Neutral Citation Number: [2017] EWCA Civ 334

Case No: 2015/1983

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM MR JUSTICE JAY
[2015] EWHC 1536

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 12/05/2017

Before :

LORD JUSTICE JACKSON
LADY JUSTICE KING
and
LADY JUSTICE THIRLWALL

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Between :

FB (Suing by her Mother and Litigation Friend, WAC)	**Appellant**
- and -	
PRINCESS ALEXANDRA HOSPITAL NHS TRUST	**Respondent**

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- -

Ms Elizabeth-Anne Gumbel QC (instructed by **Attwaters Jameson Hill**) for the **Appellant**
Mr John Whitting QC and **Mr Alasdair Henderson** (instructed by **Kennedys Law LLP**) for the **Respondent**

Hearing dates: 1st and 2nd March 2017

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Approved Judgment

LADY JUSTICE THIRLWALL :

1. This is an appeal against an order of Jay J dismissing the appellant's claim in negligence against the respondent hospital at the end of a trial on liability. The respondent was the second defendant to the appellant's claim in negligence. There is no appeal against the judge's dismissal of the claim against the first defendant, a GP in a local out-of-hours service.

2. Jay J made an order for anonymity for the appellant and her mother and litigation friend. We made an order in the same terms at the outset of the hearing of the appeal. In this judgment I shall refer to the appellant as FB and to her mother as WAC.

3. FB was born on 14th August 2002. She became unwell on 18th September 2003. On the evening of 29th September she was admitted to the hospital. She was very ill. On 1st October 2003 she was transferred to Great Ormond Street Hospital where a diagnosis was made of pneumococcal meningitis and multiple brain infarcts. FB recovered but she had sustained permanent damage to her brain; she has learning difficulties and is profoundly deaf.

4. The trial concerned the medical care FB received in the days running up to her admission. On 27th and 28th September her mother contacted the out-of-hours GP service several times and FB was examined by a number of doctors, including the first defendant who examined her at home at around 10pm on 28th September. Nothing now turns on any of those examinations and I record only that they occurred at the instigation of WAC.

5. This appeal arises out of the judge's findings and conclusions about the conduct of Dr Rushd, a Senior House Officer (SHO) who saw FB in the Accident and Emergency (A&E) Department of the hospital early in the morning of 29th September 2003.

6. It was the appellant's case that Dr Rushd was negligent in:
i) failing to take an adequate history and
ii) failing to conduct an adequate examination.
Had she performed either task to the standard of a competent SHO she would have been bound to refer FB to the paediatric team. Instead she discharged her. It was agreed that had FB been referred to the paediatric team she would have been given antibiotics by 9am on 29th September. The antibiotics would have prevented the spread of the infection and FB would not have suffered any injury. The issue at trial therefore was breach of duty. The judge found that there was no breach in respect of either history taking or examination. Both conclusions are challenged in 10 Grounds of Appeal and in a detailed skeleton argument. The oral submissions were directed principally to the conclusion on history taking but in order properly to consider those submissions it is necessary to set out the judge's findings of fact and his approach to the standard of care.

The facts

7. I take the facts from the judgment.

8. Between 4.00am and 4.24am on Monday 29th September, WAC telephoned the out-of-hours service and spoke to the triage nurse. As a result of what she said the triage nurse called the ambulance service. The nurse told the ambulance control room that FB was presenting with *"temperature ...up to 40 she is rolling her eyes and her breathing is a little bit erratic"*. WAC confirmed that information when she spoke directly to ambulance control.

9. An ambulance was dispatched immediately, it arrived at 4.32am. The paramedics recorded, amongst other things *"Mum says patient v lethargic. O/E patient eyes rolling not coordinated"*. There was some discussion about the correct interpretation of that entry during the trial. The judge found that the paramedics had not seen the eyes rolling but that they were repeating what the mother told them she had seen. Nothing turns on this. Having considered the mother's evidence about FB's presentation at that time (see paragraph 49 of the judgment) the judge found that "FB did not suffer a convulsion in the precise technical sense of the term, but it is probable that her eyes did appear to roll, or lose control, for a period of time and in a manner which was extremely worrying." He concluded, "Accordingly I have no doubt that this is what prompted the further call to the out-of-hours service and the arrival of the ambulance."

