



Neutral Citation Number: [2020] EWHC 642 (QB)

Case No: QB-2017-003077

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: Thursday 19th March 2020

Before :

HIS HONOUR JUDGE AUERBACH
SITTING AS A JUDGE OF THE HIGH COURT

Between :

JOANNE DOWSON

Claimant

- and -

DR ASHLEIGH LANE

Defendant

Mr P Dean (instructed by **Armstrong Foulkes**) for the **Claimant**
Ms H M Mulholland (instructed by **CMS Cameron McKenna Nabarro Olswang LLP**) for
the **Defendant**

Hearing dates: 27 – 31 January 2020

Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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HIS HONOUR JUDGE AUERBACH

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Introduction

1. The Claimant brings a claim of clinical negligence against the Defendant, who is a GP. The claim was begun in 2017. The GPs' practice at which the Defendant was working at the time was previously also a party, but the claim against that practice, as such, was discontinued at the start of 2019. So I shall simply refer to the parties as the Claimant and the Defendant.
2. The Claimant has type 1 diabetes. The negligence is said to have been by way of a failure to appropriately treat and refer a problem with her left foot. It is claimed that, in the spring of 2014, the Defendant should have made an urgent referral to the Medical Foot Clinic, which would have led to a diagnosis of a condition called Charcot foot or Charcot arthropathy. In the event, following a referral to that Clinic, that was diagnosed by it at the very end of December 2014. It is claimed that an earlier referral, diagnosis, and ensuing treatment, would have had a critical impact on outcome.
3. The amended particulars of claim specifically made three specific allegations of negligence. As originally framed, these were as follows. The first was of the Defendant failing:

“... on 14 March 2014 to identify and treat appropriately the potentially significant problem in the Claimant's left foot. Charcot's arthropathy should have been considered in a diabetic, such as the Claimant, if there was redness, warmth or swelling, with or without deformity or pain, especially in the presence of peripheral neuropathy. While it would have been reasonable to arrange an urgent Doppler scan to eliminate DVT, this would have taken at most a week. Thereafter, once a DVT had been excluded, as it would have been, the [Defendant] should have made an urgent referral to the Medical Foot Clinic where the Claimant would have been seen by the end of March 2014.”

4. The second allegation was of the Defendant failing:

“...on or shortly after 14.4.14, when the results of the Doppler scan excluding DVT became available to her, to make an urgent referral to the Medical Foot Clinic where the Claimant would have been seen by the end of April 2014.”

5. The third specific allegation was of the Defendant failing

“...on or shortly after 25.4.14, when the results of the ultrasound scan she had commissioned became available to her, and she already knew that DVT had been excluded, to make an urgent referral to the Medical Foot Clinic where the Claimant would have been seen in early May 2014.”

6. There was also a generalised pleading that the Defendant had failed to exercise reasonable skill and care. It was also claimed that there was a treatment window of about three months from the onset of the active stage of the disease, which in this case (it was claimed) had started in mid to late February 2014; and that the time for effective treatment had passed by early June 2014. So it was alleged that, had the Claimant been referred to, and seen by, the Medical Foot Clinic in late March, late April or early May 2014, she would, on balance, probably “have made a reasonable recovery, remaining fully mobile.” Alternatively, the delay in diagnosis and treatment were said to have made a material contribution to the outcome.
7. The claim is fully defended. This trial had been directed to be of the issues of both breach of duty and causation of injuries generally. However, on day two, following a discussion with both counsel about aspects of the state of the medical evidence, and potential further issues that might arise, should breach of duty be found, and by consent, I directed that this trial be restricted to breach of duty and one aspect of causation only. That aspect concerns a deformity of the Claimant’s left foot identified at the Foot Clinic on 31 December 2014 and in an X-ray that day and an MRI scan then carried out in January 2015.
8. Further, in closing submissions, in light of how the evidence had unfolded, Mr Dean, for the Claimant, conceded that the second of the three particularised allegations could not succeed; and that no significance could properly be attached to the DVT test referral and results, so that references to that in the pleaded case should be ignored.
9. The lay witnesses were, for the Claimant, the Claimant herself and her husband, Melvyn Dowson, and, for the Defendant, the Defendant herself. Following the Claimant’s initial cross-examination, Mr Dean tabled a copy of her initial proof of evidence, taken by his instructing solicitors. Following a discussion of this, and an associated issue concerning her evidence, and by consent, this document was admitted into evidence, and the Claimant was recalled and gave some short further evidence in chief on which she was also further cross-examined.
10. There were the following expert witnesses, who all gave live evidence. As to breach of duty, there were experts in general practice: Dr Bhatt for the Claimant and Dr Middleton for the Defendant. As to causation, there were physicians whose expertise is in diabetology – Drs Bodansky and Ahlquist respectively; and experts in orthopaedic surgery – Messrs Chell and Singh respectively. In all cases the agenda for joint discussions had not been wholly agreed, so there were pairs of joint statements, though there was a good deal of overlap.
11. I had a four-volume bundle, of which three volumes consisted of the medical records. I benefitted from written skeletons, closing notes, and extensive oral closing submissions from Mr Dean and, for the Defendant, Ms Mulholland.

The Factual Background and Chronology

12. The Claimant was born in 1970. She has a longstanding history of type 1 diabetes, having been first diagnosed in 1992. She has for some years had diabetic retinopathy and is partially sighted. In autumn 2012 she had a heart attack.

13. On 28 February 2014 the Claimant attended her GPs' practice, accompanied by her husband. She was seen by the Defendant. The Defendant was, at the time, a GP Registrar. That is to say, she was a GP in the third and final year (part-time equivalent) of her rotational training. Although it was the practice to inform patients when they booked an appointment, if the doctor they would be seeing was a Registrar, and the Defendant was so designated on the door of the consulting room, I accept that, for whatever reason, the Claimant did not appreciate that the Defendant was a trainee at the time.
14. There was a factual dispute about whether the Claimant had, at this particular consultation on 28 February 2014, raised a concern about her left foot.
15. The standard format for the electronic record of a consultation created by the GP was: Problem, History, Examination, Diagnosis, Plan. The standard appointment length, to which the Defendant was by this time working, was ten minutes. In principle, a patient ought to raise only one problem per consultation. The GP might be persuaded to consider a second, if time allowed, but a patient with more than one problem was liable to be told to book a further appointment.
16. The record made by the Defendant, of the consultation on 28 February 2014, refers to the Claimant having attended with her husband and with "a list of problems". It specifically identifies two problems being raised and assessed, being depression (at some point re-labelled "grief reaction"), and indigestion. The fact that the Claimant had had a heart attack (MI – myocardial infarction) is noted. The general electronic patient record also flagged to the Defendant that the Claimant was diabetic. The Defendant recommended a counselling service for the depression and she prescribed medication for the indigestion. There is nothing in the record about the Claimant's foot.
17. The Claimant's evidence was that her left foot had swollen up overnight following a trip with her husband to the supermarket on 21 February 2014. After a week the swelling had not improved, and she decided to go to the GP about this, and other problems that had been building up. Because her foot was swollen, her husband took time off to take her to the appointment. Her evidence was that the foot was her priority concern.
18. The Claimant's evidence was, further, that she asked the Defendant if the foot should be X-rayed. The Defendant asked if she had any pain, and, when she said not, said that in that case it was not broken and an X-ray was unnecessary. The Defendant glanced at the foot but did not physically examine it. The Defendant said she did not know the cause of the problem, but told the Claimant to rest and elevate the foot, and, if it had not improved within a week, to come back. The Claimant maintained that account under cross-examination.
19. Mr Dowson, in evidence, also referred to the swelling beginning following the supermarket visit, to the Defendant saying that the Claimant did not need an X-ray as she was not in pain, and that she did not know the cause of the swelling, and telling the Claimant to rest and elevate the foot. In cross-examination he said that the Claimant had a slipper or sandal on, which she removed when she mentioned the foot, and that the Defendant glanced at it, but did not touch it. She said to come back in two weeks if it had not improved. He said that the foot was the Claimant's priority,

and the reason he took time off to take her to the GP; but he could not say in what order the different matters had been raised.

