OUTER HOUSE, COURT OF SESSION

[2018] CSOH 91

A696/14

OPINION OF LORD TYRE

in the cause

JERRY TAYLOR and OTHERS

Pursuers

against

DAILLY HEALTH CENTRE and OTHERS

Defenders

First Pursuer: Maguire QC, Drysdale; Drummond Miller LLP
Second Pursuer: Galbraith; Drummond Miller LLP
Third Pursuer: Waugh; Shoosmiths LLP
Fourth Pursuer: Galbraith; Balfour + Manson LLP
Defenders: Duncan QC, Paterson; MDDUS

4 September 2018

Introduction

[1] The pursuers are the husband, the two children, and the *curator ad litem* of the third child of the late Linda Taylor, who died on 26 March 2009, aged 32. In this action they seek reparation from the general practice, and the partners thereof, responsible for Mrs Taylor's care at the time of her death. The case came before me for a proof on the question of liability only.

[2] On the morning of 26 March 2009, Mrs Taylor felt unwell. A friend telephoned the defenders' surgery on Mrs Taylor's behalf, and reported that she was suffering from pain in

her chest and down her left arm. Dr Thomas Malloch, a partner in the defenders, immediately made a home visit to Mrs Taylor. After questioning and examining her, Dr Malloch concluded that Mrs Taylor was suffering from musculo-skeletal pain and gastro-intestinal upset. He prescribed analgesics. Approximately one hour later Mrs Taylor died. The cause of death was coronary artery atherosclerosis. In the present action the pursuers contend that Dr Malloch was negligent in failing to summon an ambulance to take Mrs Taylor to hospital to investigate whether she was suffering from an acute coronary syndrome (ACS; ie, a heart attack), as was in fact the case. It is accepted by the defenders that if Dr Malloch had diagnosed ACS and summoned an ambulance, Mrs Taylor would not have died. The defenders contend, however, that Dr Malloch did not depart from usual practice and that his actions were consistent with those of a general practitioner exercising the ordinary skill and care reasonably to be expected of him.

[3] At the proof, oral evidence was led from Mr Taylor, the first pursuer; from Ms Shona Barr, the friend who telephoned the defenders' surgery; and from Dr Malloch. Statements by certain other persons were agreed to constitute their evidence without the need for personal attendance; these included James Meredith, one of the ambulance paramedics who answered the 999 call referred to below. Expert evidence was led on behalf of the pursuers from Professor Ian Wall, whose professional qualifications include fellowship of the Royal College of General Practitioners, and on behalf of the defenders from Dr Niall Cameron, whose professional qualifications also include fellowship of the RCGP. Both expert witnesses were amply qualified and experienced to express opinions upon the matters upon which they gave evidence.

Mrs Taylor's medical history

[4] At the time of her death, Mrs Taylor lived with her husband and children in a house in Dailly, Ayrshire. She had been a patient of the defenders' practice for about nine years. She was clinically obese, weighing approximately 104 kilogrammes, and was a smoker, although the evidence of her daily cigarette consumption was inconclusive. She had been prescribed Brevinor, a combined oral contraceptive pill (COCP). Her mother, who had also been a patient of Dr Malloch, had died of cancer but had suffered from angina, although the age at which this occurred was not clearly established. Mrs Taylor's GP records contained no further relevant information.

Eye witness evidence

The first pursuer

[5] Mr Taylor stated that on the morning of his wife's death she had taken the children to school and returned to the house. In the meantime he had gone to Girvan to buy pet food, and also baguettes for his and Mrs Taylor's breakfast. While in Girvan he received a call from Ms Barr telling him that she was with Mrs Taylor who did not feel well. Mr Taylor advised her to call the doctor; Ms Barr reported that Mrs Taylor did not wish to. A few minutes later Ms Barr phoned again, asking him to return to Dailly. Mr Taylor went home without completing his purchase of baguettes. He was accompanied by two friends, Billy Robertson and Stacey Slaven. On his return he found Mrs Taylor sitting on the couch in her pyjamas. She stated that she had pains across her chest and down her left side. She looked pale and sweaty and seemed to be struggling to talk. He asked Ms Barr to call the defenders' surgery, which she did, requesting a house call and stating that Mrs Taylor had pain in her chest and down her left side.

[6] Dr Malloch arrived at the house about five minutes later. Ms Barr let him in and then went into the kitchen. Mrs Taylor was lying on the couch in the living room. Mr Taylor looked on while Dr Malloch questioned and examined Mrs Taylor. Dr Malloch asked her what was wrong and she said she had pains across her chest and travelling down her left side. She made a gesture with her hand, indicating pain in her chest. Dr Malloch examined Mrs Taylor using a stethoscope, and attempted to measure her blood pressure with a cuff on her left arm. He could not obtain a reading from that arm but obtained one from her right arm. He did not touch any part of her body with his hands. When he asked if she had been to the toilet, she said that she had and that her stool had been quite soft. She had then given a "dry boak", ie a dry heave. There was no discussion of what she had had to eat that day, but according to Mr Taylor she had had nothing because he was bringing breakfast from Girvan. Dr Malloch did not question her about her family medical history. Having carried out his examination, he stated that Mrs Taylor had sickness and diarrhoea and indicated that there would be a prescription waiting for her at the surgery in about 15 minutes. He then left. Ms Barr went to the surgery and collected the prescription. Mr Taylor considered that if his wife had been advised that she required hospital admission by ambulance she would have agreed to that course of action.