10. At 4.45am, the ambulance arrived at the hospital under a blue light. At 4.50am, the triage nurse assigned to FB green status. This was the second of four levels of status representing escalating levels of concern. The judge records that the "NT Discriminator" was *"atypical behaviour"*. According to the Manchester Triage scales, the former means *"a child behaving in a way that is not usual in the given situation ... Such children are often referred to as fractious or 'out of sorts'."* According to the nursing note timed at 04:50: *"Patient brought in by ambulance…."*.

11. The judge found that Dr Rushd began the consultation, which took about 25 minutes, at around 5.20am. Dr Rushd wrote up her notes afterwards, beginning at 5.48am. She recorded, amongst other things: *"Impression-Upper Respiratory Tract Infection"*. I shall return to the detail of the examination later in the judgment. FB was discharged at 5.55am.

12. FB's condition worsened and that afternoon WAC contacted the GP. She examined FB and immediately called an emergency ambulance. At 5.53pm, FB arrived back at the hospital, was seen by a triage nurse who referred her straight to the paediatricians. After a delay (which the experts agreed was not material) she was examined, antibiotics were administered and the illness took the course I have already described.

The records

13. As the judge records, according to Dr Rushd's witness statement it was normal practice for the ambulance records and the paramedic records to be attached to the triage nurse's notes. She said that when she saw FB she "would have had available to [her] the A&E front cover sheet already completed by the triage nurse which included basic patient details including name, address, GP name, and time of arrival

in A&E. This indicated that FB had arrived in A&E with her mother at 4.48am with a presenting complaint of pyrexia/unwell. This front sheet was placed in a small booklet with any ambulance record attached. The booklets were then prioritised by the triage nurse for review by the A&E SHO." Later in her statement she said "I can see that I obtained a history from FB's mother and this suggests that I was not aware that FB had arrived by ambulance and nor had I seen the ambulance patient report form with any observations by paramedic staff".

14. At trial Dr Rushd said in terms for the first time (and the judge accepted in his judgment) that the ambulance, paramedic and triage notes were not with the A&E front sheet. The judge gave Ms Whipple QC time to consider whether she wished to amend the pleadings to include an allegation of negligence against the hospital for failing to include the notes with the papers to be seen by Dr Rushd. Counsel did not apply to amend the pleadings. The judge observed that this was the right strategic decision since he would not have allowed the amendment.

15. Whatever the pleaded case, the failure to make this important information available to the doctor has not been explained. It is not easy to see how it might be excused.

The consultation

16. Dr Rushd's evidence about the way she took the history from the parents is set out at paragraph 76 of the judgment. It was her practice to begin a consultation with an open ended question along the lines of "why are you here?" and then if necessary ask follow up questions. Her detailed notes, which are reproduced in full in the appendix to this judgment, record, amongst other things, a four day history of a raised temperature, vomiting, no diarrhoea etc. She also physically examined FB. The judge found that the notes may not have reflected the order in which information was given, the notes being written up in a structured way. He observed that there were a number of errors but considered these minor or immaterial and he accepted that there had been an apparently thorough examination of FB by Dr Rushd which led her to conclude that this child had an upper respiratory tract infection "which was a common diagnosis in a child of her age in the autumn months". She therefore advised the use of Calpol and Nurofen to keep FB's temperature under control and advised FB's parents to return if FB started vomiting, not tolerating oral fluids or developed a non blanching rash.

17. The judge expressly recorded Dr Rushd's evidence that children with this type of presentation were seen by her in A&E at least once a day, and several times a night.

18. Dr Rushd had said in her witness statement and repeated in evidence that if WAC had said that her child's eyes were not tracking or were uncoordinated she would have recorded it but "that on its own is not a worrying sign. Rolling eyes can be voluntary. I would have taken it into consideration. But if her eyes were responding normally [on examination], that would not have altered the subsequent management." The judge was concerned that the evidence may not have been adequately tested in cross-examination. Dr Rushd was recalled. The judge records that Ms Whipple QC, for the appellant, asked a number of questions including the following:

> "Q: If you had been told FB's eyes were rolling and not coordinating that, together with the rest of the history, should have led to a referral to paediatrics?
> A: no."

