Medical report by Dr Oliver D Starr

Dated
28th June 2016 (3 years 1 month after the event)

Specialist field
General practice

On behalf of the claimant
Mrs Riding Hood of Forest Lodge, Nursery Rhyme Town, Dreamland, date of birth 01/01/1990.

On the instructions of
Busy Solicitors LLP, Disney.

Subject
The care provided by Dr Notgood, a general practitioner working at the Deep Dark Medical Practice, Sherwood, to Mrs Riding Hood on 10th April 2013.

Written by
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Report

1. Introduction and sum

1.01 Technical terms and explanations

I have indicated any technical terms in **bold type**. I have defined these in a glossary in appendix 3.

1.02 The expert witness

I am Dr Oliver Dominic Starr. My specialist field is general practice. Full details of my qualifications and experience entitling me to give expert opinion evidence are in appendix 1.

I have been asked to examine the care given to Mrs Riding Hood by the GP Dr Notgood on 10th April 2013 with regard to the need for a scan of her early pregnancy to exclude an **ectopic pregnancy**.

1.03 Sum background of the case

Mrs Riding Hood had suffered a miscarriage before the birth of her first child in January 2009. A year later she fell pregnant, but had an ectopic pregnancy which required the removal of her right **fallopian tube**. In December 2010 she gave birth naturally to her second child. In April 2013 she found herself pregnant again and went to see Dr Notgood at the Deep Dark Surgery, Sherwood, on 10th April to let him know she was pregnant.

Mrs Riding Hood claims she told Dr Notgood that doctors had asked her to have an early pregnancy scan if she ever fell pregnant again, after her **salpingectomy** in January 2010. Dr Notgood examined her and, finding nothing wrong, reassured her that an early scan was not necessary.

She called the maternity hospital and was booked for a scan on 4th May 2013 at which point a large mass was found near the right side of her uterus. She was admitted to hospital and underwent keyhole surgery the next day which revealed a large ectopic pregnancy. The surgeon had to convert to open surgery and remove the ectopic pregnancy which was situated near the site of the previous one.

1.04 Sum of my conclusions

This report will show that in my professional opinion the standard of care offered by Dr Notgood fell below that expected of a responsible body of general practitioners.

1.05 The parties involved:

- Dr Notgood, general practitioner and defendant.
- Mrs Riding Hood, claimant.

1.06 Sources and background to this report

- This report has been prepared for the court after instructions from Busy Solicitors and examination of Mrs Riding Hood's full general practitioner records and records from Nurseryland Hospital. I am also in receipt of a letter of response by Dr Notgood addressed to Ms Grandma, the deputy practice manager at the Deep Dark Surgery, Sherwood.

1.07 In this report I will concentrate on liability issues pertaining to the general practitioner involved and I will not address aspects of liability pertaining to the hospital staff nor causation. These are better dealt with by an appropriate consultant expert.

1.08 I have not seen or examined Mrs Riding Hood, nor have I ever worked with or have any professional relationship with Dr Notgood.

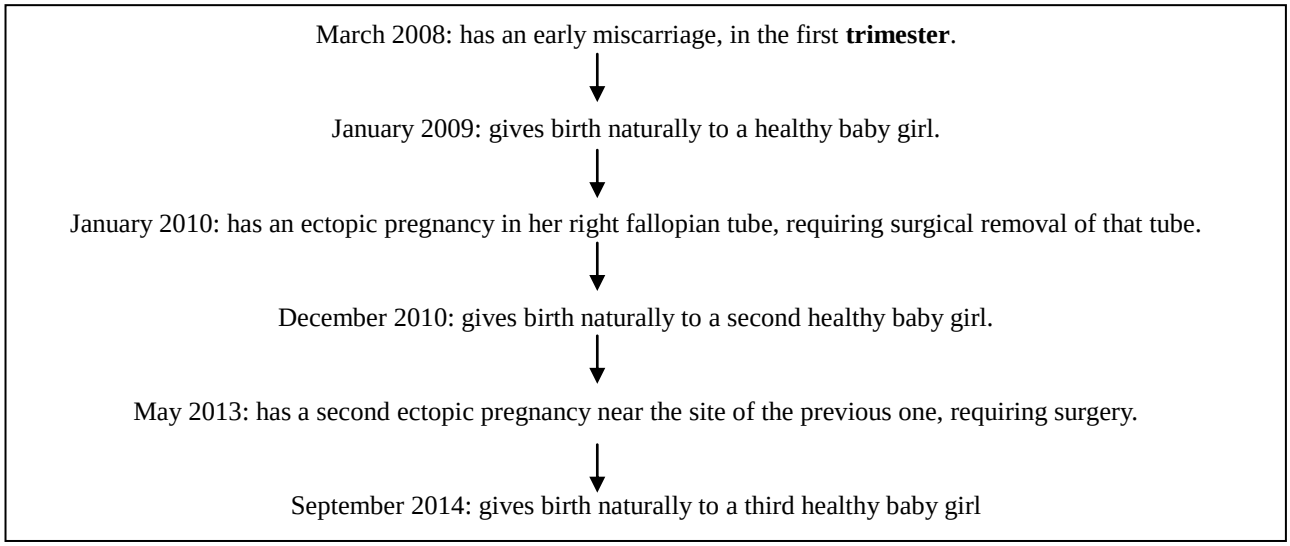
2 The issues to be addressed and statement of instructions