[7] After Dr Malloch left, Mrs Taylor went to bed. When Ms Barr returned with the prescription she sat in the bedroom with Mrs Taylor while Mr Taylor made coffee. Billy Robertson and Stacey Slaven were in the kitchen with him. While he was making coffee, he heard a shout from Ms Barr that Mrs Taylor had taken "a right bad turn". When he entered the bedroom he observed that she was turning grey. Somebody (Mr Taylor could not remember who) phoned the surgery and was told to phone 999, which they did. They were told to try to carry out CPR while waiting for the ambulance to arrive. After the

ambulance arrived, one of the paramedics told him that Mrs Taylor had died. Dr Malloch was informed, and he returned to the house to pronounce her dead.

[8] Mr Taylor was questioned about his history of alcohol and drug abuse. He accepted that he was a registered alcoholic, that he had been a heroin user until about 1999 when Mrs Taylor got him clean, and that thereafter he had had a methadone prescription. He denied having taken heroin again until he relapsed on the day of Mrs Taylor's funeral. He specifically denied that he had been taking drugs along with Billy Robertson and Stacey Slaven on the day of Mrs Taylor's death, or that when Ms Barr phoned him that morning he had been buying drugs.

Shona Barr

[9] Ms Barr had been a close friend of Mrs Taylor for many years, and was in the habit of visiting her at home every morning. Ms Barr's partner was Mrs Taylor's brother. On that morning she had received a call from Mrs Taylor at about 9.30 asking her not to come as she (Mrs Taylor) did not feel well and was going back to bed. However Mrs Taylor called again and asked her to come, stating that she could not stand on her legs and that Mr Taylor was out buying drugs. When Ms Barr arrived at about 10 am, Mrs Taylor was lying on the couch. She complained that she was cold, and that she had pain radiating from her back through to her chest. Ms Barr wanted to call the doctor but Mrs Taylor asked her to call Mr Taylor first. She did so, and Mr Taylor said that he was buying pet food and something else. After that call, Mrs Taylor began to complain about pain in her left arm, and Ms Barr called the doctor's surgery. She spoke to a receptionist and reported that Mrs Taylor had pain in her back and chest, travelling down her left arm. At this time Mrs Taylor looked pale. Dr Malloch arrived shortly afterwards at about the same time as Mr Taylor returned

home with three friends (the two individuals already mentioned plus Paul Green). Ms Barr went into the kitchen with the others and did not hear the conversation between Dr Malloch and Mrs Taylor.

[10] Dr Malloch stayed for about 15-20 minutes. After he left, Mr Taylor came into the kitchen and told Ms Barr that the doctor had diagnosed sickness, diarrhoea and heartburn. At this time Mrs Taylor looked okay. Ms Barr went out to pick up the prescription, together with a bottle of Lucozade that Mrs Taylor had requested. When she got back to the house Mrs Taylor was in bed. She continued to complain about pains in her chest and took the tablets that had been prescribed. Ms Barr left at about 1 pm to pick up her children from school. Before leaving she had been in the bedroom with Mrs Taylor and Stacey Slaven. Mrs Taylor looked fine when she left. Mr Taylor was under the influence of drugs. Soon afterwards, Ms Barr received a call from Stacey Slaven which was impossible to understand. She returned to the house to be told by the ambulance crew that Mrs Taylor had died. She too considered that if Mrs Taylor had been advised to go to hospital in an ambulance she would have accepted that advice.

Dr Malloch

[11] Dr Malloch was at the surgery when the call from Ms Barr came in. The report, as he recalled, was of Mrs Taylor suffering from chest pains and pain in the left arm, which he regarded as concerning. On arrival at the house, he began by asking Mrs Taylor open questions to obtain a description of her symptoms from her directly. She described the pain as a stabbing pain, radiating through to her back. She pointed to the upper part of her abdominal area. When asked how long she had had the pain she said that it started after she had a tuna sandwich at breakfast time. She stated that she had been sick and had soft stool.