20. Both the Claimant, and Mr Dowson, disagreed with the suggestion that they had confused this consultation with the next one, on 14 March 2014.
21. The Defendant's evidence was that she recalled this consultation, as the Claimant came with her husband, was particularly upset and had a long list of problems. The Claimant's main issue was with marked anxiety. The Defendant asked the Claimant to book a follow-up for three weeks. Under extensive cross-examination the Defendant's evidence was, in summary, that she did not recall the Claimant raising the matter of her foot, that if the Claimant had done so, she would have recorded it in the notes, and that, as she had not recorded it, and given that she had made fairly full notes, she did not accept that it had been raised. If it had been, she would have physically examined both feet, and recorded what was found on examination.
22. The Defendant further said that the Claimant was upset, and jumping around between subjects. By the time the mental health issue, irritable bowel syndrome and reflux had been discussed, the consultation had already gone on twenty minutes. She would not have allowed anything else to be raised. She recorded matters in the order raised. The primary issue was mental health. She could "guarantee" that the foot was not raised at the start. Had it been the first problem raised, it would have been first on the record, and explored fully. Pressed as to whether the Claimant might have mentioned it, however casually, she accepted that possibility, but maintained that if the Claimant had said she had come because of her foot, she'd have started the consultation by considering it first.
23. My findings of fact in relation to this particular dispute are as follows.
24. I accept that the Claimant had been experiencing some swelling of her foot in the week prior to this visit, in particular bearing in mind that she and Mr Dowson were both able to identify its onset as having followed a particular supermarket outing, and this was also mentioned, as I will describe, on a later visit to A & E. However, I also accept the Defendant's evidence that, if the Claimant had identified it as the, or the main, reason for the consultation at the outset, she would have conducted a full examination, and the record would have reflected this. I also find that the Claimant was upset, not entirely clear and orderly in the way she discussed things, and that, by the time the topics which *were* recorded had been discussed, the consultation had run some twenty minutes.
25. However, on the balance of probabilities, I find that there was also some mention by the Claimant of her foot, after these other matters had been fully discussed. I accept the Claimant's account, in essence, of how the exchange went. But the context was as I have described – effectively by way of a query about something else, and in particular whether she might need an X-ray, rather than being advanced as a specific reason for the consultation. The consultation had already covered more than one problem and had overrun. The Defendant offered the Claimant reassurance on the subject of an X-ray, and thought it sufficient to tell her to come back if the foot did not improve.

26. That is the conclusion which emerges to me as most probable, in light of the picture painted by all of the evidence. Though it is not essential to my reasoning, this conclusion is also, to my mind, supported by the fact that, in the entry made by the Defendant on the occasion of the next consultation, on 14 March 2014, under “History” she wrote: “Continued swelling from L foot”. I think it more likely that this reflected the fact that it had been mentioned last time, than that this reflected the Defendant recording the word used by the Claimant to describe an ongoing problem that she had not in fact mentioned before. “Continued” would not have been a natural word to describe something which had been ongoing for some time, but was being raised for the first time.
27. The Claimant indeed returned to see the Defendant on 14 March 2014, again accompanied by her husband. The record identifies three problems that were discussed. The first was diabetic retinopathy. In the course of the discussion the Defendant asked the Claimant to book a review with the practice’s diabetic clinic, to discuss her control of her diabetes, which the Claimant said was, though improving, not good. The second problem discussed was grief reaction.
28. There is no dispute that on this occasion the Claimant also raised the subject of her foot. The printout in the trial bundle, from the electronic GP’s record, refers to the “Problem” as “Charcot’s joint of foot”, with an associated code. However, the Defendant confirmed in evidence that that was not her diagnosis at the time, and that entry, in those words, was not made at, or around, that time. A letter from the Practice Manager explains that it was a feature of the software that, after Charcot foot was diagnosed by the Diabetic Foot Clinic at the end of 2014, the original entry made at this consultation was retroactively amended. The same applies to other references to Charcot foot that also now appear in the notes respecting later consultations prior to 31 December 2014.
29. This meant that I did not have before me any printed record of the precise words of the entry that the Defendant actually made, under “problem” at the time. However, in evidence she told me that what she would probably have written either “leg oedema” or “foot oedema”, being terms from the menu that she commonly used.
30. As to the history, the record was: “Continued swelling from L foot. Achy. No trauma.” As to examination, the record was: “Swollen, pitting oedema.” “Achy” was the word that was used by the Claimant when asked if there was pain. The Defendant accepted in evidence that she did not consider that this might be Charcot foot. She did not know what was causing the swelling, but there were a number of possible causes in her mind. She decided as the next step to refer the Claimant for a routine ultrasound scan of the left foot.
31. Prior to that ultrasound taking place, on 2 April 2014 the Claimant’s husband took her to A & E. The swelling had not abated and the discomfort had increased. The initial assessment record describes the complaint as a swollen leg and the Claimant reporting a “shooting pain on foot 5 weeks ago” and having noticed swelling immediately. It recorded “swelling is going up the leg” and numbness of the 4th and 5th toes. The further assessment record refers to the left foot pain having “come on suddenly when in supermarket.” A Doppler imaging scan was carried out, which excluded the possibility of a deep vein thrombosis (DVT). She was discharged back to the care of

- her GP. The fact that a DVT had been excluded was entered into the GP notes on 14 April 2014.
32. The Defendant carried out a routine medication review on the Claimant's patient record, on 14 April 2014. She did not see or speak to the Claimant for this purpose, but reviewed the relevant part of the electronic file. She did not look at any other part of the record, and so did not see the A & E report on that occasion, and hence did not see at that point that a DVT had been excluded.
 33. The ultrasound scan was carried out on 25 April 2014. The report referred to soft tissue swelling and oedema of the subcutaneous tissues. The Defendant reviewed the Claimant's records, and became aware of the position regarding the A & E and ultrasound reports, on 30 April 2014. She made a note in the record: "US Foot Lt Report, Abnormal, but expected, No Further Action". She explained in evidence that this was because it had been confirmed that there was oedema, but no pathology had been detected; and she considered it sufficient to leave it to the Claimant to come back if the problem persisted.
 34. On 16 May 2014 there was a telephone discussion between the Claimant and the Defendant. The note refers to the outcome of the ultrasound being discussed and continues: "No idea what is causing this. Suggest referral to lymphoedema clinic as still swells, pt happy to monitor for now. Will contact if wishes referral to lymphoedema clinic." Effectively, the Defendant's approach was that, if the Claimant felt sufficiently troubled by the foot, then the lymphoedema clinic might be able to help; but it was up to her whether she wanted to go. The Claimant, however, did not want to go that clinic at that point.
 35. Despite chasing letters, the Claimant did not book an appointment with the GP practice's diabetic clinic. However, she did attend the hospital diabetic clinic on 19 June 2014. She was seen by the head diabetic nurse. She mentioned her swollen foot. Her evidence was that the nurse suggested she see the chiropodist, but she thought that a chiropodist was someone who dealt with things like care of toenails; so she did not go. In evidence she did not agree that it was more likely that a podiatrist, not a chiropodist, had been mentioned.
 36. On 8 July 2014 the Claimant saw the Defendant again. Her husband again attended with her. The problem specifically raised related to her digestion and the Defendant arranged for a coeliac screen and blood tests. The Claimant also said that her foot was still swollen and was painful. The Defendant made a note querying whether an ultrasound of the abdomen and pelvis might be carried out, "as continued swelling of L foot and no cause found." The Claimant returned to see the Defendant again with digestive problems on 14 July 2014. On 23 July 2014 the Claimant had a telephone consultation with the Defendant to discuss the blood test results. The Claimant reported that her leg was getting worse. The Defendant referred her for a pelvic ultrasound.
 37. The Defendant's training period at this particular GPs' practice then came to an end and thereafter she had no further contact with the Claimant.
 38. The Claimant had three consultations with other GPs in the practice in August 2014. On 4 August she consulted Dr Collingwood by telephone regarding a different matter.

On 13 August she saw Dr Hearmon regarding that other matter, but it was also noted that a further ultrasound re her swollen left foot was awaited. On 20 August the Claimant spoke on the telephone to Dr Wilson, needing a letter in support of DLA. The history of the swollen foot since February, and negative scan results hitherto, were noted. A result of the pelvic scan was awaited “and then likely to be referred to lymphoedema clinic.”