I have received a detailed letter of instruction from Busy Solicitors. I have been asked to consider the following allegations:

- There was a failure by Dr Notgood to refer Mrs Riding Hood for an early pregnancy scan when she presented to him on 10th April 2013.
- Dr Notgood failed to inform Mrs Riding Hood of her right to self refer for an early pregnancy scan.
- Dr Notgood wrongly reassured Mrs Riding Hood that a referral was not indicated on 10th April 2013 and that she should book in to see the midwife in due course.
- Dr Notgood failed to refer her for an early scan after she asked to be referred.

3 The medical records

3.1 Mrs Riding Hood has a significant obstetric and gynaecological history, which I have summarised as follows:



3.2 I will now go through the relevant medical records chronologically.

10th Apr 2013: saw Dr Notgood (who I believe was a locum at the surgery) to inform him of her pregnancy. She thought her last menstrual period was 20th Feb, which would have made her approximately five weeks pregnant. Dr Notgood made note of her previous ectopic pregnancy and **salpingectomy**.

Mrs Riding Hood described some 'crampy pain' in her lower tummy which was coming and going. She had not experienced any vaginal bleeding. Her examined her and found her tummy to be pain free.

He asked her to book with the midwife and provided back up advice to come back or see a GP out-of-hours if she experienced worse or constant pain, a fever, vomiting, or vaginal bleeding. (Page 76 of the medical records bundle).

3.3 26th Apr 2013: phoned the maternity services at Nurseryland Hospital at 1550hrs and spoke to a healthcare assistant about her ectopic of 2010. She did not describe any pain or vaginal bleeding.

The healthcare assistant discussed her case with a midwife who considered her to not be 'at risk' and arranged an ultrasound scan. The notes describe that Mrs Riding Hood was offered an earlier scan (the date 30/4/13 is written in) but that 'patient unavailable'. A scan was therefore booked for 4th May 2013, with advice to call if there were any problems. (Page 372 of the bundle).

3.4 4th May 2013: attended Nuserylands as planned for her scan, by then about 10 weeks pregnant. The scan showed a suspicious mass between $4cm^3$ and $5cm^3$ and she was admitted to the ward at 1100hrs. By that time Mrs Riding Hood had experienced some vaginal 'spotting'. But was not in any pain.

Note that at that time her blood pressure was 102/54 and heart rate 72 which are normal. In addition the hospital records note that her abdomen was soft and pain free. (Page 376 of the records bundle)

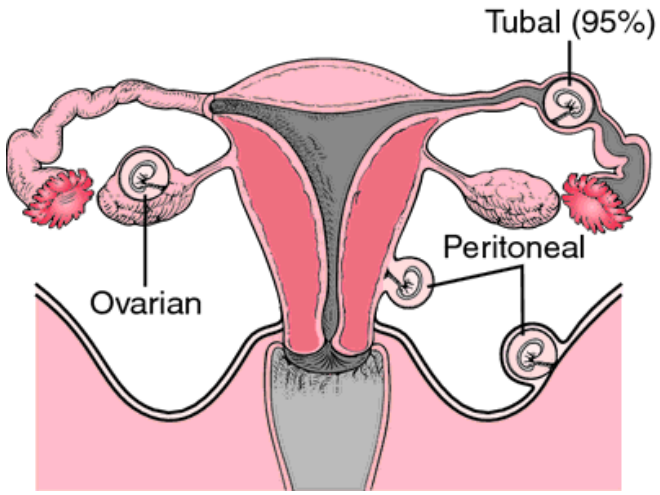
3.5 5th May 2013: underwent a **diagnostic laparoscopy** and then a **laparotomy** to remove the mass, which proved to be an ectopic pregnancy.