She was not sweaty or distressed. She was not breathless. He asked her to remove her upper clothing and palpated her chest. He used a stethoscope to listen to her heart and lungs, and found no abnormality. Her pulse was regular and her blood pressure was borderline. Dr Malloch was able to get blood pressure readings in both arms with no difference between them. Mrs Taylor complained of tenderness between her shoulder blades and in the left trapezius muscle, and in the middle of her back. It became apparent that she also had tenderness in her lower sternum. In response to a question she confirmed that she had pain in her left arm. He did not require to ask her about her family history because he knew her father and had known her mother before she died. He did not think that her mother's heart disease had had premature onset. He considered and rejected a diagnosis of myocardial infarction. Tenderness over her muscles indicated a muscular cause. He considered that the site of the pain indicated by Mrs Taylor was the epigastrium, but he could find no evidence of a problem with any of the abdominal organs.

[12] When carrying out his examination, Dr Malloch had been aware of the need to exclude heart malfunction. Left arm pain was a common complaint which did not usually have a cardiac cause. Chest pain associated with cardiac issues was normally described as a heavy, constricting pain, and not as a stabbing pain going through to the back. Tenderness, as opposed to pain, was not normally associated with a cardiac cause. On the basis of the history given to him by Mrs Taylor and his findings on examination, Dr Malloch diagnosed muscular pain, with sickness and diarrhoea. In so doing he took account of Mrs Taylor's age, obesity and smoking history.

[13] Dr Malloch was in the house for around 15 minutes. On his return to the surgery he made the following note in Mrs Taylor's medical records:

"26/03/2009 Dr Thomas Malloch at Home visit

Problem (FIRST)	**[D]Musculoskeletal pain**
History	story was of chest pain going down left arm. on arrival she tells me that it came on after eating a tuna sandwich at about 9am & is stabbing in nature, going into back as well. on specific questioning, also has diarrhoea. paracetamol not helpful
Examination	retching helped the discomfort. did not vomit when I was there. chest clear. CVS nad. abo nad. only positive findings were tenderness lower sternum & midthorax posteriorly also tender left trapezius and pain on moving neck
Medication	Co-Codamol 8/500 Tablets 50 tablet TWO TO BE TAKEN FOUR TIMES DAILY Ibuprofen Tablets 400 mg 24 tablet ONE TO BE TAKEN THREE TIMES DAILY
Test Request	Stool"

[14] Dr Malloch was called back to the house by the ambulance crew to confirm the death. There were a number of people milling around and one of them was drinking from a beer can. The atmosphere was hostile. He examined Mrs Taylor and certified her death. He spoke briefly to Mr Taylor but could not remember what had been said.

James Meredith

[15] Mr Meredith was the driver of the ambulance sent in response to the 999 call from the house, which was received at 1.17pm. On arrival he found a lot of people there, including Mr Taylor and a number of young children. It was "pandemonium". Mrs Taylor was lying on top of two or three mattresses, which meant that any CPR that had been attempted could not have been effective. Mr Meredith and his colleague carried out a standard procedure to check airways, breathing and pulse. They attached a heart monitor and found Mrs Taylor to be asystolic. Mr Meredith formed the view that Mrs Taylor had

been dead for a short while before the ambulance crew had arrived, but could not say for how long.

Assessment of the factual evidence

[16] For the purposes of the present action, the crucial factual evidence consists of the information sought and obtained by Dr Malloch prior to making his diagnosis at the end of the house visit. The only other person present while Dr Malloch questioned and examined Mrs Taylor was Mr Taylor. As there are inconsistencies between the evidence of Mr Taylor and of Dr Malloch as to what Mrs Taylor said, and what Dr Malloch did, it is necessary for me to form a view as to whose evidence to accept.

[17] I begin by considering the evidence of Mr Taylor. In certain notable respects it is at odds with the evidence of Ms Barr. According to Mr Taylor, he received two phone calls from Ms Barr and had arrived home in response before Ms Barr called the surgery. According to Ms Barr, there was only one call to Mr Taylor, following which she called the surgery, so that Dr Malloch arrived at about the same time as Mr Taylor returned home. More strikingly, the accounts of Mr Taylor and Ms Barr of what happened after Ms Barr returned with Mrs Taylor's prescription are entirely different. According to Mr Taylor, Ms Barr was with Mrs Taylor in the bedroom when Mrs Taylor began to turn grey and subsequently died: he would "swear on his weans' life that she was there". According to Ms Barr, on the other hand, she had left the house at a time when Mrs Taylor looked "fine".

[18] In relation to the latter discrepancy, I have no difficulty in preferring the evidence of Ms Barr. She gave her evidence in a straightforward manner and was able to provide further detail when asked to do so. Her account of leaving the house to pick up her children and returning after receiving an incomprehensible telephone call from Stacey Slaven was

coherent and credible. In contrast, Mr Taylor was dogmatic on many matters but vague on others. It is significant that he could not remember who had made the 999 call at 1.17 pm, although he appeared to think that it must have been either himself or Ms Barr. A transcript of that call was lodged. The identity of the caller, who claimed to be a first-aider, was not disclosed, although he or she referred to Mrs Taylor as "my friend Linda", so it was presumably not Mr Taylor. There is no record of any call having been made at this time to the defenders' surgery. I am satisfied that Ms Barr's account of events is reliable and that Mr Taylor's is not. It may be that his recollection of events at the time of Mrs Taylor's death was affected by having consumed drink or drugs; I make no finding on that, but I do not accept that his recollection is accurate. I find that during the minutes prior to her death Mrs Taylor was either alone in the bedroom or in the company of the person who made the 999 call, and that Mr Taylor was with one or two (or possibly more) other friends in the kitchen. Ms Barr was not in the house.