39. On 3 September 2014 the ultrasound scan of the Claimant’s pelvis was carried out and reported as normal.
40. On 17 October 2014 the Claimant had a consultation with another GP in the same practice, Dr Nicholas. The swelling was continuing and pitting oedema was noted. The doctor also recorded: “Foot pulses palpable and sensation intact.” The Claimant now requested a referral to the lymphoedema clinic, which was subsequently made.
41. On 19 November 2014, there was a telephone consultation with Dr Wilson. She recorded: “Ongoing foot pain, not seen by diabetes clinic, left foot.” She decided to refer the Claimant to the Diabetic Foot Clinic and the Wheelchair Service. The appointment was deferred until after the Claimant had eye surgery. On 2 December 2014 there was a telephone consultation with Dr Wilson, who instigated a re-referral. In the referral letter of 5 December 2014 the reason given was: “Left foot pain and swelling”. The letter referred to palpable foot pulses and normal sensation but unilateral pitting oedema above the left ankle.
42. On 23 December 2014 the Claimant was seen by the lymphoedema service at the Community Hospital. Soft pitting oedema to the left foot was recorded. As to pain, “dull ache to left foot” was recorded. The skin temperature was recorded as normal. It was recorded that “swelling fluctuates.”
43. The Claimant attended the Diabetic Foot Clinic on 31 December 2014. On examination, her left foot was swollen. A temperature difference between the two feet of nearly 3 degrees was noted. The podiatrist and then the consultant physician both considered this to be a case of Charcot foot. An X-ray was carried out. The report identified “destruction of the tarso-metatarsal joint with associated deformity. In addition there is dislocation of the tarsometatarsal joint. Overall appearance is in keeping with Charcot’s joint.” A total contact cast was applied to render the foot completely non-weight bearing. An MRI scan in early January 2015 referred to “marked modelling deformity of the bones of the midfoot with loss of normal alignment, diffuse patchy bone oedema and multiple abnormal articulations including the metatarsal joints. The appearances are in keeping with Charcot deformity.”
44. The records of further visits to the Foot Clinic during the course of 2015 include the following. On 21 January 2015 the record includes a note that a temperature difference “of around 3 degrees persists suggesting active Charcot’s.” The record for 4 March 2015 includes: “Mid foot swelling has come down significantly on TCC but temperature difference persists.” On 18 March 2015 there was a temperature difference of 4 degrees.
45. On 29 April 2015 the temperature difference had settled to less than a degree “and clinically swelling has receded as well.” There was improvement in bone oedema but the structural deformity persisted. The possibility of corrective surgery further down

the line was flagged. The total contact cast was changed to an aircast. On 13 May 2015 the podiatrist recommended that the Claimant return to a total contact cast, and, under history, noted “prominent rocker bottom deformity of midfoot.”

46. On 27 May 2015 the temperature difference had settled, but there had been an increase in swelling. A total contact cast was again advised.
47. At the diabetic clinic on 8 July 2015 the Claimant was using a removable cast. There was no significant temperature difference and the swelling had settled. However, she reported some swelling of the right foot. But at the Foot Clinic on 15 July an X-ray had revealed the right foot to be normal and the swelling in it had settled. On 15 September the Claimant had developed an ulcer on the left foot and there was a temperature difference of four degrees. A complete cast with a window for the ulcer was advised. On 22 July she had been referred for orthotic footwear, but the orthopaedic surgeon was also asked to see her with a view to possible reconstructive surgery. In January 2016 surgery was carried out to remove a bony prominence from the sole of the Claimant’s foot.
48. Records from the Claimant’s consultant orthopaedic surgeon give the picture of more recent events. In early 2019 an external frame was fitted, attached to the left leg by pins, and a leg plate was fitted. Unfortunately, the Claimant incurred a fracture at the site of one of the pins in April 2019. However, by 21 May 2019 the fracture had begun to heal and the foot was doing well. Unfortunately, in September 2019 a varus deformity in the tibia had been identified, that is to say, the fracture had healed into a bowed shape. Surgery to address this was scheduled, she told me during this trial in January 2020, for February 2020. She agreed, when giving evidence, that the Charcot has been quiescent for some months now. She currently spends most of her time seated or using a wheelchair to mobilise.

Further Findings of Fact – Signs and Symptoms

49. In light of all the evidence, I draw the following conclusions about the signs and symptoms which the Claimant reported, which were found on examination, or which may have been present, though not detected, on the relevant occasions.
50. As I have found, the Claimant began to experience unilateral swelling in her left foot following the supermarket visit on 21 February 2014. The degree of swelling might fluctuate during the course of a given day, and over the weeks and months, but it remained a constant feature throughout 2014. As I have found, swelling was present, and mentioned by her, when she saw the Defendant on 28 February 2014. It was found by the Defendant on examination, and identified by her as pitting oedema, on 14 March 2014. It was detected in the ultrasound scan on 25 April 2014, which the Defendant reviewed on 30 April 2014. It was still present, and mentioned again by the Claimant to the Defendant, in the telephone consultation on 16 May 2014.
51. As to pain or discomfort, the word “achy” used by the Claimant on 14 March 2014 fairly captures how her foot felt to her at that point. It was uncomfortable to the point of an ache, but one that was not so bad as to be described by her as a pain, still less a severe pain. I accept that it felt worse than that, when she went to A & E on 2 April 2014, but my impression is that the persistence of the swelling and discomfort over time also wore down the Claimant’s tolerance of it, making it perhaps feel that the

increase in pain had been greater. I am satisfied that the recollection she gave, on the occasion of the A & E visit, of having had a shooting pain going back five weeks, though no doubt genuinely expressed on that occasion, was not in fact accurate.

52. Signs of neuropathy were not detected by the Defendant. Dr Middleton, in his initial report, noted that there was no reference to peripheral neuropathy in the notes during the spring 2014 period, and considered it to be an erroneous assumption that it was present. However, in the joint experts' statements Dr Middleton deferred to the diabeticians and orthopaedic surgeons on this question. Both consultant physicians and both consultant orthopaedic surgeons consider that neuropathy was likely present from February 2014. But that is essentially because they all agreed that the onset of the Charcot in this case was probably on the day of the shopping trip in February 2014, and that some degree of neuropathy is a characteristic feature of the Charcot process in persons with diabetes. But they also broadly agreed that the presence of some neuropathy might go undetected by both patient and GP, using the tests that GPs conventionally use.
53. I turn to the symptom of warmth, or, more precisely, of the affected foot being, or not being, on examination, detectably warmer than the other foot. This was not recorded as having been detected by the Defendant. Her evidence was that, in particular on 14 March 2014, she carried out a standard test, running the backs of her hands (which are more sensitive to heat than the palms) across both feet and legs to test for any temperature difference; but she detected none. She made no record on this subject, precisely because the outcome of the test was negative. Had she detected a differential, she would have recorded it. Dr Bhatt, in oral evidence, accepted that some GPs would not record a negative result, and accepted that this practice did not, as such, amount to a breach of duty.
54. The joint orthopaedic surgeons agreed that the Claimant's left foot would likely have been, and felt, if examined, warm in the period February to May 2014. The joint physicians also agreed that the left foot would likely have been warm in February and March 2014. However, once again this was because they all agreed that the Charcot had started in February, and was active at this time, from which it could be *inferred* that some warmth would be a symptom. However, all agreed that the Medical Foot Clinic, and specialists, will use a digital thermometer, which can pick up smaller differentials that the hand test will not detect; and so raised temperature could be present, but go undetected by a GP.
55. In this case the first occasion on which any clinical note records a temperature differential being detected, was at the Medical Foot Clinic on 31 December 2014, when, it must be assumed, the specialist thermometer will have been used. I conclude that *some* temperature differential was probably present during the February to May period, but *not* of an extent that the hand test should have picked up. I accept that the Defendant did perform that test, and did so properly, on 14 March 2014; but I find that, for this reason, she did not detect the small differential that probably was present.
56. As to the question of discolouration, the Claimant did not assert in evidence that her foot was visibly red or discoloured on 14 March 2014 or around this time. The Defendant did not record any redness. She examined the foot on that occasion, including testing for warmth, and could have been expected to notice redness, if visible, and to record it, had she observed it.

57. In her witness statement for trial the Claimant referred to the foot and leg turning a mottled purple colour thereafter, but this suggestion does not appear in her earlier proof of evidence, the letter before action or the particulars of claim. Mr Dowson also referred to this in his statement; but he also suggested that redness was visible on 14 March 2014, with which the Claimant herself disagreed. I note that there is no reference to redness or discolouration in the A & E record of 2 April, nor to its being mentioned by the Claimant on 16 May, nor in any of the other clinical records at any point in 2014. I do not consider that the Claimant's, or Mr Dowson's, recollection on this subject can be safely relied upon. Mr Dean indicated in closing arguments that he did not invite me to find that there was any visible mottling on 14 March 2014. I conclude that there was, in fact, no noticeable redness on that occasion, at all.
58. In summary I conclude that, during the relevant period, the Claimant's foot was visibly swollen, and identified as such by the Defendant. Though the discomfort, whilst fluctuating, was persistent and did not go away, the Claimant did not report pain beyond something that she described as an ache, and certainly did not report severe pain to the Defendant. Though the left foot was probably in fact somewhat warmer than the right foot, this was not to a degree that was, or should have been, detected by the Defendant. There was no severe discolouration, either reported, or obviously visible, to the Defendant.

