OUTER HOUSE, COURT OF SESSION

[2017] CSOH 31

A377/14

OPINION OF LORD BRAILSFORD

In the cause

MELISSA MALONE

Pursuer

against

GREATER GLASGOW AND CLYDE HEALTH BOARD

Defenders

Pursuer: Clancy QC, McConnell; Drummond Miller LLP
Defenders: Kinroy QC, Khurana; NHS Scotland Central Legal Office

24 February 2017

[1] In this action the pursuer seeks damages in respect of alleged clinical negligence on the part of a consultant haematologist employed by the defenders.
[2] Proof was heard in the case over 10 days between 10 May and 2 June 2016. The proof was confined to issues of liability, the parties having reached agreement in relation to quantum in the event of a finding of liability on the part of the defenders[1].
[3] The pursuer gave evidence on her own behalf. In addition evidence was adduced by the pursuer from five clinicians involved in her care in 2002/3: Dr Mark Drummond, Dr Anne Parker, Dr Grant McQuaker, Dr Andrew Seaton and Dr Smith. The pursuer further adduced opinion evidence from two experts, Dr Barry Valance, consultant physician and cardiologist, Ross Hall Hospital, Glasgow and Dr H W Habboush, consultant haematologist, Royal Glamorgan Hospital, Mid Glamorgan. The defenders led evidence from Mrs Kate Blacklock. Expert opinion evidence was adduced on behalf of the defenders from Dr Peter Bloomfield, consultant cardiologist, Royal Infirmary of Edinburgh, Dr Dominic Culligan, a consultant haematologist and Dr Jane McLennan, a consultant psychiatrist.

Overview
[4] It is possible and, given the relatively complicated factual background, probably helpful to state an overview of the case.
[5] In 2001-2 the pursuer, then aged 25, consulted her GP complaining of a number of non-specific symptoms. The GP performed a number of tests and ascertained that the pursuer was

anaemic. He was unable to determine the cause of the pursuer's anaemia and therefore in February 2002 the GP referred her to the Haematology Department of Glasgow Royal Infirmary ("GRI") for investigation. The pursuer's treatment in that department at GRI is the subject matter of this action and is examined in detail in my discussion of the factual evidence.

[6] The cause of the pursuer's symptomology was, as a matter of fact, an atrial myxoma. An atrial myxoma is a rare, non-malignant tumour of the heart. Whilst atrial myxoma are benign they grow and pieces can break off the tumour and cause a stroke or embolus. Atrial myxoma will be detected if a sufferer undergoes an echocardiogram ("ECG"). As part of the investigation into the cause of the pursuer's anaemia an ECG was instructed by a consultant in the Haematology Department of GRI in August 2002. The purpose of the clinician when instructing the ECG was to exclude the possibility that the pursuer was suffering from sub-acute endocarditis ("SBE"), an infective disease. The pursuer failed to attend the appointment for an ECG. No case of failure to diagnose atrial myxoma is pled in the current action but it was common ground between the parties that had the ECG instructed in August 2002 been performed the pursuer's atrial myxoma would have been detected, treatment given and she would thereafter have avoided a stroke she suffered on 27 October 2006.

[7] The complaints in the present case arise out of the management of the pursuer's care in the Department of Haematology, GRI in 2002-3, the clinician whose actions are criticised being Dr Grant McQuaker, a consultant in that department.

[8] Dr McQuaker is alleged to have fallen below the standard required of him on two separate instances, one in 2002 and the other in 2003. In respect of the first ground it is alleged that Dr McQuaker failed to exercise the skill and care of an ordinarily competent consultant haematologist acting with ordinary skill and care by discharging the pursuer from his haematology clinic on 9 December 2002 without having obtained ECG results previously instructed. The second alleged ground of negligence was an alleged failure by Dr McQuaker to arrange to see the pursuer in May 2003 following referral from the pursuer's general practitioner in April of the same year. A third case is pled against Dr McQuaker alleging that he failed to take reasonable care to ensure that the pursuer was aware of an alternative treatment or investigatory option, an ECG, open to her both in December 2002 and again in 2003.

Factual Evidence

[9] The pursuer gave evidence that in 2001 she had consulted her GP in relation to complaints of weight loss, excessive tiredness and discolouration of her fingers and toes. Blood tests were taken and in August 2001 she was diagnosed as being anaemic. The pursuer's anaemia did not resolve with drug treatment prescribed by the GP and as a consequence on 15 February 2002 she was referred to the Department of Haematology at GRI for an opinion as to whether further investigation was required in order to determine the cause of her amnesia[2].

[10] The pursuer was given a series of outpatient appointments in the said department and attended appointments on 26 March 2002 when she was seen by Dr Marie Hughes[3], 23 April 2002 when she was seen by Dr Mark Drummond[4], 21 May 2002 when she was seen by Dr Fiona Cutler[5], 18 June 2002 when she was seen by Dr Grant McQuaker[6] and 26 August 2002 when she was seen by Dr Anne Parker[7]. Drs Hughes, Drummond and Cutler were specialist registrars in haematology. Drs McQuaker and Parker were consultant haematologists. It should also be noted

that the pursuer was given an appointment in the department for 16 July which she failed to attend.

[11] A number of investigations were conducted on the instructions of the said clinicians in the department into the pursuer's anaemia in the period March to August 2002. The conclusion of these investigations was that the pursuer was diagnosed as suffering from anaemia of chronic disease. Tests were conducted to ascertain the cause of this illness and a number of common infections, inflammatory diseases and malignancies were excluded. The tenor of the evidence was that by August 2002 when Dr Parker saw the pursuer the likely causes of the anaemia had been excluded and Dr Parker had reached the stage where she regarded it necessary to consider unlikely causes for the anaemia and consult with other medical specialities who might be able to offer advice into the underlying cause of the condition. Dr Parker explained this situation to the pursuer's general practitioner in a letter dated 3 September 2002[8]. On the same date Dr Parker wrote a referral letter to Dr Seaton, a consultant in infectious diseases at Gartnaval General Hospital in Glasgow[9]. In that letter Dr Parker described the pursuer's symptoms as known to her and the investigations which had been conducted in her department in the period March-August 2002. In relation to the state of her investigations she stated in the course of the letter:

> "I have arranged for an echo to exclude occult SBE but I am really reaching the end of my investigative limits. I have sent off blood this time for CMV, EBV and toxoplasma and I note that we have not checked Brucellosis or for Lyme disease but would welcome any thoughts that you might have."

The procedure referred to as "an echo" is an echocardiogram designed to exclude the possibility that the pursuer was suffering from SBE, a bacterial infection of the lining of the heart. In her evidence about this letter and her thoughts about the underlying cause of the pursuer's anaemia at this stage Dr Parker stated that she was "scraping the bottom of the barrel trying to diagnose what this was". Her expressed view was that she felt she needed to seek the help of a specialist in either infectious diseases or rheumatology. She said that a specialist in infectious diseases would have greater insight than she possessed on infectious or non-infectious diseases which might cause chronic anaemia. A rheumatologist would have greater insight into causes associated with an underlying malignancy. As between these two options her view was that she could properly have chosen either but having regard to the pursuer's overall clinical presentation she felt that an infection was a more likely cause than a malignancy and therefore she preferred to refer to an expert in infectious diseases than to one in rheumatology.

[12] Dr Seaton saw the pursuer on 12 September 2002 and reported his findings to Dr Parker in a letter dated 13 September 2002[10]. In evidence he stated that he found no clinical grounds to suspect that the pursuer might have SBE. In his opinion the pursuer looked relatively well when she attended his clinic, a factor which he would not expect if she had been suffering from SBE. He examined her heart, and found no murmur, a sign which could be expected in any cases of SBE. As he saw no signs of that illness he took none of the steps such as prescribing antibiotics, taking blood cultures, admitting the pursuer to a ward or expediting the echocardiogram which had been ordered by Dr Parker which he would have done had he considered a diagnosis of SBE likely. In reporting his findings to Dr Parker he said that "[E]xamination today was really unremarkable…". He concluded by stating: "I do not feel I can add very much to your already very thorough

assessment of this lady. I suspect one diagnosis will not explain all the problems." Dr Seaton also made arrangements for the pursuer to have screening for some sexually transmitted infections and indicated to Dr Parker that he had arranged to review the pursuer in his clinic in six weeks time. Dr Seaton subsequently wrote to Dr Parker on 5 December 2002[11] informing her that the pursuer did not attend for her review appointment at his clinic. In the same letter he informed Dr Parker that the tests he had carried out at his meeting with the pursuer in September had resulted in negative findings.