The judge then asked her some questions. He records the exchange thus

> "Then in answer to my questions Dr Rushd said that if the history given was of the child's eyes rolling and being uncoordinated in the context of a high fever, she would have considered that this might have been a febrile convulsion. Then she said that if there had been any hint of a febrile convulsion, she would have referred the case to the paediatricians. She would not have spent time thinking about it."

19. This was a significant change in important evidence at a very late stage of the case. Later in his judgment the judge said "Dr Rushd was far too slow to accept what she would have done had she been told about the eyes rolling incident, or had elicited it, but I put that down to inexperience with the forensic process and understandable defensiveness, rather than to anything more concerning". This was a generous conclusion given the central importance of the evidence and the very late stage at which the change was made.

The judge's conclusion on the standard of the examination

20. It was the parents' evidence that FB was (amongst other things) lethargic. WAC had said so to the paramedics, as the record shows. Both parents said she was lethargic during the examination. Dr Rushd said she was not lethargic during her examination and that the parents did not say that she was.

21. The judge found that the expert evidence was clear that a child with high level of bacteraemia (which all agreed FB had at the time she was being seen by Dr Rushd) would on the balance of probabilities show "abnormal state variation" and appear more unwell than a child who merely has a simple URTI. Dr Rushd recorded that FB looked well. At paragraph 106 the judge records "I am satisfied on the balance of probabilities that FB was at the very least exhibiting abnormal state variation when Dr Rushd examined her. More specifically she probably was unusually quiet and passive." Notwithstanding the experts' view as to the likely presence of lethargy the judge did not accept "important parts of the parents' evidence relating in particular to obvious lethargy at the time of Dr Rushd's examination". He therefore concluded that such signs as were there, on the expert evidence, were subtle and would need an experienced eye to pick them up. He relied on the observation of the defendant's causation expert, Dr Ninis that "the level of what you are trying to identify often needs a senior pair of eyeballs". Having recorded that Dr Rushd's note that FB looked well, was alert and active, and responsive to her surroundings, reflected her genuinely held professional view, the judge said "Dr Ninis, did not say in terms that it would not be unacceptable practice for an SHO to fail to pick up this abnormal state variation but that is the conclusion I draw from all the evidence I have heard." He therefore concluded that there had been no breach of duty in the way Dr Rushd carried out the examination of FB.

The judge's conclusion on the standard of history taking

22. It was common ground that nowhere did Dr Rushd record why the parents had brought FB to hospital at 4.30am. As the judge had found, it was the eye rolling episode which precipitated the emergency call and the ambulance to hospital.

23. At paragraph 167 the judge recorded the parents' evidence that they would have given this information if asked and concluded "I have no doubt that they would have done and they are not to be criticised in any way for failing to do so". The judge identified the issue for him to determine as "whether it was sub-standard practice for an SHO in Dr Rushd's position to fail to obtain this information from the parents".

24. This judge found this difficult. He said that the "final point has proven to be the most troubling, namely whether Dr Rushd was negligent in failing to elicit the history of eye rolling being the immediate and direct prompt to the advent of this family to A&E at this particular time."

25. Having referred back to some of the evidence and set out the respective arguments to which I shall return, the judge expressed his conclusion at paragraph 169, "In my judgment, a Consultant A&E doctor or paediatrician either would have picked up the abnormal state variation or embarked on a line of inquiry which was likely to have elicited Ms Whipple's coda [ie the information about the eye rolling episode which precipitated the emergency call]. In particular an experienced doctor would probably have said to the parents something along the lines – "this child looks fine to me, how was she different earlier?"

26. He developed the conclusion further, by reference to the fact that an experienced clinician "acquires an armamentarium of diagnosis and inquisitive resources, part intuitive and part knowledge-based, which enable her or him to penetrate more deeply into any given situation". He concluded "overall that it was not substandard practice for Dr Rushd to fail to elicit the relevant history".

Grounds of appeal

27. Ms Gumbel QC who did not appear below, concentrated her oral submissions on ground 1, that when dealing with the history taking the judge applied the wrong standard of care. Grounds 2-5 are directed to that same issue. She submitted, and I agree, that if she succeeded on ground 1, it was not necessary to consider grounds 6-10. If she failed on ground 1 she was unlikely to succeed on the other grounds.