The standard of care – the law.

59. The classic statement of the underlying test was expounded by McNair J in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 583 at 587. A skilled professional clinician:
- “... is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art ... Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view.”
60. Both counsel agreed that the Defendant was not subject to any lesser or different standard of care, on account of having been a GP Registrar at the time, than would have applied had she been a GP who had completed her training. They both referred me to *Wilsher v Essex Area Health Authority* [1987] QB 730 (CA); and *FB v Princess Alexandra Hospital NHS Trust* [2017] EWCA Civ 334. Nevertheless, they disagreed as to the doctrinal route to this conclusion. Mr Dean submitted that the principle, is, straightforwardly, that trainees or learners must be judged by the same standard as their more experienced colleagues. Inexperience cannot be an excuse for negligence. Ms Mulholland submitted that the appropriate standard was that applicable to a GP Registrar, but this was in fact no different from that applicable to an ordinary GP.
61. It appears to me from the authorities that the standard which is to be expected is that which is appropriate to the task. A difference of post or status may be relevant, but only where it is germane to the nature of the task which the individual clinician in question performs. Being a trainee is not relevant if the task is no different. In this case the task was precisely the same, whether performed by a GP or a GP Registrar.

The fact that the Claimant was a Registrar was, in all respects, irrelevant, and the standard was therefore the same.

62. Importantly, *Bolam* expressly addresses the position where there is a difference of practice within the relevant profession. So long as the individual has acted in accordance with a practice accepted as proper by a responsible body of professionals, they will not be in breach of duty merely because there is also another body of opinion that is of a contrary view.
63. The notion of a “responsible”, or what some authorities refer to as a “respectable”, body of professional opinion, was further explored in *Bolitho v City & Hackney Health Authority* [1998] AC 232. Lord Browne-Wilkinson (the other members of the House of Lords concurring) said this (at 241F – 243D):

“My Lords, I agree with these submissions to the extent that, in my view, the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. In the *Bolam* case itself, McNair J. stated [1957] 1 W.L.R. 583, 587, that the defendant had to have acted in accordance with the practice accepted as proper by a “responsible body of medical men.” Later, at p. 588, he referred to “a standard of practice recognised as proper by a competent reasonable body of opinion.” Again, in the passage which I have cited from *Maynard's* case, Lord Scarman refers to a “respectable” body of professional opinion. The use of these adjectives -responsible, reasonable and respectable--all show that the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter.

There are decisions which demonstrate that the judge is entitled to approach expert professional opinion on this basis. For example, in *Hucks v. Cole* (a case from 1968 reported in [1993] 4 Med. L.R. 393), a doctor failed to treat with penicillin a patient who was suffering from septic places on her skin though he knew them to contain organisms capable of leading to puerperal fever. A number of distinguished doctors gave evidence that they would not, in the circumstances, have treated with penicillin. The Court of Appeal found the defendant to have been negligent. Sachs L.J. said, at p. 397:

“When the evidence shows that a lacuna in professional practice exists by which risks of grave danger are knowingly taken, then, however small the risk, the court must anxiously examine that

lacuna--particularly if the risk can be easily and inexpensively avoided. If the court finds, on an analysis of the reasons given for not taking those precautions that, in the light of current professional knowledge, there is no proper basis for the lacuna, and that it is definitely not reasonable that those risks should have been taken, its function is to state that fact and where necessary to state that it constitutes negligence. In such a case the practice will no doubt thereafter be altered to the benefit of patients. On such occasions the fact that other practitioners would have done the same thing as the defendant practitioner is a very weighty matter to be put on the scales on his behalf; but it is not, as Mr. Webster readily conceded, conclusive. The court must be vigilant to see whether the reasons given for putting a patient at risk are valid in the light of any well-known advance in medical knowledge, or whether they stem from a residual adherence to out-of-date ideas."

Again, in *Edward Wong Finance Co. Ltd. v. Johnson Stokes & Master* [1984] 1 A.C. 296, the defendant's solicitors had conducted the completion of a mortgage transaction in "Hong Kong style" rather than in the old fashioned English style. Completion in Hong Kong style provides for money to be paid over against an undertaking by the solicitors for the borrowers subsequently to hand over the executed documents. This practice opened the gateway through which a dishonest solicitor for the borrower absconded with the loan money without providing the security documents for such loan. The Privy Council held that even though completion in Hong Kong style was almost universally adopted in Hong Kong and was therefore in accordance with a body of professional opinion there, the defendant's solicitors were liable for negligence because there was an obvious risk which could have been guarded against. Thus, the body of professional opinion, though almost universally held, was not reasonable or responsible.

These decisions demonstrate that in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence (I am not here considering questions of disclosure of risk). In my judgment that is because, in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied upon is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.

I emphasise that in my view it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence. As the quotation from Lord Scarman makes clear, it would be wrong to allow such assessment to deteriorate into seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported. It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the bench mark by reference to which the defendant's conduct falls to be assessed.”

GP Expert Evidence

64. As the Defendant was performing the task of a GP, it is the opinions of the expert GPs that are most germane to whether her conduct fell below the appropriate standard in this case. That said, the evidence of the other experts contributed something to the picture on this issue, as well.
65. In his initial report Dr Bhatt wrote [4.1]:

“Charcot’s joint is the progressive degeneration of a weight bearing joint, resulting in disruption and deformity. Typically, there is lack of sensation, resulting in continued destruction of the joint. This neuropathy is more common in diabetes. The NICE guidelines state that this condition should be suspected in a diabetic if there is redness, warmth, swelling or deformity, especially in the presence of peripheral neuropathy. However, the diagnosis should be considered even if deformity is not present or pain is not reported. If this diagnosis is suspected, a referral should be made to the multidisciplinary foot team within a day. These guidelines were published in 2015, after the diagnosis was made for Mrs Dowson. However, whilst NICE provide guidelines which GPs will use as a guide, the basis of the practice, applying the Bolam test has been in place many a year in any case. It is with this in mind that I will provide my opinion on the management by the Defendant GP.”
66. Dr Bhatt observed, of the 14 March 2014 consultation, that “[a] swollen foot presenting in such a manner is more likely to be a DVT than Charcot’s foot. Thus a reasonably competent GP should rule this out first.” [4.2] However, the Defendant only requested a routine ultrasound, which fell below the standard of a reasonably competent GP. Once a DVT had been ruled out, she should have referred the Claimant to the diabetic foot clinic to rule out Charcot foot. “The NICE guidelines state that this should be considered in any diabetic foot, even if swelling is the only abnormality” [4.6]
67. I interpose that the NICE guidelines to which Dr Bhatt referred, are those in respect of “Diabetic foot problems: prevention and management” published on 26 August 2015. Attached to them is a disclaimer, that professionals “are expected to take NICE clinical guidelines fully into account when exercising their clinical judgment.

However, the guidance does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of each patient ...”.

68. In relation to Charcot arthropathy the NICE guidelines address first investigation and then treatment. As to investigation they provide:

“1.7.1 Be aware that if a person with diabetes fractures their foot or ankle, it may progress to Charcot arthropathy.

1.7.2 Suspect acute Charcot arthropathy if there is redness, warmth, swelling or deformity (in particular, when the skin is intact), especially in the presence of peripheral neuropathy or renal failure. Think about acute Charcot arthropathy even when deformity is not present or pain is not reported.

1.7.3 To confirm the diagnosis of acute Charcot arthropathy, refer the person within 1 working day to the multidisciplinary foot care service for triage within 1 further working day. Offer non-weight-bearing treatment until definitive treatment can be started by the multidisciplinary foot care service.

1.7.4 If acute Charcot arthropathy is suspected, arrange a weight-bearing X-ray of the affected foot and ankle. Consider an MRI if the X-ray is normal but Charcot arthropathy is still suspected.”