[13] As noted in her letter to Dr Seaton dated 3 September Dr Parker made arrangements for the pursuer to have an ECG in Glasgow Royal Infirmary. The date of that appointment was 7 October 2002. The pursuer failed to attend that appointment. The pursuer was also given an appointment in the Haematology Department as a follow up from Dr Parker's consultation on 26 August. This appointment was scheduled for 8 October 2002. The pursuer failed to attend at that appointment. A further follow up meeting was arranged for 5 November 2002. Again the pursuer failed to attend. As a consequence a third follow up appointment was made for 3 December 2012. The pursuer also failed to attend for this appointment.

[14] The consultant in charge of the Haematology Department outpatient clinic on 3 December was Dr McQuaker. It fell to him to decide what to do in relation to the pursuer who had last been seen in the department on 26 August and had since that date failed to appear for three review appointments. Before making that decision Dr McQuaker read the case notes. The decision which Dr McQuaker took is stated in his letter dated 9 December 2002 to the pursuer's general practitioner[12] in the following terms:

> "This girl has failed to attend the Haematology Clinic on the last 3 occasions she has been given appointments. Given that she has also been seen by the Infectious Diseases Team, I have not sent her out any further appointment for the time being but if you think it is appropriate for us to see her again then please let us know."

[15] In evidence Dr McQuaker said that when he dictated this letter he was aware that there was no result from the ECG ordered by Dr Parker in August 2002. Dr McQuaker further explained that he had interpreted Dr Seaton's letter to Dr Parker dated 13 September as meaning that Dr Seaton did not consider that the pursuer's underlying illness was infective in origin. Having regard to the consideration that SBE is an infective illness he therefore considered that there was no need to obtain the result of an ECG. In cross-examination it was put to him that he should not have discharged the pursuer from the Haematology Department in December 2002 without ensuring that an ECG was carried out. His response to this question was to say:

> "The patient for whatever reason had disengaged with our service. I was reassured by Dr Seaton's letter, and there seemed little value in sending out a further appointment."

He also took issue with senior counsel for the pursuer's characterisation of his actings as amounting to a "discharge" from the haematology clinic. Dr McQuaker's position was that he did not use the term "discharge" in his letter to Dr Notman dated 9 December. The situation he was faced with was not, in his view, one of discharge. He considered a patient to be "discharged" from his department when it had no more to offer that patient. He regarded the situation he faced as different, the pursuer had, for whatever reason, disengaged from contact with the department. He

was aware of no current clinical risk to the pursuer. He advised the pursuer's general practitioner of the position leaving it open to that clinician to arrange a future appointment for the pursuer if he considered it appropriate.

[16] Dr Parker, who dependent on the clinician's rota could have been the consultant in charge of the Haematology Department outpatient clinic on 3 December, was asked how she would have dealt with the situation if she had discovered on that date that the pursuer had not attended her last three appointments in the outpatient clinic and had also seen Dr Seaton's letter dated 12 September 2002. Her position was that she would have done the same as Dr McQuaker.

[17] There was some evidence in relation to the issue of whether or not the pursuer received appointment letters relative to her missed appointments in the Haematology Department and the missed appointment for an echocardiogram. Mrs Kate Blacklock, formally the Heath Records Manager at GRI who retired in August 2015 gave evidence that in 2002-3 she was employed in the hospital as the senior supervisor in the Health Records Department. Her department was responsible for outpatient appointments. She indicated that her department were responsible for arranging appointments in the Haematology Department. Her department also covered cardiology, although she qualified this by saying that she did not know if that extended to the making of appointments for ECG's. For the avoidance of doubt she explained that her department had no responsibility for appointments at Gartnavel Hospital. She explained the operation of the system whereby case files for appointments in the Haematology Department outpatient clinic would be prepared in advance and made available on the morning of the clinic for the clinicians who would therefore have sight of records in advance of attendance on patients. A number of doctors attended each clinic. Patients would be dealt with sequentially, the applicable doctor collecting the file when a patient was allocated to him or her. At the end of the clinic if patients had failed to attend, a not uncommon occurrence, their files would remain on the desk of the outpatient clinic receptionist. The file would then be marked "DNA", denoting "did not appear" and a decision would be made by a clinician as to whether an alternative appointment should be made or, in the alternative, some other action should be taken. So far as she could determine from examination of the relevant case notes this procedure had been followed in relation to the appointments in the Haematology department which the pursuer failed to attend in 2002.

[18] The pursuer was questioned about her failure to attend her appointments in 2002 in the Haematology Department and for an ECG. She stated that she "didn't remember an appointment for an echocardiogram". She also said that "I would have kept an appointment for an echocardiogram if I had received one". When it was put to her that she missed three appointments after August 26 in the Haematology Department outpatient clinic she accepted that she missed "one or two" appointments. She explained this by saying that she was "getting frustrated about getting no answers". She then went on to state "maybe I did miss appointments". She ultimately accepted that she may have missed appointments but simply could not remember the details.

[19] Following Dr McQuaker's letter dated 9 December 2002 the next involvement of the Haematology Department at GRI with the pursuer was in April 2003. The pursuer had no contact with her general practitioner between 14 October 2002 and 18 February 2003. On 20 March 2003 the pursuer attended her general practitioner complaining of, amongst other symptoms, right arm pain, intermittent paresthesia, and discolouration of the fingers. Bloods were taken at that visit and on receipt of the results of these tests her general practitioner, Dr Smith, wrote a referral letter

dated 7 April 2003 to the Haematology Department at GRI[13]. The letter drew to the reader's attention that the pursuer had been investigated the previous year in the department and then proceeded:

> "She has had recent new symptoms of tingling in her right forearm and cyanosis of her right and little finger of her right hand. This has been going on for two or three months but has become more intense recently and it is not related directly to temperatures. Her CRP is still raised at over 50 and her ESR has fallen to 12. Blood tests show she is no longer anaemic but in view of this new and rather worrying symptom I would be grateful if she could be seen again at your clinic as no firm diagnosis was ever reached."

On receipt of the letter its terms were apparently considered by Professor Walker, head of the department and referred to Dr McQuaker, as a matter of inference because he was the last treating clinician to have considered the pursuer's case notes. Dr McQuaker's evidence on this matter was that he saw the letter and reviewed the pursuer's notes. Thereafter he telephoned Dr Smith, which he said was an unusual thing for a consultant to do. His reason for taking this course was that his consideration of the case notes and the pursuer's new symptoms led him to form the view that the pursuer's complaints had the appearance of a vascular condition rather than being due to any haematological problem. He was also aware, having considered Dr Seaton's letter of September 2002 in the file, that no infectious cause for the pursuer's underlying condition had been found. He also considered that all avenues for a possible haematological explanation for the underlying symptomology had been excluded. For all these reasons he considered there was little point in having the pursuer attend an outpatient clinic in the Haematology Department. He thought that would only have led to the pursuer being referred therefrom to another department. His view was that it made more sense both clinically and as a matter of practicality if the pursuer was seen in the rheumatology department. His recollection was that he discussed all these issues with Dr Smith, andthat the conversation lasted approximately 10 minutes. At the conclusion of the conversation he understood that Dr Smith had agreed with his reasoning and, further had agreed to refer the pursuer to the rheumatology department at GRI.

[20] Dr Smith confirmed that he had had a telephone conversation about the pursuer with Dr McQuaker. His notes indicated that this conversation took place on 5 May 2002. His understanding of Dr McQuaker's position was that having reviewed the patient's notes the consultant thought that the pursuer's problem was not primarily haematological. The doctors agreed that they discussed the findings reported by Dr Smith in his referral letter and in particular the discolouration of the pursuer's fingers. They agreed that the likely cause was rheumatological, a number of potential diagnoses being discussed. At the end of the discussion they came to the conclusion that it would be appropriate for Dr Smith to refer the pursuer to the rheumatology department. Dr Smith described his agreement to this course as being "consensual". Following this conversation Dr Smith wrote to the rheumatology department asking for an appointment for the pursuer by letter dated 9 May 2003[14]. The pursuer was subsequently given a routine appointment in the Centre for Rheumatic Diseases, GRI for November 2003 but failed to attend for that appointment[15].