[19] Nor do I see any reason to reject Ms Barr's evidence of what had happened earlier in the morning. Here too she gave a straightforward account which appeared to me to be credible and reliable. Again Mr Taylor's evidence was, in my view, unsatisfactory. It was noteworthy that he did not mention that he had brought friends back with him until it was put to him in cross-examination. His account of abandoning the baguettes in mid-purchase was curious, especially as he had told Ms Barr that he was on his way home. I conclude that I cannot rely on Mr Taylor's evidence of this part of the day's events either. In particular, I do not accept as reliable his assertion that Mrs Taylor had not eaten anything that morning.

[20] Turning now to the critical conversation between Dr Malloch and Mrs Taylor, I likewise have no difficulty in preferring the evidence of Dr Malloch. His account of what he was told by Mrs Taylor was detailed and consistent with the notes he made immediately

afterwards. I reject a contention on behalf of the pursuers that the reference in his notes to being told that "it" came on after eating a tuna sandwich demonstrated that he had been told on arrival by Mrs Taylor that she had chest pain going down her left arm. I accept his explanation that this was not what the note was intended to mean, and that Mrs Taylor did not mention pain in her left arm until specifically asked about it. In so doing I reject as unreliable Mr Taylor's evidence to the contrary. I also accept Dr Malloch's evidence on other points of difference, namely (i) that Mrs Taylor pointed to her upper abdominal area as the location of her pain; (ii) that she told Dr Malloch that she had eaten a tuna sandwich; (iii) that he obtained a reading for her blood pressure in both arms; and (iv) that his examination included palpation of her chest and other areas where tenderness was identified.

[21] It follows that my assessment of the expert evidence must proceed on the basis of Dr Malloch's account of the home visit and not, where different, that of Mr Taylor.

Expert evidence

Professor Wall

[22] Professor Wall provided a written opinion dated 27 October 2016, based upon documentary information including an affidavit from Mr Taylor, the GP records, the pleadings in the case, a witness statement given by Mr Taylor to the police on 26 March 2009, Dr Malloch's answers to written questions from the pursuers' legal team, a precognition from Mr Meredith, and a supplementary precognition from Mr Taylor. In certain respects the factual basis upon which Professor Wall provided this opinion differs from what I have found to be established in evidence. He noted various differences between the account given by Mr Taylor on the one hand and Dr Malloch on the other, although it is

not entirely clear on what basis he proceeded. He expressed the following view (paragraph 8.8):

> "Whilst Mrs Taylor's presentation was not typical, I am of the opinion that Dr Malloch's conclusion that she was suffering from musculoskeletal chest pain, largely on the basis of chest wall tenderness, was unsafe. In discriminating between possible causes of chest pain, the history is crucial and I am of the opinion that the fact both [ie Mr Taylor and Dr Malloch] agreed that she had chest pain, which radiated down her left arm and was of relatively sudden onset, cannot be ignored. There is Mr Taylor's evidence that his wife was breathless. With risk factors of smoking, obesity, a family history of heart disease and the fact that Mrs Taylor was on the COCP, it was not possible to safely exclude serious underlying causes of an acute coronary syndrome or a pulmonary embolism, despite her relatively young age, and that the only safe management was to admit Mrs Taylor to hospital via a 999 ambulance. No ordinarily competent doctor exercising ordinary skill and care would have failed to admit Mrs Taylor."

[23] Professor Wall and Dr Cameron held a meeting by telephone on 6 June 2018 and produced an agreed statement. They had been asked to consider two scenarios (A and B) broadly corresponding to Mr Taylor's and Dr Malloch's respective versions of events, and to answer certain questions in relation to these. The pursuers' allegations of negligence were noted to be as follows: (1) failure to detect that the deceased's symptoms were consistent with ACS; (2) failure to have been aware that the deceased was at risk of deep vein thrombosis and therefore pulmonary embolism due to her obesity and on the COCP, and (3) failure to summon an immediate blue light ambulance. The questions, with Professor Wall's answers on Scenario B, included the following:

> "(i) Were the deceased's symptoms, on this hypothesis, consistent with ACS?
>
> We are agreed her symptoms were not consistent with ACS. However, Professor Wall is of the opinion that it would be unusual for a patient to complain of sudden onset chest pain and it be explained on the basis of a muscle strain whilst retching with tenderness in three different anatomical positions. Some other condition needed to be considered, and in view of other risk factors, this was a potentially fatal pulmonary embolism…