69. Dr Middleton noted in his report that the Claimant had previously presented with a swollen left foot in May 2013. Normal monofilament sensation and normal foot peripheral pulses were noted. Foot care advice was given. “It was concluded that the Claimant’s diabetic feet were at low risk.” [3.01]

70. After reviewing the records of consultations during 2014, Dr Middleton came to the referral in November 2014 to the diabetic Foot Clinic. He observed [3.08]: “... of importance in my opinion, Dr Wilson stated that the foot pulses were palpable and there was normal sensation.”

71. Further on, Dr Middleton wrote [4.01]:

“It is considered that acute Charcot arthropathy should be suspected if there is redness, warmth, swelling or deformity, especially in the presence of peripheral neuropathy or chronic kidney disease. The presentation of Charcot foot is variable, depending on the stage of the disease. There may be swelling, distortion, loss of function and pain is considered to be present in 75%. Examination of the affected joint will usually reveal the presence of heat and redness over the skin of the joint, with an effusion and there may be instability. Investigation of a suspect Charcot joint involves performing an X-ray.”

72. He continued that all responsible practitioners should be aware of the symptoms and signs of Charcot foot, though a GP might never see one in their entire career. If a diabetic patient presented with unilateral foot swelling they should be examined,

which “will involve assessment of sensation and also assessment of the swelling itself. The skin should be examined for temperature changes and the foot should be examined for function.” [4.03] He continued [4.04]:

“From the above explanation, in my opinion a GP would suspect the presence of a Charcot joint, even though it is a rare occurrence, if a diabetic patient presents with a swollen foot and ankle and if, following examination, it is revealed that there is warmth, tenderness and swelling, especially in the presence of peripheral neuropathy.”

73. He continued that the documentation contained no evidence that the Claimant suffered peripheral neuropathy, and there was no indication in her statement, or the records, of the presence of warmth in the joint. There was no record of any symptoms other than swelling. “Therefore, in my opinion, if these were the only symptoms and signs present, possibly including some discomfort, it is unreasonable to expect Dr Lane or any responsible practitioner on the basis of these facts, to consider that a Charcot joint might be present.” [4.07] Her actions “were appropriate actions and would be supported by a responsible body of GPs.” [4.09]
74. As I have noted, in their joint responses to the questions posed by the parties the GPs both deferred to the other experts on the question of whether the Claimant did in fact have peripheral neuropathy at the relevant time.
75. Dr Middleton remained of the view that on the basis that the only recorded symptom was of swelling, a reasonable body of competent practitioners would not consider the need to refer to the foot clinic. It was also reasonable to suspect lymphoedema, based on the ultrasound report. Dr Bhatt remained of the view that, in view of the history of diabetes and lack of a clear diagnosis, referral to the Foot Clinic should have been made, as Charcot does not always present with redness and warmth.
76. Dr Middleton also considered that the relevant criteria to refer for a Doppler scan in respect of a possible DVT were not fulfilled. Having reviewed those criteria, Dr Bhatt agreed, and subsequently produced a supplementary report revising his original opinion in relation to investigation of a DVT.
77. The GP experts agreed that all competent GPs should be aware of the symptoms and signs of Charcot foot. They also agreed that it should be suspected in a diabetic patient “in the presence of unilateral redness, warmth, swelling or deformity, even in the absence of pain, especially if there is, but even if there is not, peripheral neuropathy.” That is a quotation from one of the Claimant’s questions, to which their joint response indicated that they both agreed. They both confirmed their agreement with that statement during oral evidence.
78. The language in which this question was formulated is identical to that of the 2015 NICE guideline. However, while both GP experts agreed to this form of words, this agreement was more apparent than real, because they disagreed as to what the underlying standard was, that they each, in their own way, regarded this form of words as reflecting. Dr Bhatt was of the view that if any *one* of the symptoms of redness, warmth, or swelling was present in a diabetic patient, then Charcot should be suspected. Dr Middleton was of the view that these were a group of related symptoms that could be expected to be present together in a case of suspected Charcot, so that if

there was swelling, but no redness or warmth, that would not be sufficient to trigger that suspected diagnosis.

79. In oral evidence Dr Middleton maintained that the inflammatory nature of acute Charcot meant that it tended to cause swelling, redness and warmth together. Redness and warmth went together, and swelling alone, even in a diabetic, would not be a sufficient cause to refer to the Foot Clinic. He had seen many diabetics with swollen legs which had various other causes, but only one case of Charcot, which is extremely rare.

Other Expert Evidence

80. It is convenient to set out at this point what seem to me to be the most significant features of the evidence of the other experts, focussing my review of it to reflect the narrowing of the issues considered at this trial.

81. I consider first, the evidence of the expert diabeticians.

82. Dr Bodansky opined that the Claimant could have been diagnosed with Charcot foot at any time from February 2014, had the condition been considered. Any deterioration in the foot post March 2014 was a result of the delay in diagnosis “i.e. on balance, with earlier treatment, this deterioration would have been avoided.” The earlier the treatment (beginning with immobilisation and off-loading, preferably with a full contact cast) the better the outcome.

83. However, in this case, without serial imaging one could not say when the final destruction took place, but on the balance of probabilities the rocker bottom deformity occurred in mid to late 2014. On balance, with diagnosis by May, treatment would have avoided the development of the rocker bottom foot and there would have been no bony prominence.

84. Dr Ahlquist opined that, had the Claimant been referred to the foot clinic in or after March 2014, Charcot would likely have been diagnosed, leading to earlier treatment, which would likely have reduced or limited the risk of progression of deformity. Further on, he observed [5.1]:

“The clinical features which indicate a diagnosis of Charcot disease of foot include swelling of part of the foot, such as the mid-foot, usually in the context of reduced sensation, and progressive deformity of the foot. In the acute phase of Charcot degeneration of the foot there is increased warmth of the affected region, reflecting the inflammatory process which accompanies the Charcot changes.”

85. It was unclear when the changes began in this case; but on the basis of the report on 2 April 2014 of a sudden onset shooting pain five weeks earlier, it was likely around late February 2014. Referral and X-ray from 14 March 2014 would likely have led to diagnosis of Charcot, and immobilisation of the foot, which would probably have reduced the risk of deformity.

86. As to the lasting effects of the delay in diagnosis, both diabeticians deferred to the orthopaedic surgeons. In their joint replies to questions, both considered that the

Claimant had peripheral neuropathy in February 2014 on the basis that it is a common complication of long-term diabetes, and it is an essential predisposing condition for Charcot. It was therefore likely present to a degree in February-March 2014. But they added: “We recognise that this may not have been noted by the patient or her general practitioner at that time.” They also agreed that foot pulses may be present in patients with peripheral neuropathy, and deferred to the GP experts on how easy it would be for a GP to check these in someone with the Claimant’s condition.

87. In light of the Foot Clinic and associated test records from December 2014 onwards they both considered that the inflammatory process was still active in December, but fading by April 2015. They also agreed that the foot would have been warm if examined between February and May 2014. If there was no radiological evidence of rocker bottom deformity in December 2014, they presumed it had not developed at that time. Early treatment in March 2014 would probably have avoided the need for reconstructive surgery. Without imaging it was not possible to opine on this as of April or May 2014.
88. I turn to the evidence of the orthopaedic surgeons. In view of the narrowing of the issues for this trial, this is of less wide-ranging significance for my present decision than it might have been; but nevertheless was of importance.
89. Alone among the experts, Mr Chell met the Claimant, as well as reviewing the records. He noted that orthopaedic surgeons were typically only involved in Charcot cases when the need for possible surgical intervention was indicated. The majority of treatment was undertaken by diabetologists and often podiatrists in the diabetic Foot Clinic. He observed that A & E departments do not refer to the Foot Clinic, but, rather, back to the GP.
90. Mr Singh considered that the Charcot process had probably begun in February 2014. He did not agree with the claim that there is a treatment window for Charcot of three months from onset. In the Claimant’s case none of the examinations prior to December 2014 recorded any deformity and there probably was none before that date. Even if she had had the best care in terms of early diagnosis and treatment she would probably have developed a stiff midfoot. That can be compensated by insoles and a foot rocker, and does not impair a patient’s ability to walk.
91. In their joint opinions they agreed that, as Charcot is associated with pre-existing peripheral neuropathy, this would have been present from February 2014; the presence of peripheral pulses in October and November 2014 did not affect the diagnosis. The presence of all normal sensation would be inconsistent with peripheral neuropathy; but not all sensation needs to be absent for peripheral neuropathy to be present. It was more than likely that the foot would have felt warm if examined between February and May 2014. The period of inflammatory change in this case appeared to be up to 14 months.