28. Mr Whitting submitted that ground 1 and the grounds that support it are challenges to the judge's findings of fact and should be dismissed.

29. Ms Gumbel submits that in paragraph 169 (see above at paragraph 25) the judge conflates two things: the standard to be expected of an SHO when confronted with subtle signs on examination and the standard to be expected of an SHO in obtaining a history. There is force in that submission.

30. I have had the advantage of reading the judgment of Jackson LJ in this case. He there sets this appeal in the context of the law of negligence generally and of

professional negligence in particular. I agree with his analysis and add only that in every case of alleged clinical negligence the court is concerned with the acts and/or omissions of a doctor or other medical professional in the context of a particular task or tasks whether it be the delivery of a baby, the examination of a patient, the performing of surgery, the taking of a history and so on. There is often a correlation between the complexity of the task and the seniority of the doctor but many tasks are carried out by doctors of different seniority; surgery is often performed by a consultant surgeon. When it is performed by a registrar the standard of competence required is the same as that required of the consultant. As Jackson LJ observes where a doctor in a particular post does not exercise the degree of skill required for the task in hand, the health trust is liable.

31. There is some debate about the standards that may apply in respect of specialist procedures in tertiary centres. In such cases the second limb of the *Bolam* test is in sharp focus. This is not such a case. It concerns the standard of competence of an SHO taking a history in the A&E department of a District General Hospital.

32. Ms Gumbel submits, without fear of contradiction, that history taking is a basic task, taught from a very early stage at medical school. Dr Maconochie, the respondent's expert on paediatric emergency medicine, gave evidence to that effect and described communication as a fundamental aspect of the work doctors have to do.

33. Dr Evans, an expert in emergency medicine, called on behalf of the appellant, was firm and consistent in his evidence that it was a breach of duty to fail to elicit the reason FB had been brought to hospital in the early hours. He accepted that the question Dr Rushd said she asked "why are you here" was a reasonable opening gambit, "but I'd want to know specifically why they presented then and try and find out why. Temperature of a few days isn't a reason to present in the early hours of the morning….. the doctor is the trained individual who has to ascertain why a child is presented in the early hours of the morning and what was the precipitant of that…what was the anxiety that caused them to be present that evening…It's essential history taking."

34. In answer to questions from this court about whether there was any exploration in evidence or in submissions of the novel proposition that there was a variable standard of care applicable to history taking in A&E depending on the seniority of the doctor, Ms Gumbel referred us to the single passage in the transcript where it was raised. The judge asked Dr Evans a number of questions directed to the standard of care. It is sufficient to refer only to the following exchange "My question was does there come a stage where a doctor says to the parents "The child is looking well to me. Is this how she has been over the recent period?"

> **A** that's a very reasonable way of assessing how the child is and is the parent happy with the child."

The judge went on to ask whether that was an answer he was giving as an experienced consultant or "is it an answer which you say an SHO in Dr Rushd's position…should have asked?

> **A** every A&E doctor, particularly a doctor with some paediatric

> experience, would know that the parental opinion is very important and parental concern and it's why have they brought that child into that department that night, what's worrying them? You have to home in on that."

35. This issue was not developed by either side and no submissions were directed to it. There was no evidence to the effect that a question of the type identified by the judge would be outwith the competence of an SHO in A&E. There was no evidence or submission to the effect that there was any difference between the standard required of an SHO and the standard required of a consultant in taking a history in A&E.

36. At paragraph 134 the judge found that "I have no doubt but that Dr Rushd tried to elicit a full history from the parents and adopted her standard practice in asking an open facilitative question. She may well have asked follow up questions". He later pointed out that no expert had criticised her technique. True it is that no one criticised her for asking an open question to start the process but Dr Evans was, as I have already described, highly critical of her failure to ask a question or questions which elicited the reason the parents had brought FB to hospital in the early morning. The judge recorded "As Dr Evans put the matter, the SHO failed to ascertain the key issue of why the parents were in the A and E Department at 05.00; this was an "essential facet of the history"". Dr Evans had written his report and given evidence in chief on the understanding that Dr Rushd had seen the ambulance record. When he learned that this was not the case he remained of the view that Dr Rushd should have elicited the history. The judge said "Dr Evans' evidence…..proceeds along a path of reasoning that I cannot accept. Because there is no reason for the parents failing to detail this evidence, Dr Evans says, it follows that there was a failure to elicit it. That, in my view, involves a non-sequitur". This is puzzling. The judge observed in several parts of the judgment (including at the end of paragraph 169) that there was a failure to elicit the reason/prompt/precipitant for FB's parents to bring her to hospital at that time. There could be no doubt about that. The question was whether that failure was a breach of duty. The judge had accepted that the parents would have given the information if asked. It followed therefore that they were not asked.