> (ii) On this hypothesis, with regard to each of the three assertions of negligence above, was there a usual and normal practice in 2009? If so what was this, and what is the basis for this?
>
> Professor Wall is of the opinion that it was not negligent with respect to (1) above but it was negligent with respect to (2) and (3) because a pulmonary embolism needed to be excluded and the only safe way to do this was to admit the deceased to hospital via an immediate blue light ambulance…"

[24] In a letter dated 1 July 2018, Professor Wall provided the following clarification of his answers as set out above. He stated:

> "In the section headed 'the disputed facts' and Scenario B set out in paragraph 2, I had stated that the symptoms were not consistent with ACS. In coming to this conclusion, I had based my opinion on Dr Malloch having clarified that the deceased did not have chest pain and never had but that the pain was in the epigastrium ie that the claim of chest pain made by a relative over the telephone had been withdrawn. If there was a history of chest pain going down the left arm, then as stated above, this was consistent with ACS. If there is any suspicion of ACS or other serious cause, or any concern regarding the patient's general well being urgent hospital assessment and admission is mandatory…"

[25] In his evidence to the court, Professor Wall confirmed his view that the symptoms described by Ms Barr in her call to the surgery were typical of ACS. A pain in the area of the epigastrium was consistent with ACS but not a typical feature of it. The symptoms noted by Dr Malloch on arrival (sickness, tenderness in the shoulders and sternum, pain in the neck and arm) were consistent with ACS. Tenderness and pain when moving her neck were not however typical of ACS and would seem to have some other cause. Pain in the middle of her back was typical. Diarrhoea was consistent but not typical. The lack of abnormalities on examination was neutral. A family history of heart disease was relevant if the onset had been before age 60. If Mrs Taylor had pointed to her epigastrium as the source of the pain, Dr Malloch had to ask specific questions such as whether she had pain down her arm. He had to proceed on the assumption that the initial report by Ms Barr of chest pain had not been withdrawn. Before diagnosing a musculo-skeletal cause for tenderness in three

different places, it was necessary to identify a cause for this. The symptoms described by Mrs Taylor did not exclude ACS and it was therefore necessary to call an ambulance.

[26] Pulmonary embolism had been another potential cause of Mrs Taylor's pain: there were various high risk factors including smoking, obesity and being on a COCP. The symptoms of pulmonary embolism were chest pain on one side and in the back, breathlessness, coughing up blood and sudden onset in much the same way as reported here. If it could not be excluded, the only appropriate course was to summon an ambulance. There was nothing in the records to indicate that Dr Malloch had considered this diagnosis.

[27] In cross-examination, Professor Wall agreed that a high percentage of chest pain presentations did not have a cardiac cause. He also agreed that some of the symptoms described were not typical of ACS, including a stabbing pain in the stomach area, vomiting, diarrhoea, and tenderness (as opposed to pain) at the sites identified, and that some of the symptoms were not consistent with ACS. He further agreed that some of the symptoms of pulmonary embolism were not present in Scenario B, but maintained his view that Dr Malloch had to go further to exclude it.

Dr Cameron

[28] Dr Cameron provided a written opinion dated 20 January 2017, based upon documentary material including Mrs Taylor's GP and hospital records, the pleadings, and a precognition, further comment and a report on Mrs Taylor's care by Dr Malloch. His opinion was that the decision not to require immediate hospital admission of Mrs Taylor was appropriate and in keeping with usual and standard practice. He concluded (page 13):

> "The aim in the general practice setting is to exclude a significant condition causing chest pain which needs immediate intervention from other more common but less serious causes of chest pain. It is my opinion that given the recorded history and

> findings Dr Malloch's management was appropriate and there were no reported cardiac symptoms (characteristic ischaemic chest pain, abnormality of pulse rate or rhythm, hypotension, dizziness, unexplained nausea, sweating or breathlessness) and no further relevant history or findings to suggest the patient was suffering an acute ischaemic event. I do not consider that it would have been in keeping with usual practice to refer the patient as an emergency to exclude acute ischaemic disease on the basis of the recorded history and examination findings."

Dr Cameron further considered, under reference to the Wells score and Geneva score used to predict deep vein thrombosis and pulmonary embolism, that Mrs Taylor had a very low probability for pulmonary embolism (PTE), and that Dr Malloch's management was appropriate.