Breach of Duty – Submissions, Discussion and Conclusions

92. As I have noted, the first alleged occasion of negligence was on 14 March 2014. The second was, by the end of the trial, no longer pursued. As to the third, Mr Dean confirmed in closing submissions that this was maintained on the basis that the

Defendant should have made a referral to the Foot Clinic, once apprised of the ultrasound results on 30 April 2014.

93. Despite the dispute of fact, which I have addressed, about whether the Claimant mentioned her foot on 28 February 2014, that was not an occasion of alleged negligence. Further, the only such occasion on which the Defendant actually saw and examined the Claimant was on 14 March 2014.
94. In closing submissions, Mr Dean indicated that he did not invite a finding that the examination conducted by the Defendant on that occasion, was, as such, below the appropriate standard. In light of my findings of fact, I consider that he was right to take that stance. In particular, I accept that the Defendant on that occasion carried out the test for warmth, using the backs of her hands, in the manner that a competent GP would and should do. She did not record that she did this, because the result was negative. She was not challenged about that, as such, and Dr Bhatt accepted that at least some GPs would take that approach.
95. I accept that it was in fact the Defendant's practice at the time only to make a record of having conducted such a test, where something of note was detected. I also accept that it was not through incompetence that she failed to detect warmth, or, more precisely, a temperature differential between the two feet on that occasion. Any differential (and there probably was some) was simply not great enough for this type of examination to pick it up.
96. I also accept that, though it must be inferred that some partial neuropathy was present on this occasion, again it was not through failure to carry out the competent examination that ought to be carried out by a GP that the Defendant failed to pick this up. As I have noted, the non-GP experts generally agreed that the tests that she, as a GP, appropriately performed, could have missed the presence of a partial degree of peripheral neuropathy.
97. I also accept, in light of my earlier findings, that there was not any level of redness or discolouration present that, through incompetence in examination, the Defendant failed to detect.
98. The nub of the issue in this case, was not about the competence of the examination on 14 March 2014, but about whether the fact that the Claimant was diabetic, and the swelling and limited symptoms of pain and discomfort alone, should have led the Defendant to include Charcot in the suspected or differential diagnosis, and to make a referral to the Foot Clinic on that date; or, at least to do so, once she learned the result of the ultrasound on 30 April 2014.
99. Both counsel challenged the quality of evidence of their opponent's GP expert, referring to various aspects of the written and oral evidence of each of them. Ms Mulholland highlighted that Dr Bhatt had, on his own admission, initially got it wrong about whether a DVT Doppler scan was indicated. Mr Dean highlighted that Dr Middleton remained adamant in disputing whether peripheral neuropathy was present, despite deferring to the other experts, who agreed that it probably was present.
100. These criticisms did not, in either case, particularly strike home with me. Dr Bhatt did make a mistake about the indicators for a DVT Doppler scan, but he immediately

acknowledged and corrected it, when this was pointed out to him by Dr Middleton. It did not mean that his evidence on other matters was necessarily unreliable. Dr Middleton, for his part, was merely anxious not to concede that the Defendant should be in any way criticised for not having detected neuropathy – and he had good reasons for being reluctant to do so.

101. I turn to the NICE guidelines. Ms Mulholland submitted that it would, in principle, be wrong to judge the Defendant by a direct application of the specific wording of the NICE guidelines. That was for two reasons. Firstly, they are just that – guidelines, and not rigid rules. While, in an appropriate case, current and relevant guidelines should be taken into account by a responsible professional, they will only form one input contributing to the overall exercise of their clinical judgment in the overall circumstances of the particular case. They should not be slavishly or automatically followed; and a failure to follow the guidelines in a given case is not necessarily a breach of duty.
102. On this first point, Ms Mulholland drew attention to the “health warning” to that very effect that appears in the published guidelines themselves; and she cited *Darnley v Croydon Health Services NHS Trust* [2017] EWCA Civ 151 and *Sanderson v Guy’s & St Thomas’ NHS Foundation Trust* [2020] EWHC 20.
103. Secondly, in this case, submitted Ms Mulholland, it would be plainly wrong to judge the Defendant’s conduct, in 2014, by reference to guidelines that were only published in August 2015.
104. Mr Dean agreed with Ms Mulholland as to the general approach to be taken to the status of NICE guidelines, and that the Defendant plainly could not be criticised, as such, for not considering or following guidelines that were not in existence at the relevant time. But he submitted that I could and should properly take into account that both GP experts agreed that the language used in the guidelines fairly captured the approach that ought to have been followed by the Defendant in 2014; and, in so far as they disagreed about what that language actually meant, Dr Bhatt’s approach was the one which accorded with the natural grammatical meaning: the guidelines do not refer to “redness, warmth *and* swelling” as a group of symptoms, but to “redness, warmth *or* swelling” (emphasis added).
105. Further, submitted Mr Dean, a practice of not referring a diabetic patient who presented with swelling and pain, but no redness or warmth, was, in the *Bolitho* sense, illogical. He referred to an extract from the report of the NICE Internal Clinical Guidelines team, which discusses the evidence review and thinking underlying the recommendations in the August 2015 guidelines. Mr Dean highlighted that these stressed the paramountcy of identifying acute Charcot, and beginning early treatment, because of the gravity of the irreversible consequences to which this disease may, if untreated, lead.
106. Ms Mulholland, by contrast, drew attention to the observation in this material that “the most important symptoms that may lead to a suggested diagnosis of Charcot foot were redness, warmth and swelling. The group agreed that these were the commonly seen signs and symptoms in the literature and in clinical experience.” She submitted that Dr Bhatt’s approach depended upon an unreasonably restrictive interpretation of the guidelines, which was out of step with a reasonable body of professional opinion.

The guidelines needed to be read in a practical and purposive way. Charcot did not usually present with swelling alone. If every diabetic with a swollen foot was referred to the Foot Clinic, such clinics would be inundated. It could not be said that the opinion expressed by Dr Middleton passed the high threshold of *Bolitho* illogicality. It was not out of step with reasonable GP practice.

107. My conclusions on this aspect are as follows.
108. First, I conclude that the practice in fact followed by the Defendant – of not referring to the Foot Clinic a diabetic who presented with swelling, but not redness, warmth or deformity – did, as a matter of fact, accord with a body of professional opinion and practice at that time. My reasons are as follows.
109. Firstly, the witnesses generally agreed that swelling or oedema *alone* could be caused by a good number of conditions, all of which would, even in a diabetic, be considerably more likely explanations than Charcot arthropathy, which is a comparatively rare and unusual condition.
110. Secondly, the inflammatory nature of Charcot in its acute or active phase is the reason why, where swelling is a symptom of Charcot, it is liable usually to be accompanied by redness and warmth. Though the degree of inflammation may, itself, wax and wane over time, this is why these three symptoms, in a case of Charcot, form a relational group. The tenor of the evidence of all the experts, save for Dr Bhatt, was to the effect that, whilst it *could* present with swelling alone, Charcot would normally present with swelling, redness and warmth, though whether there was visible deformity would depend on how advanced the disease was in the given case. The passage referred to by Ms Mulholland, in the commentary in the NICE evidence review, also reinforces that picture.
111. I note also that the abstract of one of the research papers cited by Dr Bodansky in an appendix to his report comments that “a high index of suspicion is necessary in any diabetic patient with a swollen warm foot in the presence of somatic or autonomic neuropathy”; the abstract of the second observes that acute Charcot “is characterized by erythema, edema and elevated temperature of the foot”; and that of the third begins: “In patients with long-standing, poorly controlled diabetes and peripheral neuropathy, a red, hot, swollen foot without open ulceration should raise the suspicion of Charcot neuroarthropathy...”.
112. Consistently with this, Dr Middleton, who has long experience as a teacher as well as a practitioner, explained that this is why he teaches his students to look for redness and warmth, as well as swelling, as indicative of potential Charcot. I also note that the Defendant, in oral evidence, said that the photographs she had been shown as a student, were not of swelling alone, but of swelling and discolouration. Of course that could be viewed as merely self-serving evidence, but it appeared to me to be genuinely and spontaneously given, and was in line with the overall picture of the nature of the disease that I was given.
113. What do the NICE guidelines contribute to the picture? Ms Mulholland’s points, that they are in any event only general guidelines, and that the Defendant cannot be criticised for not following them as such, when they did not yet exist, are (as I have noted Mr Dean accepted) well made. But I have also considered whether they cast

any retrospective light back on the existence or not of a practice, in 2014, as described in evidence by Dr Middleton. As to that, I do not think that they undermine the picture that he gave. My reasons are as follows.