4 Medical background

4.1 An ectopic pregnancy is when the foetus develops in the wrong place. In a healthy pregnancy it is bedded down in the uterus, which can gradually grow as the foetus develops. In an ectopic pregnancy the foetus lodges in the wrong place: it could be in the fallopian tube, up in the corner of the uterus, or even outside the uterus or fallopian tube altogether. It occurs in 1-2% of all pregnancies, meaning that over a three year period about 32000 ectopic pregnancies

will be diagnosed in the UK.

This picture illustrates where the foetus can develop in an ectopic pregnancy. The fallopian tube is the commonest site for the foetus to settle, and is indeed where the patient had her first ectopic.



4.2 An ectopic pregnancy may not normally have any symptoms at all until it grows so big that it stretches the tissues around it to cause pain, or until it ruptures and causes extreme pain and internal bleeding. Around 10% of women when they are diagnosed with an ectopic will not have had any symptoms at all; around a third will have entirely normal vital signs such as blood pressure and heart rate.

For other women the suspicion is raised when they have vaginal bleeding or a dark brown discharge. Pain in the lower abdomen in early pregnancy usually prompts investigations for an ectopic.

4.3 The diagnosis of an ectopic pregnancy usually rests on an ultrasound, done internally. If the pregnancy hormone level is high and the ultrasonographer cannot see a normal pregnancy in the womb, then that usually indicates an ectopic. They will then scan the woman further to try to detect where the ectopic has embedded.

Sometimes if it can't be ascertained if an ectopic pregnancy is definitely there, measurements of the pregnancy hormone can be taken each day. If they are steady or hovering around a similar level, that usually indicates an ectopic. In a healthy pregnancy the pregnancy level usually steadily rises each day.

4.4 The treatment for an ectopic depends on how big it has grown. If it is picked up in the early stages then usually an injection of a medicine called **methotrexate** can be given to the woman. It kills the foetus which stops growing and then is dissolved away by the body. This treatment can only be used if the pregnancy hormone is below a certain level.

If it has progressed too far to be treated with the injection then key-hole surgery (laparoscopic

surgery) is used. This takes the form of a **salpingostomy**, where the fallopian tube is opened up with a slit, the ectopic is removed, and the tube is sealed up again.

If that cannot be done because the ectopic is too big, a salpingectomy is performed where most of the tube, along with the ectopic inside it, is cut out.

Sometimes if the ectopic is small and seems to be dissolving away already, judged by a falling hormone level, it can just be observed and carefully monitored until it's resolved. This is called 'expectant management'.

4.5 If the ectopic is large, or has ruptured, then it is usually necessary to do open surgery rather than key-hole. This is known as a laparotomy.

4.6 Even if one fallopian tube has been removed completely, the woman can still have children providing the other tube is normal. Once a woman has had one ectopic pregnancy, there is a 5-20% chance of having a second.

4.7 The risk factors for an ectopic have been explored in many studies. The main ones are: having had a previous ectopic; having had surgery on the fallopian tubes; being an older mother; smoking; having had a pelvic infection; using an intrauterine contraceptive device (often called a 'coil'); and using in-vitro fertilisation (IVF).

4.8 The literature suggests that once a woman has had an ectopic, should she fall pregnant again she should have an early pregnancy scan to check she does not have a second ectopic.

5 My opinion

5.1 In my professional opinion Dr Notgood should have ordered an early pregnancy scan for Mrs Riding Hood when she presented to him on 10th April 2013. In that respect I consider his standard of care that day to have been below that expected of a reasonably competent GP.

5.2 I believe most, if not all, general practitioners would have ordered an ultrasound scan on 10th April and that not to do so constituted a breach of duty of care.