[29] In the agreed statement produced after his telephone discussion with Professor Wall, Dr Cameron's answers on Scenario B included the following:

> "(i) Were the deceased's symptoms, on this hypothesis, consistent with ACS?
> …
> Dr Cameron is of the opinion that the deceased's symptoms on this hypothesis were not consistent with ACS or PTE and that Dr Malloch's assessment that these symptoms were secondary to musculo-skeletal pain and gastro-intestinal upset was reasonable. Dr Cameron notes that the patient was haemodynamically stable and that Dr Malloch specifically sought to exclude other possible causes including ACS and PTE.
>
> (ii) On this hypothesis, with regard to each of the three assertions of negligence above, was there a usual and normal practice in 2009? If so what was this, and what is the basis for this?
> …
> Dr Cameron is of the opinion that immediate admission was not mandated and Dr Malloch's management was in keeping with usual and normal practice."

[30] In his evidence to the court, Dr Cameron reiterated that it was not usual practice to refer all patients complaining of chest pain to hospital as an emergency. As Mrs Taylor was only 32, with no previous history of cardiac problems, it was unlikely at first sight that her pain would have a cardiac cause, but it was necessary to obtain a history, identify significant areas and undertake an examination to try to confirm or refute such a hypothesis. Left arm pain could be present with many non-cardiac chest pains. A stabbing pain in the stomach

area would most often have a gastric cause. Tenderness was not consistent with a cardiac cause because cardiac pain was unaffected by palpation. It was characteristic of cartilage inflammation. Pain on movement was indicative of a musculo-skeletal cause. A family history of heart disease was relevant only, in relation to females, if the onset was before age 65.

[31] The presenting features on examination did not indicate a likelihood of pulmonary embolism, for which the main feature would be breathlessness, along with sudden collapse, blood stained spit, low blood pressure and a feeling of being unwell. Mrs Taylor's age also went against a risk of pulmonary embolism.

[32] In cross-examination, Dr Cameron accepted that if a patient's presentation, history and examination raised even a small likelihood of ACS, they should be admitted to hospital. Chest pain did not have to be accompanied by breathlessness. It was normal practice to inquire about family history. Although the epigastrium was relatively close to the heart, it was not adjacent. Normal pulse and blood pressure were reassuring signs, despite the history of chest pain. Diarrhoea was not a symptom of ACS.

Submissions for the pursuers

[33] On behalf of the pursuers it was submitted that Dr Malloch had a duty to exclude ACS and that if there remained any possibility of it, he had to refer Mrs Taylor to hospital. He had failed adequately to address the risk factors, including in particular her mother's history of angina. His diagnosis of musculoskeletal pain was illogical. Pain in three distinct areas could not have been caused by retching. Dr Malloch had accepted that his diagnosis remained "uncertain"; there was no convincing evidence about any event accounting for all of the symptoms described by Mrs Taylor that was sufficient to displace the possibility of

ACS. The epigastrium was close to the bottom of the heart. Mrs Taylor was obese and sitting down when she made the gesture to her body. Given the proximity of the epigastrium to the heart, it was reasonable to infer that she was in fact pointing to her chest. There was very little in the reported symptoms to suggest a gastrointestinal issue.

[34] It was a matter of agreement between the expert witnesses that there were features of Mrs Taylor's presentation that were either typical of or at least consistent with ACS. The typical features were chest pain and pain down the left arm, vomiting, and pain in the mid-thorax posteriorly. The consistent features were pain/tenderness in the lower sternum, pain in the epigastrium, pain in the back of the neck going down the arm, and pain over the left trapezius. In these circumstances there remained a possibility of ACS such that a referral to hospital by ambulance was mandated. No ordinarily competent GP would have failed to do so.

[35] In addition, Mrs Taylor had risk factors, of which Dr Malloch was aware, for pulmonary embolism. He failed to consider the significance of her COCP prescription. It was not in accordance with usual and normal practice to disregard these risks. No ordinarily competent GP would have done so.

[36] Finally, it was submitted, Dr Malloch failed to obtain Mrs Taylor's informed consent to the course of action which he decided to take. He did not inform her that her symptoms and risk factors could mean the presence of ACS and that if she wanted to exclude ACS as a cause, hospital admission by ambulance was required. She had been entitled to be told this information to allow her to make her own assessment. This failure was a breach of the 2008 General Medical Council Guidelines, and a breach of the duty incumbent upon him as set out by the Supreme Court in *Montgomery* v *Lanarkshire Health Board* [2015] AC 1430. It is reasonable to conclude that Mrs Taylor would have wished to be made aware of the risks of

ACS and her options to exclude it. It was likely that if she had been advised of the risks of ACS and pulmonary embolism, she would have agreed to hospital admission by ambulance. Had that occurred she would have survived.

Submissions for the defenders

[37] On behalf of the defenders it was submitted that the present case was one in which the negligence was said to lie in a conscious choice among available courses of action, of the kind discussed by Lord Hodge in *Honisz* v *Lothian Health Board* 2008 SC 235 (at paragraph 39). Dr Cameron's view that, upon the history supplied to Dr Malloch by Mrs Taylor together with her presentation and his examination of her, she did not require to be admitted to hospital in connection with ACS or pulmonary embolism was logical. There was no basis for rejecting it as being incapable of being logically supported.

