cross-examination carried out of him by Mr McNulty. Whilst this may have rendered him somewhat assertively overprotective of his position at times nonetheless the overall impression he made on me was a favourable one.

[88] Dr de Burca was qualified in 1990 and had been a member of Roedoc for about 4/5 years at the time this incident occurred. He had referred possibly three to four patients for suspected SAH over the previous five years. He also said that in his opinion typical symptoms would be severe headache of sudden onset. Had he been advised of that that would have been sufficient for referral? Although Dr de Burca agreed that the threshold for concern about SAH was a low one given the seriousness of the condition, he did expect to find a history suggestive of acute bleed which pointed towards SAH before making such a diagnosis or referral to hospital .

[89] His evidence was that he had some recollection of seeing Mrs Shaw in the surgery rather than at her home. He would have been passed the information recorded by the receptionist prior to seeing the patient. However his recollection, which I think was faulty, was that the plaintiff was accompanied by another woman. I was satisfied that she was accompanied by Mr Shaw. His practice was that after a consultation with the patient he would complete a call sheet for return to the patient's GP. This was achieved by posting the call sheet to the GP on the internal mail the following morning, unless it was a matter of great urgency. He was unable to account for these sheets not having reached Dr Devlin. I pause to observe that this is a system that requires revision in light of the experience of this case

[90] Whilst he did not have a clear recollection of the plaintiff coming into his room, he was adamant that it would have been obvious if she was unsteady , had difficulty walking or was confused. I believed him when he said that he would let the patient talk first when taking a history and I therefore consider that Mr Shaw's recollection that his wife did not speak at all or rarely was faulty. I have no doubt that if she did not speak or rarely spoke any doctor, including Dr de Burca would have ascertained the reason, questioned her as best he could, and have made an appropriate record of this state of affairs . The absence of any reference whatsoever to confusion or that she did not speak, is in my view sufficient to satisfy me that she did speak during the consultation and did not evidence confusion. Whilst, as I will shortly mention, his note taking was at times inadequate, I am satisfied that he would have recorded such a cardinal matter. He did refer to her as being extremely anxious tremulous and of course this he had recorded .Why would he not record that she had not spoken or rarely spoke? Why would he not record that she was confused or dizzy when he had noted she was tremulous?

[91] I also believed that this practitioner would be sufficiently careful to have asked her how long the headache had been there together with the nature of the onset. I am certain that if she had told him that it was of sudden onset he would have recorded this. Indeed the evidence of Mr Shaw before me was that it was of gradual onset. The absence of any reference to type of headache or onset, albeit in my view it should have been recorded, indicates that there was nothing untoward elicited by his questioning about these matters. It was his evidence that he would have recorded significant features and sudden onset would have been such a significant factor. In my view there is a material difference between not recording positive findings and not recording negative findings. For example he was certain that vomiting was not mentioned as he would most definitely have recorded this. It is a red flag symptom and it would be very important to actively ask the patient about it. I was convinced, having watched him carefully that he would have recorded this had it been intimated to him.

[92] Dr de Burca then proceeded to take her temperature, ascertain her blood pressure, examine her throat and her range of neck movements to see if there was any evidence of acute stiffness. He found her to be tender to the left side of the neck muscles. The witness also recorded that she had no focal neurology. He said that he would have carried out his standard examination which would include a brief examination of the cranial nerves checking eye movement, facial and tongue movements, gag, asking whether the patient had any numbness and looking at the power/tone and co-ordination of limbs and reflexes. I was satisfied from watching this man carefully that had he not carried out such tests, he would not have recorded "no focal neurology".

[93] Although he could not recall examining with an ophthalmoscope this was something he would normally do when assessing the optic fundi which he recorded in his notes. I again was satisfied that he was telling me the truth about this.

[94] The defendant did note that the telephone details had indicated that the plaintiff had "trouble seeing". A standard question when asking about headaches would have included whether there was any visual disturbance or vomiting. As he had not recorded any visual disturbance he concluded that none must have been reported to him. Once again I was satisfied that this was a sufficiently conscientious doctor who would have made such enquiries and had there been any positive suggestion of visual disturbance or vomiting he would have recorded that.

[95] Dr de Burca said he had considered the symptoms of hyperventilation, being tremulous and shaking together with her posture, facial expression, behaviour, blood pressure, raised pulse, nature of the headache as described to him and tension in the cervical musculature. These were all indicative of an anxiety state in his opinion particularly when coupled with a gradual evolving headache which had not been of sudden onset.

[96] Although he had not recorded the precipitant for his diagnosis of acute anxiety state, he said that in his experience often it is impossible to discover at the time of presentation what is the cause of an acute panic attack or anxiety state. He felt it was highly unlikely he would not have asked about it. It is right to say that Mr Shaw in his examination in chief said that Dr de Burca asked his wife if there was any event leading her to be anxious to which the reply was "No". Anxiety attacks were common in his practice and almost as often as not there was no clear precipitant. The condition can occur spontaneously. He did not accept that it was significant to ask whether or not the anxiety came first or the headache came first.