Opinion Evidence

[21] The pursuer adduced evidence from Dr Barry Vallance, a consultant physician and cardiologist. Dr Vallance had retired from full time clinical practice in 2012 but since that time had practiced as a locum consultant physician and cardiologist at Hairmyres Hospital, East Kilbride. Dr Vallance produced a report relative to the pursuer's treatment in GRI in 2002/2003, the report being dated 30 December 2009. He also produced a supplementary report dated 15 March 2010. Dr Vallance spoke to both these reports in his evidence.

[22] In relation to the pursuer's attendances and treatment at GRI in 2002 Dr Vallance initially summarised the relevant history. He had regard to Dr Parker's involvement and noted that she had considered a diagnosis of SBE and instructed investigation with an ECG. He agreed that this course of action was appropriate. He noted that the ECG "appeared never to take place". He expressed the opinion that Dr Parker was negligent for not ensuring that the ECG was performed. It was his opinion that all consultants have a responsibility to have robust systems in place to ensure that all results of tests requested are received and acted upon. The involvement of Dr McQuaker was not considered by Dr Vallance in his first report but in his second report this issues was addressed. There he noted that Dr McQuaker had considered the position of the pursuer in December 2002 and in his letter to the pursuer's general practitioner dated 9 December 2002 had noted that the patient had failed to attend the haematology clinic on three occasions. Dr Vallance's opinion was that

> "...it was incumbent upon Dr McQuaker to have reviewed the previous record and note that the echocardiogram result was not as yet available, ascertain why and point this out to Dr Parker who had made the initial request for the echocardiogram."

He further considered that both doctors Parker and McQuaker had failed to recognise and document that the pursuer had failed to attend for the ECG and in those circumstances he considered that both should have reappointed her for the ECG and let the pursuer's GP know that she had failed to attend for this appointment. Still further, he considered that the pursuer should have been written to informing her of the missed appointment for the ECG and that she was being reappointed.

[23] The pursuer adduced opinion evidence from Dr Husni Habboush, a consultant haematologist. Dr Habboush produced his *curriculum vitae*[16]. Dr Habboush had practiced as a haematologist between 1979 and his retiral approximately 15 months prior to giving evidence. His last clinical appointment was in the Clinical Haematology Department at the Royal Glamorgan Hospital. For the purposes of proof he produced a report, which was undated but had attached to it a covering letter dated 16 November 2014[17].

[24] In relation to the pursuer's 2002 attendances at GRI Dr Habboush considered the relevant history. He noted Dr Parker's consultation with the pursuer on 26 August 2002 and made no criticism of that. He expressed the opinion that the instruction by Dr Parker of an ECG to exclude SBE was appropriate albeit he considered that that possibility was "rather remote". He then considered Dr McQuaker's consideration of the pursuer's case in December 2002. He noted that by that stage the pursuer had failed to attend for three appointments in the haematology outpatient clinic and that against that background Dr McQuaker had, in Dr Habboush's view, discharged the pursuer from further attendance at the clinic without considering the clinical suspicion of SBE

raised by Dr Parker and/or the fact that the ECG was either outstanding or had not been carried out. Dr Habboush's view was that that constituted negligence. No reason for that expression of opinion was stated in his report however in oral evidence he elaborated and said that Dr McQuaker should have written to the pursuer's GP informing him that ECG had not been performed and asking the GP to arrange for his patient to attend for that procedure.

[25] In relation to the pursuer's attendance at GRI in 2003 Dr Habboush noted the pursuer had developed new symptoms including tingling in the right forearm and cyanosis in the right ring and little fingers and that her GP had referred the pursuer back to the Haematology Department at GRI. He also noted that Dr McQuaker had discussed this referral with the general practitioner, had advised the GP that referral to the rheumatology department was more appropriate but did not make arrangements to see the patient himself. Dr Habboush expressed the opinion that this was negligent practice. In stating this opinion he acknowledged that the pursuer's anaemia appeared to have resolved by that stage but in his view "the new symptoms especially the cyanosis should have prompted an urgent clinical assessment particularly to exclude a thrombotic event or an embolic disorder". He also considered that Dr McQuaker had failed again to notice that the ECG had not been carried out. He criticised Dr McQuaker's recommendation to refer to rheumatology "without a proper and up to date clinical evaluation". In cross-examination it was put to Dr Habboush in dealing with the pursuer's clinical history in 2003 he had stated in his report that the pursuer's inflammatory markers "persisted to rise"[18]. It was put to him that no such information appeared in the pursuer's clinical case notes and that his statement was incorrect. He accepted this and further accepted that he did not check the clinical notes in relation to the inflammatory markers before making the said statement. It was also put to him that in his repot he had criticised Dr Seaton for noting the presence of an audible fourth heart sound at his examination in September 2002 but not appearing to have taken that factor into consideration and not commenting upon it particularly in circumstances when SBE was one of the suspected illnesses. In his oral evidence he said that Dr Seaton was on "the verge of negligence" in not seeking cardiology advice about the fourth heart sound. In cross-examination he conceded that he himself did not know that the fourth heart sound had no sinister significance and was not a sign of SBE.

[26] Dr Peter Bloomfield gave opinion evidence on behalf of the defenders. He had prepared a report dated 1 June 2015[19] and produced his *curriculum vitae**[20]*. Dr Bloomfield held the position of consultant cardiologist at the Royal Infirmary and Western General Hospitals, Edinburgh between 1989 and April 2013 when he retired. Since 2013 he has been a locum consultant cardiologist at the Royal Infirmary in Edinburgh and Borders General Hospital in Melrose. He has published extensively on the subject of echocardiography both in peer reviewed articles and in medical textbooks. He was part of a team which set up and thereafter operated the ECG service in Edinburgh Royal Infirmary and the Western General Hospital. For the purposes of preparing his report and giving his evidence he considered the pursuer's medical case notes and also had regard to reports prepared for the present case provided by Dr Culligan and Dr Vallance.

[27] At the outset of his evidence Dr Bloomfield explained the difference between infective and non infective endocarditis. He described infective endocarditis as an acute process in which infection attacks the heart valve. By contrast non infective endocarditis was an inflammatory process causing damage to a heart valve.

[28] In relation to the pursuer's attendance at GRI in 2002 Dr Bloomfield noted that an "...echocardiogram was requested because Dr Parker was considering the possibility of endocarditis as a cause of the anaemia and the raised inflammatory markers." He noted that the pursuer failed to attend for her ECG and, further, failed to attend for three repeat appointments in the haematology clinic. He also noted that the pursuer failed to attend for follow up appointments at the infectious diseases clinic and subsequently at an appointment in the rheumatology clinic. Dr Bloomfield's opinion was that the pursuer had therefore failed to attend "...for five of six consecutive clinic appointments as well as the appointments for the echocardiogram". His view was that having regard to those considerations on the balance of probabilities she would have failed to attend for a further ECG appointment had that been made. Dr Bloomfield then went on to consider the disease process involved in cases of endocarditis. His evidence was that "the overwhelming majority of patients" suffering from this condition will have a heart murmur and that none was recorded in the present case. He noted that some patients suffering from the disease will have elevated white blood cell count but in the pursuer's case this factor was normal on all occasions it was recorded. He stated that in all patients suffering from the disease the CRP will be elevated, often to very high levels, but that "...it does not rise and fall spontaneously and usually only falls when successful antibiotic treatment has been started." These features were again absent in the pursuer's case. He stated that it was recognised that there was commonly a delay between onset of symptoms and diagnosis of SBE. He cited a number of studies to support this proposition[21]. In relation to symptomology his opinion was that the majority of suffers had symptoms of fever and malaise. The large majority had a heart murmur, stigmata of endocarditis and abnormal blood tests. In the present case his view was that on the basis of Dr Seaton's examination in September 2002 there were no stigmata of endocarditis. None of the examining physicians in 2002 had detected a heart murmur. He also noted that the pursuer's white blood count was persistently normal and that CRP rose and fell rather than, as he considered would be expected in a case of endocarditis, remaining persistently elevated. His last observation in relation to symptomology was that "[T]he duration of symptoms extending over two years make it inconceivable that the patient's problem could have been related to underlying endocarditis." On the basis of all this clinical information it was Dr Bloomfield's opinion that in December 2002 at the time when Dr McQuaker considered the pursuer's case there were no signs of SBE. In expressing this opinion Dr Bloomfield was asked to consider the terms of Dr Seaton's letter of 9 September 2002. Dr Bloomfield's construction of what Dr Seaton was saying was that he saw none of the stigmata of SBE and no signs that there was an infective process. Dr Bloomfield regarded it as "a perfectly sensible letter". Having regard to all these considerations Dr Bloomfield made no criticism of Mr McQuaker's decision in December to offer the pursuer no further appointment and inform her GP that he could re-refer if thought appropriate.