37. At paragraph 146 of the judgment the judge sets out an exchange between Ms Whipple and Dr Maconochie: "Ms Whipple rightly pressed Dr Maconochie on whether Dr Rushd's history-taking appears to be deficient because there is no explanation of why the parents were present in A&E *then*. The clinical notes record that the child had been pyrexial for four days, from which it might be inferred that there was no particular urgency. My note of the key features of Dr Maconochie's evidence on this theme reads as follows "It is quite common to see people present whenever [ie irrespective of the time of the day or night] with children with temperatures. It depends on parental anxiety, and on the quality of access of other services…we understand why parents come, and to manage their anxiety…Yes, there is a negotiation entailed in taking a history from parents. I have had to reprimand an SHO for asking, "why have you come at this time?"…asking the question "what is the problem?" is usually adequate to ascertain the precipitator". Three things arise from that:
First, Dr Maconochie did not disagree (nor could he) with Ms Whipple's proposition

that Dr Rushd had not elicited an explanation for FB being brought in at that time. Second, in Dr Maconochie's own example the SHO was seeking to ascertain why the child had been brought in at that time. Dr Maconochie did not suggest this was something that would normally be expected only of a consultant. His criticism was about the way in which the question was asked (as is clear from the transcript). Third, in saying that the open question he identified is "*usually* adequate to ascertain the precipitator" Mr Maconochie was recognising (as Dr Evans had before him) that such a question is not always adequate, as was the case here.

38. Although not included in the judgment the transcript reveals that during his evidence Dr Maconochie agreed with Ms Whipple's proposition that it was a "really important feature of a sensible proper history taking" for an A&E doctor who had not elicited an explanation of what has triggered this trip to A&E to follow up with a "sensible, nicely phrased question, again seeking to work out what is the precipitant." He went on to say that "the doctor had taken a history, determined what the cause in the history was for them to be concerned to come. She then did the examination and then from that then concluded what the diagnosis was."

39. What Dr Maconochie's evidence (and the respondent's defence) came to was that Dr Rushd had elicited *a* history from which (in conjunction with her examination) she could make a diagnosis which fitted with the most common diagnosis. Despite persistent cross examination Dr Maconochie never directly addressed the fact that given that Dr Rushd had not elicited the precipitant she had not obtained *the* history of this child. As the judge observed, he had also failed in his written report to deal with the question of the failure to elicit the information. That was a significant omission in the light of the evidence of Dr Evans.

40. Mr Whitting submits, for the first time on appeal, that history-taking is not a one-size-fits-all task. He draws attention to the different skills needed when taking history from different groups of patients eg children or the elderly. These submissions are correct; that is why there are no NICE guidelines or pre-set questions for history taking, as Mr Whitting reminded us. It is for the doctor in A&E to use appropriate techniques to elicit why the patient is there at that time. The standard of care imposed on the history taker is the same, how it is discharged may well be different depending on the patient and the context. Here it was a young child with very anxious parents in the early hours of the morning. What was it that caused her to be there then was the fundamental question.

41. The judge records that Dr Rushd told the court

> "usually, if [there are] rolling eyes, that is scary. I wouldn't need to ask the right question; the parents would tell me first of all. In all my years in A&E and as a GP subsequently, you don't need to ask the question."

Dr Rushd seemed to be unaware or had excluded from her consideration that the parents in this case had observed the frightening eye rolling episode but had not told her about it. More importantly, she could not know how often a parent had not volunteered information. The judge considered that she was "really expressing an opinion, admittedly one based on her experience of human nature and her practice as a doctor. By definition, however, she cannot know the number of occasions on which patients, for whatever reason, have omitted to give a full history." This

evidence does not feature in the judge's analysis of whether the doctor's history taking was substandard. An approach predicated on a mistaken belief that there are some things that do not need to be asked about is plainly flawed.