[97] I found his note taking however to have been flawed. He asserted that in general he tried to note important points particularly positive findings and

some negative findings if he deemed them to be significant. However he conceded that it would have been helpful to have written "gradual onset" with reference to the headaches. He also recognised that it would have been preferable to have recorded that she had no significant ongoing problems with vision given the note he had received from the receptionist. He further conceded it would have been prudent to have written "no obvious precipitant" with reference to the anxiety symptoms. I recognise that this doctor was under a degree of pressure operating in an out of hours context and that in such circumstances doctors may well be selective about what they record. Nonetheless I am satisfied that there were too many omissions in this instance if compliance with good practice in note taking was to be met. The tragedy from his point of view is that had he taken a fuller note this case might never have been mounted.

Mrs Davidson

[98] Mrs Davidson was the senior receptionist at the clinic. She recalled a telephone call from Mrs Shaw on Tuesday 19 October asking to be seen by Dr Devlin. Mrs Davidson was asked if she wanted to be seen that evening or if she could wait until the next day when she would see Dr Devlin. Mrs Shaw elected for the latter. She said she had had a headache for quite a while but was chatting normally albeit not her normal bubbly self. I believed this witness and her evidence did not suggest any confusion on the part of Mrs Shaw as recently as 19 10 1999i.e.after she had seen the defendant.

Conclusions

[99] I commence my conclusions by recognising that SAH is a rare condition which typically presents with a severe headache of abrupt onset (classically "like a blow to the back of the head") accompanied by symptoms such as neck pain, photophobia and vomiting.

[100] I consider that Mr Illingworth's book – the Oxford Handbook of Accident and Emergency Medicine – provides a good guide to general practitioners where he states in relation to headaches ;

> "Features arising of particular concern include:
>
> - Extremely severe headache.
> - Sudden severe headache (classical of subarachnoid – haemorrhage).
> - Photophobia.
> - Any alteration in the level of consciousness.
> - Papilloedema or abnormal neurological signs.
> - Associated neck stiffness.
> - Developing rash."

[101] I was presented with a number of definitions of the condition SAH and the attendant symptoms. They included an extract from a textbook of medicine edited by Souhami and Moxham, the BASH guidelines quoted by Dr Bradley, discussion papers published by the British Journal of General Practice, management guidelines from the British Association for the Study of Headache and of course definitions from the various doctors and consultants who gave evidence before me. It seems to me that the typical symptoms outlined by Mr Illingworth encompass a good cross section of all definitions that have been given to me.

[102] whilst there may well be atypical instances of this condition, for example the current case, such atypical examples are extremely difficult to diagnose as SAH. Recognition is clearly difficult and indeed in some instances without the benefit of hindsight virtually impossible especially by general practitioners.

[103] However it is an extremely dangerous and serious condition and therefore a high level of suspicion is required on the part of practitioners when examining patients with conditions that could be indicative of SAH. The bar of suspicion should therefore be set at a very low level indeed. In this context however it has to be borne in mind that the condition is so rare that I had no difficulty accepting that many GPs, including Dr De Burca, may only come across three or four instances of the condition in their lifetime.

[104] As I have already set out in paragraph 97 of this judgment I do not consider that the notes made by Dr de Burca in this case were of adequate standard. I recognise only too well that general practitioners' notes do not invariably document every negative finding. A brief note of the consultation is all that is often required. In this case however, Dr De Burca knew nothing of the plaintiff and did not have any of her previous records. He knew that he would probably not be seeing her again and it was therefore all the more necessary in my view for him to have ensured that a proper and full note was kept of the salient issues arising in the consultation so that her own doctor coming thereafter would know precisely what had happened. However this is not a case that centres on note taking. I do not consider these defects contributed to the failure to diagnose the condition or to refer the plaintiff on for more expert treatment. Nor has it seared my belief in the evidence of Dr de Burca overall.

[105] I have not been persuaded that on the balance of probabilities Dr de Burca was negligent in any of the respects relied on by the plaintiff in this action. In my view the plaintiff falls far short of persuading me to the appropriate standard that Dr de Burca was presented with typical symptoms of SAH or such signs as would have raised his reasonable suspicion that further advice was necessary. On the contrary, I am satisfied that his diagnosis of

severe anxiety state was a reasonable diagnosis and one that did not require reference for further treatment or examination at hospital.

[106] There is no compelling evidence that Mr Shaw or the plaintiff gave Dr de Burca the symptom of vomiting when he saw him on 18 October 1999. I consider that Mr Shaw was mistaken in his recollection of this. Had there been vomiting, I do not understand the absence of any mention made to the receptionist in the telephone call prior to their visit to the surgery or why Mr Shaw apparently referred to the matter having occurred only 2 days earlier according to the hospital records of 22 October 1999. Moreover having watched Dr De Burca, I am satisfied that he is a sufficiently conscientious doctor to have recorded that in his notes notwithstanding the deficiencies in other respects in his note taking. Moreover I believed him when he asserted that in his opinion the treatment that he dispensed to the plaintiff would have been wholly inappropriate if she had been vomiting .Mr Shaw's evidence on this topic was unreliable even to the extent being confused in his own mind- and in his evidence before me - when it had started.