[29] In relation to the pursuer's treatment in 2003 Dr Bloomfield noted that the GP re-referred her to the Haematology Department with new symptoms of tingling in her right forearm and cyanosis of her right ring and little finger on her right arm. He noted that the GP reported that the pursuer's CRP was still raised at 50 but that the ESR had fallen to 12. He also noted that the GP stated that the patient was no longer anaemic. In considering Dr McQuaker's decision to discuss the case with the GP and suggest referral to a rheumatologist Dr Bloomfield examined in detail in his report the pursuer's clinical history. As had been his position in relation to the events of

December 2002 he saw no evidence of an infective process. He also noted that in May 2003 Dr McQuaker, a specialist haematologist, "did not feel that there was a haematological cause for the patient's abnormal blood results and symptoms". As a cardiologist he was of the opinion that there would have been no useful purpose in pursuing investigation by ECG at this stage. It followed that since haematological issues and the possibility of infectious disease had been fully considered by this stage the logical course was to continue investigation by means of rheumatological investigation. In these circumstances he considered that Mr McQuaker's decisions in May 2003 were both reasonable and appropriate clinical procedure.

[30] The defenders adduced evidence from Dr Dominic John Culligan, whose *curriculum vitae* was produced[22]. Dr Culligan qualified as a doctor in 1989 and obtained an MD in 1994. His professional practice has always been in haematology and he has held the positon of consultant haematologist with NHS Grampian and honorary senior lecturer with the University of Aberdeen since 1996. He has published extensively in peer reviewed publications on the subject of haematology. For the purposes of giving evidence he had considered the pursuer's clinical case notes. He noted that in September 2002 Dr Parker had considered that she had almost exhausted haematological investigation of the pursuer's chronic anaemia and consequently wrote to Dr Seaton seeking his advice on the possibility of infective causes of this condition. He considered the terms of Dr Parker's referral letter. He thought it was "a very good letter" and that it summarised the comprehensive investigations which had been carried out in the Haematology Department at GRI during the course of 2002. From his assessment of the investigations carried out in that department during that time period he considered that there were no signs of SBE. He considered that the possibility of there being SBE was "a long shot". He however thought that it was consistent with Dr Parker's thorough investigation that she should seek to investigate this possibility. The same reasoning applied to his view that seeking an ECG was a reasonable course for Dr Parker to undertake. He considered the terms of Dr Seaton's reply following his consultation with the patient in September 2002. His view was that there was "nothing in the letter to suggest an infective source of the anaemia." Dr Culligan's reading of the letter was that Dr Seaton was saying that he has saw no signs of infection. Dr Culligan considered this would be how any haematologist would interpret the letter. In consideration of Dr McQuaker's management of the pursuer's case in December 2002 Dr Culligan thought that the views he had expressed in relation to the correspondence between Doctors Parker and Seaton guided his consideration of Dr McQuaker's actions. He considered that having regard to the factors examined in Dr Seaton's letter it was reasonable for Mr McQuaker to think that the necessity for an ECG had been superseded. Having regard to the number of occasions on which the pursuer had failed to attend for appointments in the haematology outpatient clinic and the clinical picture as known to him at the time he considered that Dr McQuaker's actions were within the range of decisions that one could reasonably expect from an ordinarily competent haematologist exercising ordinary care and attention to his patient.

[31] In relation to the pursuer's re-referral to the haematology clinic in April 2003 he considered that having regard to all factors known to Dr McQuaker by that time the decision to recommend investigation by a rheumatologist who would be best placed to consider an inflammatory source of the underlying symptomology was reasonable. He again considered that the decisions taken by

Dr McQuaker at that time were within the rage of decisions that could be reasonably expected from an ordinarily competent consultant haematologist exercising ordinary care.

[32] The defenders also adduced opinion evidence from Dr Jane McLennan, a consultant psychiatrist. Dr McLennan had examined the pursuer and produced two reports for this case, the first dated 2 October 2015[23] and a supplementary report dated 5 January 2016[24]. She was, relatively briefly, examined and cross-examined when she spoke to these reports. In the event the principal function of Dr McLennan's evidence appeared to be to throw some light on the pursuer's history of failing to attend for medical appointments. Having regard to that consideration I can be very brief in dealing with Dr McLennan's evidence. On the basis of Dr McLennan's examination of the pursuer's medical record's she expressed the opinion that the pursuer had experienced psychological difficulties, anxiety and low mood on a number of occasions. Most pertinently in 2001 she was diagnosed with anxiety and depression. In 2002 the pursuer again had depressive symptoms which resulted in the prescription of medication. Dr McLennan also noted that the pursuer's GP notes stated that she was chronically depressed in 2003 and that there was reference to her failing to attend appointments made by the Community Mental Health Team. Notwithstanding this background Dr McLennan gave evidence that when directly asked about depression and psychiatric symptoms the pursuer denied ever having experienced the same.

Submissions

(i) Pursuer

[33] Senior counsel for the pursuer submitted that the circumstances of the present case were "unusual, perhaps unique". This was not a case where there was a general or approved clinical practice. The question for the court was accordingly whether, having regard to all the circumstances of the case, Dr McQuaker's acts and omissions were negligent. Having regard to that consideration it was submitted that an accurate summary of the law is to be found in the now well-known opinion of Lord Hodge in *Honisz* v *Lothian Health Board*[25].

[34] Senior counsel for the pursuer then addressed the issue of the pursuer's discharge from attendance at the haematology clinic by Dr McQuaker in December 2002 without following up Dr Parker's instruction for an ECG in August 2002. The relevant starting point was said to be a consideration of Dr McQuaker's state of knowledge as at the time. It was submitted that Dr McQuaker was aware that the pursuer had a long history of symptoms of illness and that he recognised that her anaemia of chronic disease was secondary to an unknown underlying cause which could be infective, a neoplasm or an inflammatory disease process. The pursuer's symptoms were sufficiently serious to have made her seek treatment from her general practitioner who had in turn referred her to haematology. She had undergone a number of tests and attended consultations in that department. These tests showed that her ESR and CRP blood markers were "significantly deranged". Dr McQuaker should also have been aware that during the period when investigations were undertaken in the Haematology Department the pursuer's blood markers were deteriorating. Dr McQuaker would also have been aware that by the time of Dr Parker's consultation in August 2002 most avenues of haematological investigation had been eliminated. As a consequence of this it would again have been apparent that investigation was being extended to "very unlikely causes and into areas of medicine beyond primary haematological disorders." He would have known that one possible cause of the pursuer's symptoms was SBE and, further, that

that condition was potentially fatal. He knew that Dr Parker had recommended that the pursuer undergo an ECG in order to exclude SBE and that Dr Seaton had been asked by Dr Parker to assist in the exclusion of infective causes. He would be aware that Dr Seaton had written back to Dr Parker and advised her that he was interested in the results of the ECG. In relation to this aspect senior counsel submitted that "crucially Dr Seaton had not excluded the possibility that the pursuer was suffering from SBE". He further submitted that the results of Dr Seaton's own investigations into possible infective causes were still outstanding and that the ECG had not been performed. Having regard to all these features it was submitted that Dr McQuaker erroneously interpreted Dr Seaton's letter as excluding SBE and that in doing in so he erred. In regard to this it was said that the evidence from Dr Bloomfield as to whether it was likely or possible that the pursuer might have SBE in December 2002 was "essentially irrelevant" because the various clinical considerations taken into account by Dr Bloomfield did not feature in the thinking of Dr McQuaker.