[38] Although family history was relevant, it was less relevant than Mrs Taylor's relatively young age. Dr Malloch had taken into account Mrs Taylor's social/lifestyle factors. Where he had been given a clear history directly by the patient which did not include chest pain, it was open to him to be satisfied with that, without requiring to inquire whether a statement about chest pain made by a third party on the phone had been withdrawn. The proper approach was to look at the constellation of symptoms elicited on history, presentation and examination in the round. On the information available to Dr Malloch he was entitled to proceed as he had done. The fact that Dr Malloch's diagnosis of musculo-skeletal pain had not been resolved when he left was not indicative of negligence; Dr Cameron had expressed a firm view that tenderness on palpation was not consistent with a cardiac cause. Professor Wall had agreed that Mrs Taylor's complaint of pain when

moving her neck from side to side was not consistent with ACS but was instead suggestive of a musculo-skeletal problem.

[39] As regards pulmonary embolism, Dr Malloch had been entitled to exclude it. The symptoms elicited by him from Mrs Taylor were not indicative of pulmonary embolism, and her age mitigated against it. There was accordingly no need to consider the fact that Mrs Taylor had been prescribed a COCP as a risk factor.

[40] Finally, the pursuers' case based upon failure to obtain consent was irrelevant. *Montgomery* was not in point. A distinction fell to be drawn between (i) the doctor's role when considering possible investigatory or treatment options, and (ii) the doctor's role in discussing with the patient any recommended treatment and possible alternatives. The first remained an exercise of professional judgment, and no duty existed to discuss that judgment with the patient or seek consent to treat the patient in accordance with it.

Decision

[41] The test enunciated by Lord President Clyde in *Hunter* v *Hanley* 1955 SC 200 at 205 for establishing negligence on the part of a doctor is well known: whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care. Lord President Clyde went on, at page 206, to set out in greater detail what requires to be proved in cases in which deviation from ordinary professional practice is alleged: firstly, that there is a usual and normal practice; secondly, that the defender did not adopt that practice; and thirdly, that the course adopted was one which no professional man of ordinary skill would have taken if he had been acting with ordinary care. In some cases the court will be presented with evidence of two opposing schools of thought as to what is usual and normal practice, and in such cases the approach summarised by Lord

Hodge in *Honisz* v *Lothian Health Board* (above) must be adopted. But in my opinion this is not such a case. It seemed to me that there was very little dispute between Professor Wall and Dr Cameron (and indeed Dr Malloch) as to what would be usual and normal practice in relation to a decision as to urgent referral to hospital of a patient complaining of chest pains. Professor Wall and Dr Cameron were in agreement that not every chest pain is indicative of a cardiac cause, and that not every complaint of chest pain has to be urgently referred. They were also, however, in agreement that if history, presentation and examination suggest even a small likelihood of a cardiac cause, the patient should be referred, because of the potentially fatal consequences if the pain has such a cause. The issue in the present case can, therefore, be stated quite succinctly: would any ordinarily competent general medical practitioner exercising reasonable skill and care in possession of the information provided by Mrs Taylor's history, presentation and examination have referred her as an emergency to hospital? On that issue the experts differed, and I must decide which view to prefer.

[42] I have come to the conclusion that the opinion of Dr Cameron is to be preferred, because it is more securely founded upon the symptoms which I have found, as a matter of fact, to have been reported to Dr Malloch by Mrs Taylor or observed by him on examination. I have in mind in particular the following features relied upon by Dr Cameron:

- Mrs Taylor described the pain as a stabbing pain rather than a crushing pain, which would be indicative of a gastric rather than a cardiac cause;
- Mrs Taylor was not breathless or sweating;
- Complaints of tenderness, as opposed to pain, are not consistent with a cardiac cause because cardiac pain is unaffected by palpation. Tenderness is, on the other hand, a typical symptom of a musculo-skeletal cause.

In these important respects, the symptoms described by Mrs Taylor not only were not typical features of cardiac chest pain but were inconsistent with a cardiac cause.

[43] One of the significant areas of disagreement between the experts was as to whether Mrs Taylor should properly be regarded as having been complaining of chest pain. Professor Wall's final position, as I understood it, was that in the absence of an express withdrawal of the complaint of chest pain made on her behalf by Ms Barr in her phone call to the surgery, Dr Malloch had to proceed on the basis that this was such a complaint, and that it was not therefore safe to exclude a cardiac cause. Dr Cameron, on the other hand, placed greater emphasis on the description given by Mrs Taylor herself, and in particular on her gesture, described by Dr Malloch as indicating her upper epigastrium rather than her chest. I accept Dr Cameron's view that pain in the upper abdomen is more likely to be associated with a non-cardiac cause. The pursuers' submission that in interpreting Mrs Taylor's gesture account should be taken of her obesity and seated position seems to me to amount to a suggestion that Dr Malloch ought to some extent to have mistrusted the description that he was being given; there was no support for such an approach in the view of either of the expert witnesses. What seems to be clear is that Mrs Taylor's gesture did not unequivocally indicate pain in the area of her heart. Dr Cameron emphasised that a non-cardiac cause was supported by a number of other factors including those that I have already mentioned, many of which were inconsistent with a cardiac cause. In these circumstances I prefer his view that Dr Malloch was entitled, taking into account all of the information elicited, to conclude that the gesture should be interpreted as a complaint of pain in the epigastrium and not in the chest. Professor Wall's view that Dr Malloch had to go further to exclude a cardiac cause appears to me to disregard the steps that Dr Malloch did indeed take to exclude such a cause, including questioning and examination, and the