114. First, it is clear that, whatever the symptoms of the active inflammatory stage of the disease may be, deformity is the distinct result of the damage done by the destruction of the bones of the foot, as the disease advances. Secondly, (and consistently with the expert evidence presented to me) the guidelines identify that peripheral neuropathy is a *particular* risk factor (as is renal failure). Hence they indicate that Charcot should “especially” be considered where peripheral neuropathy is detected; and that the reader should “[t]hink about acute Charcot arthropathy even when deformity is not present or pain is not reported.” But they do not, in any similar way, urge the reader also to suspect Charcot even where one or more of swelling, warmth or redness is not present. In light of that, I do not think that the content of the guidelines, as such, undermines Dr Middleton’s evidence that there was at least a body of practice in 2014 that would not have regarded swelling in a diabetic’s foot, without redness, warmth or deformity, as not sufficient to trigger a referral to the Foot Clinic.
115. Pausing there, while, in 2014, there may have been a body of practitioners who would have followed Dr Bhatt’s approach, I was satisfied that there was, or was also, at least, such a body who would have followed Dr Middleton’s approach.
116. Was that, then, a “responsible” practice in the *Bolitho* sense? From the discussion in *Bolitho* itself I draw the following points.
117. First, the mere fact that a practice is widely – possibly very widely – followed does not make it immune from judicial scrutiny as to whether it is responsible. Secondly, such scrutiny may involve consideration of whether it is reflective of a logical risk analysis, weighing in the scales: the cost or difficulty of taking a preventative step, and how effective it would be in terms of reducing or obviating a given outcome, against how serious that outcome would be if it eventuates, and how likely to is to eventuate.
118. Thirdly, however, the Court should not too readily brand a recognised practice as not responsible, and therefore falling short of the duty of care. This is reflected in the observations of Lord Browne-Wilkinson (and in the authorities that he cites), that the opinion in question must be lacking a “logical basis”, that the issue is whether the experts have applied their minds to the risk analysis and reached “a defensible conclusion” on the matter, that the concern is with cases in which there is a “lacuna” in practice by which “risks of grave danger are knowingly taken”, that there may be cases in which an “obvious risk .. could have been guarded against”, that in the vast majority of cases the fact that distinguished experts hold a certain opinion will itself be evidence of its reasonableness; and that it will be a “rare case” in which their opinion “is not capable of withstanding logical analysis”.
119. In short, the Court should only conclude that a body of professional opinion is not “responsible” for the purposes of the *Bolam* standard, if it does not reflect a proper, defensible, or logical consideration of the risk/benefit analysis; it is not sufficient that other professional opinion (or the Court itself) would take a different view of how the risks and benefits of different approaches weighed up.

120. In this case I cannot say that the approach to which Dr Middleton testified fails that test. Even recognising the importance of early detection, and the serious irreversible consequences that may flow if Charcot in its inflammatory phase goes untreated, I cannot say that it was an illogical or indefensible view of the risk/benefit analysis in 2014, that symptoms of swelling and low level pain or discomfort *alone* were not enough, even in a diabetic, to warrant a reference to the Foot Clinic.
121. I note that the committee responsible for the NICE 2015 report observed that peripheral neuropathy and renal failure were “important risk factors” because they were “more common risk factors. Charcot foot always occurs in the presence of peripheral neuropathy and this was acknowledged as a pre-requisite.” Deformity could also be a relevant sign even in the absence of other signs or risk factors. It was also important to note that deformity is a sign of a late stage Charcot, so might not be present. They also referred to the existence of unrecognised chronic Charcot, as well as people presenting with acute signs of Charcot. They also observed that the evidence surrounding Charcot arthropathy was limited and of low quality; and they accordingly made recommendations for further research.
122. This material does not support the view that the practice described by Dr Middleton was illogical or indefensible, by reference to the existing research base and understanding of the mechanisms and symptoms of this disease in 2015, and hence not in 2014. Even if it might be inferred, that part of the authors’ purpose was to enhance awareness among practitioners, and effect a shift in practice, there is no sign in this material of criticism of past practice, as opposed to recognition of the difficulties of diagnosis in some cases.
123. For all of these reasons I concluded that the Defendant, in not including Charcot in her differential diagnosis on 14 March 2014, and not referring to the Foot Clinic at that time, acted in accordance with a body of responsible professional opinion, and was not in breach of her duty of care to the Claimant on that occasion.
124. I turn to the second occasion on which it is alleged that the Defendant was negligent, namely when she failed to make such a referral having, on 30 April 2014, considered the result of the ultrasound report.
125. Mr Dean submitted that, at this point, the negative outcome of the ultrasound scan should have led to a referral to the Foot Clinic, if not before. (Given, as Dr Bhatt in his revised report and oral evidence acknowledged, that a DVT scan was not indicated in the first place, Mr Dean did not invite me to attach any significance to that result.) Ms Mulholland stressed that there had been no further clinical examination of the Claimant, who had not at this point sought a further consultation. There were no new or changed symptoms. Other possibilities remained more likely than Charcot. Following the further telephone consultation on 16 May 2014 the suggestion of a referral to the lymphoedema clinic was a reasonable next step.
126. In my judgment, the key issue is whether, in the absence of any new or changed symptoms being reported, the negative ultrasound alone should have been regarded as pointing to a significant increase in the likelihood of the explanation for the symptoms found on 14 March 2014 being Charcot foot, such as to now indicate that a referral to the Medical Foot Clinic should be made.

127. In evidence, the Defendant indicated that, in ordering an ultrasound, she was looking for signs of various soft tissue pathologies, but conditions such as lymphoedema, which was far more common than Charcot, were not ruled out by that negative result. She referred to the fact that there had been no further contact from the Claimant, and hence no further report from her as to ongoing or changing symptoms, and observed that a GP is to some extent inevitably dependent on the patient getting in touch, if the symptoms worsen or change.
128. Drs Bhatt and Middleton simply disagreed, in oral evidence, about whether that was a reasonable approach.
129. Having regard to the fact that, as a matter of fact the Claimant had not come back to the practice reporting any change in symptoms since 14 March, and in light of my earlier conclusion that the approach of not referring for swelling alone, in a diabetic, reflected a responsible body of GP practice, I conclude that the ultrasound result alone was not enough to indicate that any responsible GP who had not yet referred, would have done so on consideration of that result.
130. For all of these reasons I conclude that breach of duty is not established on either of the two occasions with respect to which the claim was, by the end of this trial, maintained. That means that this claim must fail. However, since the narrow causation issue was fully argued, I shall record my conclusions in relation to it as well.

Causation

131. The experts agreed, in the very broadest sense, that, once the acute inflammatory phase of Charcot has begun, then, other things being equal, the sooner that it is detected, and addressed by offloading and casting, the better the outcome is likely to be. That is because the effect of the patient continuing to put weight on the foot during the inflammatory phase (exacerbated by the lack of awareness caused by neuropathy) is that it leads to a progressive destruction of the bones. That is liable progressively to cause the normal concavity of the arch gradually to flatten and, eventually, become convex – a so-called rocker-bottom foot.
132. However, as Dr Ahlquist, for example, acknowledged, even early treatment is not always a guarantee against the development of a deformity. As Mr Singh described, even the application of a total contact cast may not wholly arrest damage, as opposed to slowing it. Further, it is also clear from the body of the expert evidence presented to me overall, that the duration of the inflammatory phase can be enormously variable from case to case, and the inflammation can also be quiescent for a period, but then return.
133. As I have noted, in the event, the present trial was confined solely to the question of causation of the deformity of the foot identified by the Medical Foot Clinic on first presentation on 31 December 2014, on examination and in the associated X-ray, and in the subsequent MRI scan. The first question to consider is what was the extent of the deformity at that point?
134. I have set out earlier how this was described in the records. The best assessment of it in evidence came from Mr Singh, who had the advantage that his practice is not

confined to seeing patients who already require reconstructive surgery. He also sees those who are at an earlier stage. He considered that, at this point there was a medial bony prominence (a sideways deformity) and a flattening of the arch, but matters had not yet reached the rocker bottom stage. The foot was at that point suitable for a custom shoe, for which he noted the Claimant was in fact sent in early 2015 when she came out of the cast. Mr Chell and Dr Bodansky both ultimately accepted that the Claimant did not, at this point, have a rocker bottom foot.