[35] Senior counsel also submitted that regard had to be had to the consideration that Dr McQuaker had no knowledge of why the purser had not attended appointments made for her for an ECG and re-attendance at the haematology clinic. He was aware that the general practitioner did not know that the pursuer had not undergone an ECG and, further, was unaware of Dr Seaton's findings. He was aware that he himself had not seen the outcome of Dr Seaton's blood test investigations and could not therefore rule out all infectious causes. Lastly, it was submitted that he could have determined from the clinical case notes that the purser had not been told in writing what the purpose of the ECG was.

[36] Having regard to all these features it was the submission of senior counsel that Dr McQuaker was negligent in discharging the pursuer on the footing that the GP could re-refer if he thought it appropriate to do so. In making this submission counsel submitted that in his own evidence Dr McQuaker accepted that if his interpretation of Dr Seaton's letter was wrong he would not have discharged the pursuer and would have pursued the question of the ECG. On that basis the negligent misreading of Dr Seaton's letter is of itself enough to establish that Dr McQuaker's discharge was also negligent.

[37] In relation to Dr McQuaker's decision not to see the pursuer in May 2003, the pursuer's submission was that "it has long been established that it is a doctor's duty to see a patient"[26]. A general practitioner having considered, in the exercise of his professional judgement, that the pursuer should be referred to haematology it was Dr McQuaker's duty to see the patient. This was elaborated by stating that by this stage Dr McQuaker knew or ought to have known all the matters referred to in relation to the first case of negligence, that the pursuer had developed new symptoms of cyanosis and tingling, that these symptoms were deteriorating and were of concern to the GP, that these symptoms might have been caused by, amongst other conditions, a thrombotic or embolic disorder or by vasculitis. Moreover Dr McQuaker would have been aware from his conversation with the GP that since that person had written his referral letter the pursuer had again become anaemic and that he could not be aware of the extent of that condition without himself examining the pursuer.

[38] The pursuer advanced a third ground of alleged negligence in relation to the courses of treatment that Dr McQuaker implemented in December 2002 and April 2003. The case was that it was Dr McQuaker's duty to take reasonable care to ensure that the pursuer was aware of any

material risks involved in recommended treatments and of any reasonable alternative or variant treatments or reasonable investigatory options open to her. The treatments or investigatory options that were recommended by Dr McQuaker were, in December 2012, discharge from the haematology clinic and in April 2003 referral to a rheumatologist. It was submitted that in each case the alternative was an ECG and that possibility was not explained to the pursuer. Further there was no attempt to explain to the pursuer the risk she was taking in not going for an ECG.

[39] The issue raised in this case, which had been added shortly before the proof by way of Minute of Amendment, is said to come within the ambit of the law in relation to informed consent as established in the decision in *Montgomery* v *Lanarkshire Health Board*[27]. The relevant passage in that decision was submitted to be at paragraph [88] in the Opinion of Lords Kerr and Reid as follows:

> "An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable case to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it."

The submission was that the discharge which was said to have occurred in December 2002 constituted "treatment". Further an ECG also constituted "treatment". It was said that the risks involved in the pursuer being discharged were the risk that if she suffered from a condition that the ECG would have detected, in particular SBE, then that condition would go undiagnosed. That was said to constitute a material risk and that ought to have been explained to the pursuer before she was discharged from haematology. A reasonable alternative of a variant treatment was an ECG. If Dr McQuaker was minded to discharge the pursuer from the haematology clinic he ought to have explained to her that there was clearly an inflammatory process going on within her and that the same required to be fully investigated. He should have told her that these investigations were necessary in order to exclude the very unlikely possibility that she had a serious heart condition. He should further have explained to her the choice between ECG and discharge and the relative risks associated with each. Senior counsel said, correctly, that there was common ground between the parties that he did not do so. Senior counsel suggested that there were a number of ways he could have discharged this obligation, by contacting the pursuer or by writing to her GP. Failure to take either of these courses was said to constitute breach of duty.

[40] Senior counsel lastly addressed the issue of causation. The submission was, understandably, very brief. Having regard to matters agreed between the parties there is no dispute that if the pursuer had undergone an ECG prior to suffering a stroke the existence of the atrial myxoma would have been determined, appropriate treatment undertaken and the stroke she suffered in 2006 would have been avoided. It follows from this that the only remaining question in relation to causation is whether if Dr McQuaker had fulfilled the duties said to be incumbent upon him the pursuer would have undergone an ECG. In that regard senior counsel relied upon the pursuer's own evidence that if she had received an appointment for an ECG she would have

attended. If the court held as a matter of fact that she did receive an appointment senior counsel relied upon the pursuer's evidence that had she known that an ECG was concerned with the health of her heart she definitely would have attended.

(ii) Defenders

[41] The defenders' submission was that there was no negligence by Dr McQuaker either in December 2002 or in May 2003. Separately it was contended that if, contrary to the primary submission, Dr McQuaker was in breach of any of the duties averred by the pursuer that breach did not cause or contribute to the pursuer failing to undergo an ECG prior to her stroke on 27 October 2006. The third line of defence advanced was that in any event the pursuer was not entitled to damages for the consequences of not having undergone an ECG examination prior to 27 October 2006 on the basis that it was not reasonably foreseeable by Dr McQuaker that the pursuer might have had an atrial myxoma. It was not within the scope of his duty to guard against that risk. In the alternative the injury suffered by the pursuer was too remote to sound in damages.

[42] The defenders' submission was developed by pointing out that the pursuer never had SBE. The pursuer had an atrial myxoma. It was accepted by all experts that this is an extremely rare condition. That explains why despite exhaustive medical investigation the condition was not diagnosed. When the pursuer was seen in the Haematology Department at GRI in 2002 she had a number of non-specific symptoms. In addition she had some non-specific abnormalities of inflammatory markers. It proved impossible to diagnose the pursuer's condition, a matter about which no complaint is made by the pursuer. In 2002 the haematologists at GRI diagnosed the pursuer as suffering from the anaemia of chronic disease. In the context of the pursuer's case that was said to be most likely to be anaemia consequent upon chronic infection, inflammation or malignant disease. By the time the pursuer was seen by Dr Parker in late August 2002 systematic testing in the Haematology Department for the more common infections, inflammatory diseases and malignancies had been undertaken. Dr Parker was at, or very close to, the limits of her clinical resources in the Haematology Department. She instructed the performance of an ECG, the sole purpose of this being to screen the pursuer for SBE. That illness was outwith Dr Parker's specialty. She did not consider it likely that the pursuer had SBE, she had none of the signs of that illness and her symptoms were consistent with other illnesses as well as SBE. Screening by ECG for SBE was, to use Dr Parker's language, a "long shot". She simultaneously referred the pursuer to Dr Seaton, who was a specialist in infectious diseases. Dr Seaton saw the pursuer and reported his findings and views to Dr Parker. Dr Parker's interpretation of what she was told was that Dr Seaton did not think that the pursuer had SBE.

[43] The submission of senior counsel for the defenders was that shortly after she had seen Dr Seaton "the pursuer ceased to co-operate with the investigation into her illness". It was submitted that the pursuer knew about but failed to attend three consecutive appointments in the haematology outpatients department, on 8 October, 5 November and 3 December 2002. She also knew about the ECG appointment on 7 October 2002 and a review appointment with Dr Seaton on 24 October 2002 but failed to attend both of these. The position was therefore, on the basis of this submission, that Dr McQuaker required to make a decision about the pursuer after her failure to attend the third outpatient appointment on 3 December 2002. It was submitted that he read her case notes and concluded that it was unlikely that offering a fourth appointment would secure her

attendance at the outpatient clinic. At this stage he knew that an ECG had been ordered but that there was no result from it. Dr McQuaker's evidence was that as a result of the passage of time he cannot recall whether he knew that the pursuer had failed to attend the ECG appointment. He did consider the terms of Dr Seaton's letter to Dr Parker dated 12 September and on the basis of that letter considered that the need for an ECG was superseded. His understanding of the letter was that Dr Seaton had found no clinical grounds to suspect that the pursuer might have SBE. That decision was correct. Against that background Dr McQuaker wrote his letter dated 9 December to the GP explaining that as a result of her failures to attend he was not arranging another appointment for the pursuer and leaving it open to the GP to seek a further appointment if thought appropriate. When writing this letter it was Dr McQuaker's clinical judgement that there was no reason based on the pursuer's history and what were described as "her nebulous, non-specific symptoms" to suppose that she had an acute illness. The submission was that Dr McQuaker's reasoning was correct. Moreover it was reasonable for Dr McQuaker to suppose that if the pursuer's symptoms became more pronounced she would go back to her GP, which was in fact what she did in February 2003. Dr McQuaker's actions were submitted to be within the range of responses one could reasonably expect from an ordinarily competent haematologist in the circumstances.