42. The judge foreshadowed his conclusion at paragraph 168. He placed significant weight on the evidence of Dr Maconochie about the fact that parents may attend A&E at all hours of the day and night without there being any direct and obvious precipitating factor. He said, "In my judgment it is incorrect in this sort of situation to subject human nature and behaviour to an overly rigorous and inordinately logical analysis. Although we know that there was in fact a clear precipitating factor, human nature is such that there often does not have to be." He went on to reject the evidence of Dr Evans and the submissions of counsel for the appellant on the grounds that "they have a tendency towards circularity and to rely on hindsight."

43. There the judge fell into error. The fact that there is no clear precipitating factor in many cases is not an answer to a failure to elicit such a factor when there is one. That is the fundamental purpose of history taking. The fact that most children who are brought to A&E are not really unwell is not an answer to a failure to elicit the information which leads to the identification of the unwell child, particularly where, as here, the parents are willing to give the information. There is nothing overly rigorous or inordinately logical about the proposition that it is for an A&E doctor (absent special features such as drunkenness, refusal to comply etc – none of which apply here) to elicit the reason for a child being brought to A&E in the early hours of the morning. On the contrary this is the basic requirement of the history taker.

44. The judge had already found that Dr Rushd's genuinely held view was that this child was alert, active and well etc. As Jackson LJ observed during submissions, in those circumstances it might be thought obvious to seek to establish what had caused the parents to bring her to hospital in the early hours. Dr Evans had given evidence to that effect.

45. The judge followed the same line of reasoning and identified a question which would have elicited the history. I hope I fairly describe the question as entirely obvious. Unlike the examination where the judge considered, in light of the evidence of Dr Ninis, that the ability to pick up subtle signs comes with experience, there was no evidence that the need for a question like the one posed by the judge would be apparent only to a consultant. Dr Evans' evidence, which was unchallenged, was to the contrary effect. No one suggested that the question or something like it was beyond the competence of an SHO. If the question should have been asked by a consultant (and I do not doubt that it should), it should have been asked by an SHO.

46. The judge's view that there was a lower standard of care for an SHO than for a consultant in history taking in A&E was unsupported by evidence and cannot be sustained.

47. It is inescapable that Dr Rushd did not elicit why the parents had brought FB to hospital in the early hours of the morning. This was probably the result of a flawed approach to history taking:
First, she believed, wrongly, that where a parent has witnessed something

frightening it is not necessary to elicit it, it is always volunteered (see paragraph 39 above).
Second, having formed the view that the child was well (and knowing that most children brought to A&E are in fact well) either she did not think about it or she did not consider it necessary to establish why FB had been brought to hospital at that time. As a result she did not ask the judge's obvious question or anything like it.

48. In my judgment the conclusion that the history taking was not carried out to the standard to be expected of a competent SHO is inevitable.

49. In the light of my conclusions on the history taking I am satisfied that Dr Rushd was in breach of duty and negligence is established. I do not consider it necessary to deal with any other grounds. I would allow this appeal.

Lady Justice King

50. I have had the advantage of reading in draft the judgments of Jackson LJ and Thirlwall LJ. I agree with them. I would allow this appeal.

Lord Justice Jackson :

51. I agree that this appeal should be allowed for the reasons stated by Thirlwall LJ. I wish, however, to add a few words of my own about the point of principle on which this appeal turns.

52. At paragraph 169 of his judgment the judge said:

> "In my judgment, a Consultant A&E doctor or paediatrician either would have picked up the "abnormal state variation" or embarked on a line of inquiry which was likely to have elicited Ms Whipple's "coda". In particular, an experienced doctor would probably have said to the parents something along the lines – this child looks fine to me, how was she different earlier? The fact that WAC and Paul were relatively young, and possibly over-anxious, parents is a factor which cuts both ways in this case, but an experienced doctor might well have probed further. On balance and in the light of all the evidence I have heard, I have concluded FB's case under this sub-heading places too high a standard of acceptable practice on an A&E SHO. An experienced clinician acquires an armamentarium of diagnostic and inquisitive resources, part intuitive and part knowledge-based, which enable her or him to penetrate more deeply into any given situation. Overall, FB has failed to satisfy me on the balance of probabilities that it was sub-standard practice for Dr Rushd to fail to elicit the recent history."