135. In the present case, as I have noted, the consensus among the experts was that the onset of the inflammatory Charcot was probably in February 2014. However, they all faced a difficulty when asked to opine on what may have been happening, month by month, in the period from then until December of that year. That is, in particular, because there was no imaging from the period of most significance to the Court, in the period from March to May 2014.
136. Given what is generally known about the aetiology of this disease, the diabetic experts were able to agree that appropriate treatment in March 2014 would probably have avoided the need for reconstructive surgery. In their joint reports they concluded that they could not advise on whether reconstructive surgery would have been avoided by intervention in April or May 2014.
137. The tenor of Dr Bodansky's oral evidence was that treatment in May would have made a significant difference, but he seems in this to have heavily drawn on his experience in cases seen by a particular service, of an average three-month inflammatory phase. However, he recognised also that it sometimes lasted as much as twelve months. Dr Ahlquist was, I think rightly, in the absence of imaging in early 2014 in the present case, more circumspect. In oral evidence, he indicated that such evidence as there was suggested that there was some progression over the period March to October, although there were also some signs of a change of pace after October. His preferred view was probably simply of continuous progressive damage over the whole period; but he was simply not sure how much damage had occurred by April or May.
138. The orthopaedic experts similarly agreed in their written reports with the general proposition that early treatment would have minimised the deformity and avoided the need for reconstructive surgery. Beyond that, Mr Chell deferred to the diabetic experts on the issue of causation. Mr Singh, with his wider experience, considered that a referral in March 2014 would probably have meant that the Claimant could have been given custom-made insoles, rather than needing custom-made shoes at that point.
139. In written submissions, Mr Dean argued that the proper finding, in these circumstances, had I found breach of duty in not referring in either mid-March or at the end of April 2014, was that on the balance of probabilities, such breach had made a material contribution to the damage that was present in December 2014, applying what he called the modified test of causation expounded in *Bailey v Ministry of Defence* [2009] 1 WLR 1052.
140. Ms Mulholland, also citing *Bailey*, submitted that the Claimant could not show causation at all, of the injuries present in December 2014, as she could not show that the delay in referral during the course of that year had caused any material or

measurable difference to her outcome. In particular, she submitted that the difference between the damage having reached a point which might lead to a need for custom-made insoles, and one which might require custom-made shoes, was not significant.

141. In *Bailey* the claimant, in a weakened state, aspirated vomit, causing her to suffer a cardiac arrest which, in turn, caused hypoxic brain damage. The question was whether the weakened state had, in the requisite sense, been caused by the first defendant's negligent care, earlier in the month, or by a condition of pancreatitis, which did not arise from their negligence. The Judge was not able to say that the negligent care was a "but for" cause of the injury – that is, that, absent the negligent care it would not have occurred; but he did consider that both the negligent care and the pancreatitis made a material contribution to the overall weakened state which in turn caused the aspiration; and that was sufficient in law to establish causation.
142. The Court of Appeal upheld that approach and conclusion. After reviewing the authorities up to and including *Fairchild v Glenhaven Funeral Services Limited* [2003] 1 AC 32 Waller LJ (Sedley and Smith LJ concurring) said [43]:

“It seems to me thus respectfully that Lord Rodger in *Fairchild* accurately summarises the position when he says in paragraph 129 that in the cumulative cause case such as *Wardlaw* the ‘but for’ test is modified.”
143. Further on, he summed up the approach in this way [46]:

“In my view one cannot draw a distinction between medical negligence cases and others. I would summarise the position in relation to cumulative cause cases as follows. If the evidence demonstrates on a balance of probabilities that the injury would have occurred as a result of the non-tortious cause or causes in any event, the claimant will have failed to establish that the tortious cause contributed. *Hotson* exemplifies such a situation. If the evidence demonstrates that ‘but for’ the contribution of the tortious cause the injury would probably not have occurred, the claimant will (obviously) have discharged the burden. In a case where medical science cannot establish the probability that ‘but for’ an act of negligence the injury would not have happened but can establish that the contribution of the negligent cause was more than negligible, the ‘but for’ test is modified, and the claimant will succeed.”
144. *Bailey* therefore suggests that the Court should take the following approach to the evidence in a case where more than one putative cause is in play. First, ask whether it shows, on the balance of probabilities, that the injury would have occurred as it did, in the absence of the negligent conduct in any event. If so, causation is not established. If not, ask whether, but for the negligent conduct, the injury would probably not have occurred. If so, causation is shown. It is only if the evidence also cannot establish the probability of that, that one must ask whether it at least shows that the conduct made a material contribution.
145. This analysis, it seems to me, is most pertinent where the proximate cause is a single feature – e.g. silica dust or a weakened condition – but there are two possible sources

of that proximate cause, one of which derives from negligence, which potentially could have been a contributory cause, but where the evidence does not show whether, on balance, it either was or was not a 'but for' cause.

146. In my judgment, the present case is not of that kind, and resort is not necessary to the modified test. That is bearing in mind that the alleged negligence here is by way of a failure to act, in a way that, it is said, would likely have slowed, or stopped, an incremental process over time. In the present case the following conclusions can be reached, on the balance of probabilities, from the totality of the evidence before me. First, the damage to the Claimant's foot as at the end of December 2014 was not something that had all been inflicted on a single occasion. Rather, it had built up over time, by a progressive, incremental, cumulative process. Secondly (though Dr Bodansky in particular did not rule out it having begun earlier) that process probably began in late February 2014.
147. The principal uncertainty in this case was as to whether, over the period from then until the end of December, the deterioration of the bones progressed at a steady rate, and hence as to what stage it had reached in March, April or May. As to that, whilst, in the absence of imaging during this period, it is not possible to reach any precise or firm conclusion, it is, in my judgment, possible to form a view, on the balance of probabilities, as to the stage the deterioration would probably have reached, in terms of its practical implications for the Claimant.
148. In particular, drawing on the overall picture, but in particular, on the evidence of Mr Singh, which most usefully and directly addressed this aspect, I conclude that, had there been an urgent referral to the Foot Clinic in March 2014, leading to a diagnosis of Charcot, treatment would probably have arrested or slowed the process, such that the Claimant would probably have required a customised insole, but not a customised shoe. From the totality of his evidence, it seems to me that Mr Singh's best assessment was that, had the condition been detected when the Claimant attended the hospital diabetic clinic on 19 June, then, on balance, by *that* point, a customised shoe might have been needed. I conclude that, had she been urgently referred to the Foot Clinic on 30 April, a customised shoe (as opposed to an insole) would probably still have been avoided.
149. I should add that I do not think this distinction is a trivial or immaterial one for these purposes. Apart from any other implications, such as in terms of cost, and even though Mr Singh indicated that the Claimant could not have worn a (non-NHS) ladies' dress shoe with a customised insole, nevertheless, a greater range of footwear could have been used by her, if she did not require a customised shoe; and it seems to me that there would have been an appreciable difference for her in terms of general amenity, that might sound in damages.
150. I conclude that, had I found breach of duty on either 14 March or 30 April 2014, I would have concluded that this was causative of the Claimant's injuries, as they were found to be at the end of December 2014, to the extent of the difference between damage to the foot requiring a customised insole, and damage requiring a customised shoe. For completeness, it also follows that, if, contrary to my view, resort was required to the *Bailey* material contribution test, I would have found that the breach of duty did make a material contribution.

Outcome

151. For all the reasons I have given, I conclude that there was no breach of duty on the part of the Defendant on either occasion when it was, ultimately, maintained that it had occurred, and this claim must therefore fail. Had I found otherwise, I would have concluded that the Claimant was entitled to be compensated for appropriate heads of loss as would reflect the difference between damage to the foot requiring use of customised insoles, and damage requiring customised shoes. Whether any further damage or loss said to have occurred at any point after December 2014 could be laid at the door of the Defendant would have required a further trial. I have made no findings, and drawn no conclusions, about that.
152. I fully appreciate, having heard them both give evidence, with dignity and passion, that the Claimant and Mr Dowson both felt deep frustration and anguish that the problem with her left foot was not positively diagnosed for a considerable time; and that she was not referred to the Medical Foot Clinic sooner. However, what the Court has had to decide is whether there was culpable negligence on the part of the Defendant, as alleged. For the reasons I have given, I conclude that there was not, and the claim against her must therefore be dismissed.