[44] In relation to the events of March and April 2003 it was submitted that the symptoms and signs noted by the pursuer's GP in March 2003 were consistent with inflammatory disease. That was the view formed by Dr McQuaker when considering the GP's referral letter. He further considered that the most appropriate speciality to undertake the task of diagnosing a cause for such inflammatory symptoms was rheumatology. He regarded a thrombotic event in a woman of the pursuer's age to be much less likely than that the symptoms she was experiencing were the inflammatory progression of the original underlying illness. Dr McQuaker did not consider that the new symptoms might be SBE. The symptoms complained of by the pursuer were not symptoms of SBE. She had no symptoms of SBE and in any event he had already formed the view in December 2002 that Dr Seaton had ruled out SBE as a likely cause. It was submitted that Dr McQuaker's reasoning was correct. His suggestion of referral to rheumatology was because that was the best place to obtain specialist advice on inflammatory disease. He also considered that rheumatologists were specialists in diagnosing illness from vague symptoms and non-specific abnormalities of inflammatory markers. His overall view that there was no benefit in giving the pursuer an appointment in the Haematology Department which would only have occasioned further delay. Dr McQuaker's reasoning on all these matters was said to be correct. It was pointed out that the GP's referral letter resulted in a non-urgent appointment, a number of months later, being made by the rheumatology department and that this was indicative of an assessment by a clinician in the rheumatology department that there was no emergency, or indeed particular urgency, in seeing the pursuer. Having regard to all these factors the submission was that what Dr McQuaker did was within the range of responses one could reasonably expect from an ordinarily competent consultant haematologist.

[45] Senior counsel for the defenders advanced a further argument that it was not within the scope of Dr McQuaker's duty to diagnose an atrial myxoma. The pursuer had not however advanced an argument that Dr McQuaker was in breach of duty in that regard and therefore I do not require to consider the defenders' submission in this regard.

[46] The defenders' overall position was that the sole cause for the pursuer not undergoing an ECG prior to her stroke on 27 October 2006 was her failure to attend the ECG appointment on 7 October 2002. It was further submitted that, in any event, there was no basis upon which it could be found that the pursuer would have attended a second ECG appointment if one had been offered to her.

[47] A final aspect of the defenders' submissions requires to be addressed. Detailed submissions were made in relation to the reliability and credibility of witnesses. It was submitted that Dr Drummond, Dr Parker, Dr McQuaker, Dr Seaton, Dr Smith, Dr Bloomfield and Mrs Blacklock were reliable and credible witnesses. The court was invited to make adverse findings in relation to the reliability of the pursuer, Dr Valance and Dr Habboush.

[48] So far as the pursuer was concerned it was submitted that on the basis of her medical records between as early as 1996 and as late as 2015, entries within that span of time having been considered by Dr McLennan, there were numerous appointments marked "DNA" denoting did not appear. The pursuer was questioned on these and had, it was submitted, no plausible explanation for repeated failures to attend medical appointments. It was pointed out that the pursuer even went so far in evidence as to state that a letter recording a DNA might have been made up fraudulently, a suggestion which was submitted to be "wholly implausible". Moreover, it was submitted that the pursuer failed to tell, effectively concealed from, Dr McLennan, her pre-stroke psychological and psychiatric history. When faced with entries showing that she had complained of psychological and psychiatric symptoms on a number of occasions prior to the stroke in 2006 she attempted to place the cause of this on the atrial myxoma from which she was, admittedly, suffering. This was both implausible and contradictory to what she had told other doctors. It was also submitted that the pursuer had no real memory of her medical appointments and investigations in 2002/3, something which she was said to have "more or less" said during her evidence.

[49] Beyond this the submission was that, in regard to demeanour, she was "argumentative and querulous in cross-examination". She was said to be "plainly embittered" by the effects that the stroke she suffered in 2006 had upon her and that she "patently blames" this on the medical profession. In conclusion on this chapter the submission was that "[T]he pursuer's evidence about the extent and cause of her psychological and psychiatric history pre-stroke was tendentious and driven by a bitter desire to blame everything on her atrial myxoma going undiagnosed."

[50] Dr Valance was categorised by senior counsel for the defenders as being "not an impressive witness". He was said to have been "argumentative and dogmatic" in cross-examination. It was said that parts of his evidence were illogical and inconsistent and as a result the reliability of his evidence was questionable. For these reasons it was submitted that the evidence of the other doctors, with the exception of Dr Habboush, should be preferred to the evidence of Dr Valance where contrary opinions were expressed. Criticism was made of the fact that in his original report of 30 December 2009[28] no criticism was made of Dr McQuaker, only Dr Parker was criticised. In his second report dated 15 March 2010 Dr McQuaker was only criticised for the decision in his letter dated 9 December 2002. The only time he criticised Dr McQuaker for his actings in May 2003 was in the course of his evidence in this case. It was put to Dr Valance that despite accusing Dr Parker of negligence in his original report the ground of negligence he identified was not supported by Dr Habboush, the pursuer's own haematological expert. Notwithstanding the fact

that an appropriately qualified expert did not support his (Dr Valance's) allegation of negligence against a haematologist, Dr Valance declined to reconsider the view he had expressed in his original report.

[51] Senior counsel for the defenders characterised Dr Habboush as "a thoroughly unsatisfactory witness". He submitted that the doctor was argumentative and "obviously partisan". The doctor's evidence was said to be "often contradictory and illogical" and that he "often equivocated when asked a straightforward question". For these reasons the submission was that the reliability of Dr Habboush's evidence was "highly questionable" and that where it conflicted with the evidence of other doctors the evidence of the latter should be preferred.

[52] In relation to Dr Habboush's alleged unreliability senior counsel offered the example that Dr Habboush had asserted in evidence that Dr Parker had not told the pursuer about the significance or importance of the ECG she was to have. On further questioning the doctor accepted that this was an inference he made from consideration of the medical records. It was submitted that silence in medical records does not infer anything about what Dr Parker may or may not have said to the pursuer. It was accordingly an unwarranted assertion made on the part of Dr Habboush.

[53] It was further submitted that in his written report[29] Dr Habboush had made a material error in the reporting of the pursuer's inflammatory markers in April 2003. In the report he said in relation to this period "…the inflammatory markers persisted to rise"[30]. In cross-examination on this statement he stated that he could not remember whether he had checked the inflammatory markers himself and ultimately accepted that what he said in his report about them was incorrect. It was submitted that was carelessness on an important issue. This error was compounded because Dr Habboush's evidence-in-chief included the statement that rising inflammatory markers were relevant. Moreover, at least partially based upon this evidence his position was that as late as April/May 2003 the pursuer's symptoms could have been caused by SBE. This was not only inconsistent with the other medical evidence in the case but was, at least to some extent, based on his incorrect interpretation and evidence about inflammatory markers at that time.

[54] Senior counsel further submitted that Dr Habboush was "cavalier" in his suggestions of negligence. He said in evidence that Dr Seaton was "on the verge of negligence" in not seeking cardiology advice on hearing a fourth heart sound when examining the pursuer but later conceded that he himself did not know that a fourth heart sound has no sinister significance in a patient like the pursuer and, further, was not a sign of SBE. It was also submitted that Dr Habboush stated in evidence that if the pursuer's GP had referred her to the Haematology Department in the spring of 2003 when the appropriate referral was to the rheumatology department then that would constitute negligence. Counsel characterised that approach as "simplistic and precipitate" having regard to the communications between the GP and Dr McQuaker after the initial referral to haematology.