In other words, it would have been negligent if "an experienced doctor", such as a consultant A&E doctor or paediatrician, had failed to elicit the relevant facts. But such a failure by an SHO in the A&E department did not amount to negligence.

53. That paragraph raises in acute form the question: what standard of skill and care should the law require from a young professional person in the early years of her career? I shall address this question in three stages:

    i) The general law of negligence.

    ii) Professional negligence.

    iii) The present case.

1. The general law of negligence

54. The issue arising in this case is part of a wider problem with which the courts have wrestled for over a century, namely to what extent are the personal attributes and experience of the defendant relevant in determining whether he/she was negligent? The general rule is that the courts disregard them. Nevertheless, there are some characteristics of a person which the law cannot ignore, for example the fact that she was a child. In *Mullins v Richards* [1998] 1 All ER 820 the court judged the conduct of the defendant by the standard of "an ordinarily prudent and reasonable 15-year-old schoolgirl".

55. Oliver Wendell Holmes formulated the underlying principle in the third of his famous lectures on *The Common Law* as follows:

> "There are exceptions to the principle that every man is presumed to possess ordinary capacity to avoid harm to his neighbours, which illustrate the rule, and also the moral basis of liability in general. When a man has a distinct defect of such a nature that all can recognize it as making certain precautions impossible, he will not be held answerable for not taking them."

56. From the defendant's point of view, it is harsh to disregard their limitations and to hold them liable for doing that which they could not help doing or for failing to achieve that which they could not achieve. But a claimant is entitled to expect that those whom he or she encounters in the ordinary transactions of life will adhere to certain general standards. Thus in *Nettleship v Weston* [1971] QB 691 the Court of Appeal held that a learner driver should be judged by the standards of a competent and experienced driver. In effect, the law of tort achieves a compromise. It takes account of those characteristics which cannot be ignored (for example that the defendant was a child or was blind), but subject to that it imposes a general duty of care upon all members of society, which is not tailored to their individual strengths and weaknesses.

2. Professional negligence

57. In the context of professional negligence litigation, the foundational twentieth century authority setting the required standard of skill and care is of course *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582. The defendant is required to exercise the skill and care of a reasonably competent member of his/her profession. The defendant's obligation to exercise that degree of skill and care is

sometimes contractual, sometimes tortious and sometimes both. In the present case, there was no contract between the parties. So Dr Rushd's duty to exercise reasonable skill and care in assessing the claimant was a duty imposed by the law of tort.

58. In some of the earlier professional negligence cases, the courts focused upon the individual experience of the defendant in determining what constituted a reasonable degree of skill and care. In *Junior v McNicol* (Times Law Reports, March 26, 1959) the court took into account that the defendant house surgeon was "a comparative beginner". In *Hucks v Cole* (Times Law Reports, May 9, 1968) the Court of Appeal held that the defendant was to be judged by the standard of "a general practitioner with a diploma in obstetrics".

59. In *Wilsher v Essex AHA* [1987] 1 QB 730 the Court of Appeal for the first time gave detailed consideration to the standard of care required of a junior doctor. (This issue did not arise in the subsequent appeal to the House of Lords). The majority of the court held that a hospital doctor should be judged by the standard of skill and care appropriate to the post which he or she was fulfilling, for example the post of junior houseman in a specialised unit. That involves leaving out of account the particular experience of the doctor or their length of service. This analysis works in the context of a hospital, where there is a clear hierarchy with consultants at the top, then registrars and below them various levels of junior doctors. Whether doctors are performing their normal role or 'acting up', they are judged by reference to the post which they are fulfilling at the material time. The health authority or health trust is liable if the doctor whom it puts into a particular position does not possess (and therefore does not exercise) the requisite degree of skill for the task in hand.

60. Thus in professional negligence, as in the general law of negligence, the standard of care which the law requires is an imperfect compromise. It achieves a balance between the interests of society and fairness to the individual practitioner.