fact that many of those steps disclosed information which was not consistent with a cardiac cause. Assessing his evidence as a whole, I find that Professor Wall has not fully addressed the various respects in which the information available to Dr Malloch was not consistent with a pain of cardiac origin.

[44] Nor, in my view, does Dr Cameron's view fail to take account of any other features indicative of ACS. Dr Malloch's questioning of Mrs Taylor did elicit a complaint of pain down her left arm but I accept Dr Cameron's evidence that left arm pain occurs in association with many types of chest pain. Although vomiting was agreed to be a typical feature of ACS, it could also have a gastric explanation. Diarrhoea was agreed not to be a typical feature of ACS. Professor Wall placed emphasis on the risk factors affecting Mrs Taylor, of which Dr Malloch was undoubtedly aware, including the medical history of Mrs Taylor's mother. Again I am persuaded by Dr Cameron's view that it was appropriate to have regard to the fact that Mrs Taylor, although obese and a smoker, was only 32, and that even if her mother had suffered from angina at an age below 65, this was not of itself one of the higher risk factors.

[45] With regard to the contention that Dr Malloch ought in any event to have referred Mrs Taylor urgently to hospital because of the risk that she was suffering from a pulmonary embolism, I again prefer the evidence of Dr Cameron. The descriptions (above) given by the two experts of the symptoms of pulmonary embolism were broadly similar. Professor Wall's view that it could not be excluded appeared to be based upon (i) Mrs Taylor's pain being properly characterised as chest pain (which, as I have found, was not how it was described to Dr Malloch), and (ii) the presence of risk factors, including in particular the fact that she was taking a COCP. However, as Dr Cameron explained, the symptoms most characteristic of pulmonary embolism were not present and in these circumstances I accept

his conclusion that it was not necessary for Dr Malloch to arrange an urgent hospital admission to exclude this diagnosis. That conclusion is reinforced by his evidence, which I accept, based upon the Wells Score and Geneva Score, that Mrs Taylor had a very low probability for pulmonary embolism.

[46] For these reasons I hold that in deciding not to admit Mrs Taylor to hospital as a matter of urgency, Dr Malloch did not depart from usual and normal practice, and did not fall below the standard reasonably to be expected of an ordinarily competent general practitioner exercising reasonable skill and care. In short, Dr Malloch's diagnosis was wrong, but it was not negligent. The pursuers' case accordingly fails.

[47] Finally, I reject the pursuers' contention that Dr Malloch was in breach of any duty incumbent upon him by virtue of the decision of the Supreme Court in *Montgomery* v *Lanarkshire Health Board* (above). In that case the court held *inter alia* that the doctor was under a duty to take reasonable care to ensure that the patient was aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. But at paragraph 82 the court drew a clear distinction between

> "…on the one hand, the doctor's role when considering possible investigatory or treatment options and, on the other, her role in discussing with the patient any recommended treatment and possible alternatives, and the risks of injury which may be involved".

The former role was described (paragraph 83) as "an exercise of professional skill and judgment: what risks of injury are involved in an operation, for example, is a matter falling with the expertise of members of the medical profession".

[48] The present case is concerned with the first of the two roles described in paragraph 82 above, ie Dr Malloch's consideration of investigatory or treatment options. No issue arose that required discussion of possible alternatives. Had Dr Malloch – or the hypothetical

ordinarily competent doctor exercising reasonable skill and care – decided that Mrs Taylor's history, presentation and examination required her to be admitted urgently to hospital, there would have been nothing to discuss, and the same applies to the decision which Dr Malloch made that urgent admission was not necessary. It was a decision falling within the exercise of professional skill and judgment, and not a decision as to which of two or more alternative forms of treatment, carrying differing risks, ought to be undertaken. To attempt to apply the ratio of *Montgomery* to the circumstances of the present case would, in my view, be to extend it significantly beyond what the Supreme Court regarded as the scope of the duty of care that it had held to exist.

Disposal

[49] In accordance with the defenders' motion, I shall sustain the defenders' second and third pleas in law, repel the pursuers' pleas, and grant decree of absolvitor.