[107] Headaches are one of the commonest symptoms presented by patients to general practitioners. Causes clearly vary from the most trivial to life threatening. I am satisfied that Dr de Burca would never have recorded bi-frontal headache if it had been occipital. This is in itself atypical of SAH. Moreover the description of the headache by Mr Shaw was of gradual onset over a period of 1 hour which in my view is entirely atypical for SAH. This emerges clearly from both the notes in evidence of both Dr de Burca and Dr Devlin. Whilst the note taking as I have indicated leaves a lot to be desired, I am convinced that Dr De Burca would not have failed to ascertain the nature of the headache, its sight, its time of onset and its precipitating factors. Indeed Mr Shaw says he gave a history to Dr de Burca. Hence the absence of a note about the nature of the onset does not establish that the defendant failed to elicit a history.

[108] In addition, Dr De Burca was faced with an absence of any other symptoms which would have indicated even an atypical SAH. Firstly there were no neurological signs as noted both by Dr Devlin and Dr de Burca. Even when the plaintiff was admitted following her major bleed, there was no significant neurological sign.

[109] Next, there was no neck stiffness to suggest irritation of the meninges such as may occur in meningitis or SAH.

[110] High blood pressure was present but this could be present in a number of conditions including anxiety as well as more serious conditions.

[111] The tenderness of the neck muscles would have confirmed headache of tension type in someone making a differential diagnosis.

[112] In so far as there was dispute over the care that Dr de Burca took in examining the plaintiff's eyes, the fact of the matter is that Dr Devlin checked her fundi two days later and found no abnormality. Why would it have been different 2 days earlier?

[113] On the other hand I believe in the presentation to Dr De Burca there were features which were typical of acute anxiety based on the history, examination and pattern of presentation; see para 95 of this judgment. It is highly significant in my view that although he did not have the benefit of Dr de Burca's notes, Dr Devlin came to precisely the same diagnosis on the basis of a different examination 2 days later.

[114] I do not believe that Dr de Burca can be held accountable for making an incorrect diagnosis on the basis of the information that I accept he had before him. I found nothing in any of the symptoms that he recorded, in those recorded by Dr Devlin, or indeed later hospital records, which illustrate that there existed on 18 October symptoms which contradicted his version of events as given to me. I do not find these notes self serving. On the contrary they are amply corroborated by the other evidence in the case

[115] There is no doubt that SAH is a dangerous condition and the bar of the suspicion should be set at a very low level. But Dr De Burca cannot be judged by the fact that with the benefit of hindsight it is now clear that the plaintiff had suffered a minor bleed at the time he saw her.

[116] The role of a GP is that of a gate keeper to the National Health Service and to marginalise danger. There must be reason to refer a patient to the Accident & Emergency department. I am satisfied that medical management of headaches does need to be tailored specifically to the diagnosis. It is significant that probably most headache management is self care and 98% of medical management takes place in general practice according to the paper by Leone Ridsdale produced before me from the British Journal of General Practice March 2003. A fetter on uninformed referral at primary care level is protective of patients in reducing exposure to unnecessary procedures and adverse effects and fulfils the need to conserve resources in the National Health Service.

[117] In all the circumstances therefore I have come to the conclusion that the plaintiff has not satisfied me that Dr de Burca was guilty of negligence or that he has failed to act in accordance with practice accepted as proper by a responsible body of medical men skilled in that particular art. In short I am not satisfied that the symptoms of which the plaintiff complained were indicative of SAH or were of sufficient nature to have required reference to the Accident and Emergency Department.

[118] I conclude by saying that in light of my findings it is unnecessary for me to determine whether had Mrs Shaw been admitted to hospital or referred for investigation on 18 October 1999, the major bleed which she experienced could have been prevented.

[119] I therefore dismiss the plaintiff's case.

[120] I add one matter by way of comment in this case. The early passage of the evidence in this case was delayed because liability evidence was not exchanged between the parties until the first medical witness was in the witness box. I invited counsel to consider exchange and both senior counsel, after a short deliberation, agreed to do so. It was then necessary to delay somewhat further to permit Dr Chapman to read the evidence. Nothing was gained by her not having seen the reports before trial because the defence case had to be revealed to her in any event. All it was likely to do was to delay the case and perhaps lengthen her evidence by preventing her dealing immediately with what was the real issue between the parties. I was conscious when she was giving her evidence that even then she had not had the opportunity to consider the defendant's case at leisure. Precisely the same problems would have arisen with the defendant experts. No criticism of the legal advisers of the parties is merited because Order 25 of the Rules of the Supreme Court expressly removes medical and surgical negligence cases from the obligation to exchange such reports. However as both counsel frankly recognised perhaps the time has now arrived when the Civil Justice Reform Committee and the Supreme Court Rules Committee need to reconsider the possibility of exchange of both liability and value reports in clinical negligence cases if the spirit of Order 1 Rule 1A is to be observed and such cases are to be progressed efficiently and economically.