[55] Further criticism was made of Dr Habboush's evidence in relation to a spontaneous remark made in examination-in-chief, in response it was accepted by counsel for the defenders, to a question directed to a different end, that endocarditis that was inflammatory and not infective in origin might have explained the pursuer's symptoms in 2002/3. This statement was made despite the fact that the pursuer's whole case had been conducted on the basis that it was infective SBE which was the issue to the treating clinicians in 2002 and, moreover, that the whole consideration

of endocarditis in Dr Habboush's report was of SBE, not endocarditis inflammatory in origin. The spontaneous suggestion he made had no basis on anything stated on record. Dr Habboush went further in evidence and said that the term SBE includes endocarditis inflammatory in origin. It was submitted by the defenders that it was significant that this evidence was directly, and convincingly, contradicted by Dr Bloomfield. He explained that medical science makes a distinction between infective endocarditis and non-infective endocarditis. He explained the difference. He further explained that SBE is a medical term with a specific meaning, again explaining what that was. He was absolutely clear, according to counsel, that the term SBE did not include non-infective endocarditis. The same view was expressed by Dr Culligan. Dr Bloomfield's position was that these conditions are quite different things and he observed that medical textbooks treat them as different topics. He further stated that he would expect any hospital consultant to know these facts. This confusion in the evidence of Dr Habboush was submitted by counsel to present a "fundamental problem" with his whole evidence.

Analysis and Consideration

(i) Reliability and Credibility

[56] On the basis of submissions I require to make determinations in relation to the reliability and credibility of the pursuer, Dr Valance and Dr Habboush.

[57] So far as the pursuer is concerned I accept, as was submitted by senior counsel for the defenders, that on occasion she gave the impression of being tendentious and offered a number of what I regarded as implausible rebuttals for entries in her medical records which plainly showed a failure to appear for medical appointments. Counsel suggested that this demeanour was driven by bitterness at the medical profession caused by a failure to diagnose the condition which caused her stroke in 2006 and resulted in serious and adverse consequences for her health thereafter. There may be force in that submission but I am not persuaded that it is of particular importance to my consideration of the pursuer's evidence. In the first place in the absence of any evidence to support the proposition, I cannot say whether such feelings, if harboured by the pursuer, would necessarily result in any evidence she gave on oath being necessarily untruthful or unreliable. Second, having regard to the undoubtedly adverse effects on the pursuer's health of the stroke she suffered in 2006, and her very lengthy history of engagement with the medical profession, I consider the court should be slow to be critical of demeanour which in a person who had not suffered these unfortunate consequences might well be regarded as tendentious or bitter. Having regard to these considerations I would be willing to overlook the pursuer's demeanour when giving evidence. I cannot however so easily overlook the errors which are, having regard to the case notes which were examined, demonstrably incorrect. There are a very significant number of failures to attend for medical appointments recorded in the pursuer's medical records. I accept that, particularly in a person suffering from ill-health as appears to be the position of the pursuer on a number of occasions, medical appointments may be missed. I must however have regard to the number of medical appointments the pursuer missed and any explanations she offered. The pursuer offered no plausible explanation for the number of medical appointments she had missed. In relation to the missed appointments with which this case is primarily concerned, that is the three repeat appointments in the Haematology Department of GRI in the autumn of 2002, failure to attend Dr Seaton for a follow up appointment in October 2002 and the ECG in October 2002, the pursuer's

position was that she could not remember about these appointments. In considering the pursuer's credibility regard also has to be had to her denial about ongoing psychiatric and psychological problems despite plainly objective evidence to the contrary in the medical records.

[58] When all those factors are taken into account I conclude that she cannot be accepted as a reliable witness in relation to her evidence about attendance at medical appointments. It follows that I cannot accept her evidence in relation to her attitude to any appointment she may have been given for an ECG.

[59] In relation to Dr Valance I accept the criticisms made against him by senior counsel for the defenders in relation to allegations of negligence made by him against Dr Parker. I consider that these allegations require to be taken into account when I consider the issue of negligence but that they are not, of themselves, sufficient to entitle me to make a finding of unreliability so far as this doctor is concerned.

[60] Different considerations apply, in my view, to the evidence of Dr Habboush. It appears to me that the detailed criticisms advanced by senior counsel for the defenders were, on the basis of the evidence I heard, justified. The errors identified by senior counsel are such that I conclude that I am not entitled to accept the evidence of Dr Habboush on matters where it is contradicted by the evidence of other appropriately qualified specialists.

(ii) The Alleged Negligence by Dr McQuaker in December 2002

[61] In the end of the day there was little dispute in relation to the evidence about this period. The pursuer attended the Haematology Department at GRI in April 2002 with a history of anaemia which had persisted since August of the previous year. Clinicians in the department conducted investigations designed to diagnose the cause of the anaemia and she was seen by a number of clinicians at four outpatient reviews in the period April – August 2002. By the time she was seen by Dr Parker, a consultant haematologist, in August 2002 the view was reached by that doctor that she was close to the end of the investigations which could be offered in the department. She ordered an ECG only to exclude the possibility of SBE, a condition which she did not think was a likely cause of the pursuer's by then chronic anaemia. SBE is an infective disease and because of this, and because she also considered that an infective cause of the chronic anaemia was more likely than an inflammatory cause, Dr Parker referred the pursuer to Dr Seaton, an infectious diseases expert at Gartnavel Hospital. Dr Seaton saw and examined the pursuer in September 2002. His view was that the pursuer did not suffer from an infective disease. He arranged a number of further examinations designed to exclude the possibility of a sexually transmitted infection, albeit he saw no clinical signs of such a condition. He noted that Dr Parker had arranged for the pursuer to undergo an ECG to exclude SBE and considered that an appropriate step to have been taken. His examination did not however reveal any signs which led him to believe that the pursuer was likely to be suffering from SBE. He expressed these views in a letter to Dr Parker dated 13 September 2002[31] which was the focus of a considerable amount of evidence in the proof. Whilst Dr Seaton's evidence was that he did not consider SBE likely the issue is essentially whether the informed reader of the letter, which in the context of the present case means a consultant haematologist, would or would not be entitled to conclude that Dr Seaton's opinion was that SBE was an unlikely cause of the pursuer's condition. Put another way, whether or not a

consultant haematologist would be entitled to construe the letter as meaning that Dr Seaton had excluded a diagnosis of SBE.

[62] The pursuer had, with one exception, attended the appointments given to her in the Haematology Department between the initial appointment in April 2002 and the appointment with Dr Parker in August 2002. After the appointment with Dr Parker she failed however to attend three successive appointments in the Haematology Department and a review appointment with Dr Parker. She also failed to attend for the ECG arranged by Dr Parker. The pursuer's position is that she did not receive, or at least did not recall receiving, letters of appointment in relation to these consultations. I have already discussed this matter when dealing with the issue of the pursuer's reliability and credibility and from that it will be apparent that I do not accept this explanation. It follows that I accept that Dr McQuaker was entitled and correct in proceeding to consider the pursuer's case following her failure to attend in December 2002 as being one of a patient who had decided to no longer engage with his department.

[63] On the basis of the evidence I accordingly conclude that the situation facing Dr McQuaker in December 2002 was of a patient who had undergone intensive investigation in the Haematology Department for chronic anaemia over a period of months. The result of these investigations was to exclude a haematological reason for the chronic anaemia. Further, Dr McQuaker was aware that the investigation of an infective cause of the condition had been undertaken by an appropriately qualified expert, Dr Seaton, on the referral of his consultant colleague Dr Parker. He knew that an ECG to exclude SBE, an infective cause, had been ordered but when considering the case in December he did not know the result of that investigation. In these circumstances I am clear that Dr McQuaker's understanding of the position of Dr Seaton was an important matter for him to consider in reaching a clinical decision as to how to most appropriately proceed with the pursuer's case at this juncture. The only basis upon which Dr McQuaker could access Dr Seaton's opinion was the letter of 13 September 2002. The question is therefore what was a consultant haematologist such as Dr McQuaker entitled to take from that letter? That question in my view is primarily one to be answered by reference to the medical evidence available to me. In saying that I consider that if the matter of construction of the letter was, as a matter of plain English, straightforward then no doubt a judge could proceed on his or her own construction. That is not however the case in the present instance, the letter involves reference to medical matters of a specialist nature and I therefore must be guided by expert medical opinion as to its correct interpretation. I accordingly have regard to the views of the haematologists who gave evidence. On balance the tenor of that evidence was that they read the letter as Dr Seaton saying that he effectively excluded SBE as a likely cause of the pursuer's chronic anaemia. It follows that the known facts so far as Dr McQuaker was concerned in December 2002 were that there was no haematological explanation for the underlying anaemia; that Dr Seaton had excluded SBE as a likely cause and that the pursuer had persistently failed to attend for appointments in his department.