61. Where a professional negligence claim is brought in contract, the standard of care required may be more nuanced. In *Duchess of Argyll v Beuselinck* [1972] 2 Lloyd's Rep 172 Megarry J drew a sharp distinction between contract and tort. At 183 he said:

> "The essence of the contract of retainer, it may be said, is that the client is retaining the particular solicitor or firm in question, and he is therefore entitled to expect from that solicitor or firm a standard of care and skill commensurate with the skill and experience which that solicitor or firm has. The uniform standard of care postulated for the world at large in tort hardly seems appropriate when the duty is not one imposed by the law of tort but arises from a contractual obligation existing between client and the particular solicitor or firm in question."

The contractual cases are not entirely consistent on this point. Contrast, for example, *Sharp and Roarer Investments v Sphere Drake Insurance* [1992] 2 Lloyd's Rep 101 with *Andrew Master Hones v Cruikshank & Fairweather* [1980] RPC 16 at 18. Fortunately, we do not need to address that problem in the present appeal.

62. The present case is concerned only with tortious liability. I do not wish this judgment to be taken as accepting that in contractual professional negligence claims the particular experience and CV of the defendant should be ignored, as they must be in tortious claims. In a contractual case, the claimant may have selected and retained the defendant precisely because of their experience and CV. In a tortious claim, however, such as the present case, the claimant and her parents may play no part in the choice of doctor.

3. The present case

63. The conduct of Dr Rushd in the present case must be judged by the standard of a reasonably competent SHO in an accident and emergency department. The fact that Dr Rushd was aged 25 and "relatively inexperienced" (witness statement paragraph 5) does not diminish the required standard of skill and care. On the other hand, the fact that she had spent six months in a paediatric department does not elevate the required standard. Other SHOs in A&E departments will have different backgrounds and experience, but they are all judged by the same standard.

64. I agree with Thirlwall LJ that history taking is a basic skill which hospital doctors at all levels are expected to possess. The fact that FB's eyes had been rolling and uncoordinated was the event that precipitated the hospital visit. The ambulance staff picked this up. I do not accept the judge's conclusion that only a doctor more senior than Dr Rushd can reasonably have been expected to elicit this important fact. Therefore the judge's decision cannot stand.

65. Before parting with this case, I must acknowledge that junior hospital doctors work long hours under considerable pressure. They are often involved in life and death decisions. The pressures can be even greater when they are working all night, as Dr Rushd was here. If mistakes are made, it is devastating for the patient and it is expensive for the NHS trust. Doctors, however, are human. Even good and conscientious doctors may, from time to time, fall short. That is not a reason to lose heart or (even worse) to abandon medical practice. Those who have learnt from past mistakes often have even more to offer.

Appendix to judgment

Notes of Dr Rushd

"**History from parents**
05:45
Presenting complaint ↑ temperature
History of Presenting Complaint 4/7 history of ↑ temperature – fluctuating. Vomited 3 times over last few days. Runny nose. Non-productive cough.
º rash
º diarrhoea. Bowels opening daily – normal
Not eating much solids but drinking sips of water, juice etc
Passed urine 3 times today
Seen by GP, emergency Dr 2 times over last few days – No Abnormalities Detected
Dropped off urine sample to GP – awaiting results

Previous Medical History
Nil No known drug allergies
…

On examination
Looks well
Alert and active
Responsive and aware of surroundings
Pink
Well hydrated – moist mucous membranes
– good skin turgor
– capillary refill time less than 2 seconds
Temperature 36.0 (post nurofen)
Pulse 150/minute
Respiratory rate 36/minute
Oxygen saturation 98%
Pupils equal and reactive to light and accommodation [i.e. responsive to stimuli]
…
Chest examination – [normal]
Abdominal examination – [normal]
Neurological examination — normal tone, power, co-ordination. Moving all 4 limbs spontaneously
ENT examination – [both] ears, red, left more than right; throat – congested. Tonsils not enlarged. Pink. Nose – crusting around nostrils.
Impression – Upper Respiratory Tract Infection
Plan
Reassure
Regular calpol and nurofen
Encourage oral fluids
Discharge home [this was at 05:55]
Advised to return if vomiting → not tolerating any oral fluids, non-blanching rash etc
Parents happy with plan"