[64] On the basis of that factual matrix neither Dr Parker or Dr Culligan considered there was any departure from the ordinary practice of a consultant haematologist exercising ordinary care by Dr McQuaker when he decided to offer no further appointment at that stage to the pursuer and writing in those terms to her GP.

(iii) The Alleged Failure by Dr McQuaker to see the Pursuer in April 2003

[65] The clinical picture which the pursuer presented to her GP in February 2003 was the same as in the previous autumn with the exception of new symptoms of tingling in the fingers and toes and discolouration of the fingers. The GP found these symptoms troubling in a woman of the pursuer's age. He took bloods and on receiving the results again referred to the Haematology Department at GRI. The consultant in charge of that department on seeing the referral letter and, at least as a matter of inference, having regard to Dr McQuaker's involvement the previous December allocated the referral letter to him to deal with. Dr McQuaker considered the letter and formed the view that the new symptoms were indicative of a potential inflammatory cause of the pursuer's condition. His view, which went uncontradicted by any clinician who gave evidence, was that the appropriate department to investigate inflammatory conditions was rheumatology. It is plain that he could have arranged an appointment for the pursuer, examined her and if thereafter he still considered investigation would be better pursued in the rheumatology department made an appropriate referral. His view was, however, that this would only occasion further delay. He sought to avoid this by discussing the matter with the pursuer's GP, something which he said in evidence was not usual but that he considered justified in the circumstances. No other clinician contradicted him in relation to this. The outcome of the discussion with the GP was that that clinician accepted Dr McQuaker's reasoning and made the appropriate referral direct to rheumatology.

[66] Two consultant haematologists, Dr Parker and Dr Culligan, considered that in so acting Dr McQuaker was exercising sound clinical judgement. They considered that he was acting within the degree of care to be expected from an ordinarily competent consultant haematologist. Dr Habboush did not agree and considered that the pursuer's new symptoms "should have prompted an urgent clinical assessment particularly to exclude a thrombotic event or an embolic disorder". As pointed out by senior counsel for the defenders in his submissions relative to the reliability of Dr Habboush this analysis depended, at least in part, upon Dr Habboush's opinion expressed in his report that in the spring of 2003 the pursuer's "inflammatory markers persisted to rise." As subsequently accepted by Dr Habboush this was incorrect. It follows that there was an error in a part of Dr Habboush's reasoning which has the effect of throwing into question his view that Dr McQuaker fell below the requisite standard in failing to see the pursuer as a matter of urgency. I would also observe that no other clinician considered that, on the basis of the facts as known in the spring of 2002 was there any reason to suspect that the pursuer was at risk of a thrombotic event or suffered from an embolic disorder.

[67] Having regard to these considerations I do not consider that Dr McQuaker fell below the requisite standard of care to be expected from a consultant haematologist in acting as he did in April 2003.

(iv) The Montgomery Case

[68] The basis of this case is the existence of a duty incumbent upon Dr McQuaker to take reasonable care to ensure that his patient, the pursuer, was aware of material risks of injury inherent in her treatment. In the factual context of this case, as developed by the pursuer, that meant explaining to her the risks inherent to her if she did not undergo an ECG, first before her "discharge" in December 2002 and again in May 2003. As explained in *Montgomery* (*supra*) this

duty involves the exercise of professional skill and judgement by the clinician in the evaluation of risk to the patient in any proposed treatment but also requires the clinician to take account of the patient's "entitlement to decide on the risks to her health which she is willing to run"[32]. This latter part of the duty will require the clinician to take reasonable care that the patient is aware of any material risks "involved in any recommended treatment"[33].

[69] Whether or not a clinician fulfils this duty requires to be considered having regard to the facts of the individual case. In the present case the relevant facts as known to Dr McQuaker were that by December 2002 the pursuer had failed to attend at three consecutive appointments in the Haematology Department. He also considered that Dr Seaton had excluded an infective cause for the pursuer's underlying anaemia. His analysis of the situation was that the pursuer had ceased to engage with the department because she no longer required or wished their assistance. He did not consider that there was any ongoing requirement for an ECG, an infective cause of the anaemia having been eliminated. He did not consider he was "discharging" the pursuer from the Haematology Department, rather she had "ceased to engage" with them.

[70] In my opinion the analysis conducted by Dr McQuaker involved his consideration of the risks faced by his patient, the pursuer. Given her non-attendance at appointments and the discounting of an infective cause of her illness, I am of the view that his decision was appropriate. It is of significance that both Dr Parker and Dr Culligan did not criticise Dr McQuaker's judgement on this matter.

[71] I further consider that the same reasoning applies in relation to Dr McQuaker's clinical judgement in April 2003. He considered all the information before him, his view on the possibility of an infective source of the pursuer's anaemia was reinforced by the passage of time since the events of December 2002. His assessment of risk was that he could be of no further utility to the pursuer and that her needs were better served in the Department of Rheumatology. In my view that judgement was a proper exercise of his clinical function.

[72] The foregoing would be enough to enable me to be satisfied that Dr McQuaker had fulfilled the duties incumbent upon him in relation to informed consent. I can however go further.

[73] This aspect of the case is, in my view, dependent upon the pursuer being able to satisfy the court that she would have attended for an ECG had she been advised of the seriousness of the condition that test was designed to exclude. I accept that the pursuer stated when asked this question that she would have attended such an appointment. I am however of the view that this response does require to be considered having regard to her proven history of non-attendance at medical appointments over a long period of time and, further, having regard to my general view on her reliability as a witness. Having regard to those factors I am not satisfied, on the balance of probabilities, that any explanation given to the pursuer about these matters would have increased the likelihood of her attending for a further ECG appointment if made. In these circumstances I am not satisfied that this ground has been established.

[74] Having regard to all the foregoing I am of the view that the pursuer has failed to prove her case. I shall uphold the defenders' third and fourth pleas-in-law and assoilzie the defenders from the conclusions of the summons. I shall reserve meantime all questions of expenses.

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[1] Joint Minute No 36 of process, paragraph 1

[2] No 19/29 of process, page 21

[3] No 19/29 of process, page 19
[4] No 19/29 of process, page 17
[5] No 19/29 of process, page 15
[6] No 19/29 of process, page 14
[7] No 19/29 of process, page 11
[8] No 19/29 of process, page 11
[9] No 19/29 of process, page 12
[10] No 19/29 of process, page 9
[11] No 19/29 of process, page 7A
[12] No 9/29 of Process, page 8
[13] No 19/29 of Process, page 6
[14] No 19/29 of Process, page 4
[15] No 19/29 of Process, page 3
[16] No 18/12 of Process
[17] The report is No 18/11 of Process
[18] No 18/11 of Process, page 4
[19] No 19/12 of Process
[20] No 19/18 of Process
[21] No 19/12 of Process, page 7
[22] No 19/11 of Process
[23] No 19/24 of Process
[24] No 19/26 of Process
[25] 2008 SC 235 paragraphs [36] – [40]
[26] *Barnett* v *Chelsea & Kensington Hospital Management Committee* [1969] 1 QB 428
[27] 2015 SC 63
[28] No 18/9 of process
[29] No 18/11 of process
[30][30] No 18/11 of process at page 4, paragraph 10
[31] No 19/29 of process, page 9
[32] 2015 SC (UKSC) 63 at paragraph [83]
[33] 2015 SC (UKSC) 63 at paragraph [87]