5.3 The history of a salpingectomy in Jan 2010 means that the subsequent risk of an ectopic is much higher than usual. I think every reasonably competent GP would know that. The only logical step to take is then to order an early pregnancy scan. This is an easy test to order. It would have involved either faxing a scan request or ordering a scan electronically. Most early pregnancy units then contact the patient and can offer an ultrasound scan within a couple of days.

5.4 This opinion is corroborated by written guidelines. The Clinical Knowledge Summaries guidance on ectopic pregnancy state:

> 'advise the woman that she should inform her GP as soon a possible about future pregnancies so that an ultrasound scan can be arranged at 6–7 weeks to establish the location and viability of the pregnancy.'

These guidelines are not widely published however and I would not expect a GP to necessarily have read them or have ready access to them. I quote them only to show that my clinical opinion is backed up by written evidence-based guidance.

5.5 In the correspondence dated 9th June 2016 sent to me by Busy Solicitors, in the paragraph 'Factual Background' it states *'Mrs Riding Hood told Dr Notgood that her previous ectopic had ruptured at 5 and a half weeks and staff at the Nurseryland Hospital had therefore recommended an early scan to her if she became pregnant again*.' This sounds entirely reasonable and accurate to me. It fits with the advice I would expect a woman in her position to have been given.

5.6 Dr Notgood made his judgment that an ectopic was not apparent on the basis that Mrs Riding Hood did not have constant pain in her lower abdomen or vaginal bleeding. However it is important to note that in the early stages an ectopic need not have any symptoms at all. Bleeding and pain in combination would have prompted an immediate referral to hospital, not a request for an outpatient ultrasound scan.

This is borne out by the fact that when she phoned the Nurseryland Hospital on 26th April she did not have any pain or bleeding, despite having an ectopic. In fact, even when she was admitted to the ward on 4th May after the ultrasound scan she still did not describe any abdominal pain and only some 'spotting', meaning just a small amount of blood vaginally.

5.7 The converse argument, that an early pregnancy scan after a history of an ectopic and salpingectomy is *not* necessary, does not withstand logical analysis. There is no logical reason why an ultrasound in early pregnancy would ever be a bad idea, if the woman has had a salpingectomy in the past. There is no risk from an ultrasound scan, as no radiation is used.

5.8 For these reasons my opinion is that Dr Notgood fell below a duty of care expected of a reasonable general practitioner, on 10th April 2013.

5.9 I was asked specifically by the claimant's solicitor to comment on the allegation that Dr Notgood should have informed Mrs Riding Hood of her right to self-refer for an early scan. This is not a situation I am familiar with and I do not consider it to have been mandatory for Dr Notgood to inform her of this.

6 Statement of truth

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

7 Statement of conflicts

I confirm that I have no conflict of interest of any kind, other than any which I have already

set out in this report. I do not consider that any interest which I have disclosed affects my suitability to give expert evidence on any issue on which I have given evidence and I will advise the party by whom I am instructed if, between the date of this report and the trial, there is any change in circumstances which affects this statement.

Signed by Dr Oliver Starr Dated

Appendix 1

My experience and qualifications

Address: **(Private address)**
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General medical council number 6102039

Current positions: **Full-time sessional GP in Hertfordshire and north London.**
Undergraduate tutor at University College London Medical School.
Trainer of GP trainee doctors.
Case assessor for the National Perinatal Epidemiology Unit, Oxford.
Elected member of the Hertfordshire Local Medical Committee.
General practitioner appraiser.

Qualifications

MRCGP	Membership of the Royal College of General Practitioners, 2009.
DRCOG	Diploma of the Royal College of Obstetricians and Gynaecologists, 2009.
MRCS	Membership of the Royal College of Surgeons of England, 2007.
MBChB	Bachelor of medicine and surgery, University of Birmingham, 2004.
BMedSc	Bachelor of science, University of Birmingham, 2001.

Expert witness training

Member of the Expert Witness Institute.
Cardiff University accredited Bond Solon excellence in report writing training.

Other interests

Chair and organiser of the Herts Young Practitioner Group which holds educational meetings for young GPs every two months.
Member of the Primary Care Dermatology Society.

Appendix 2

List of sources examined

- Jurkovic D, Wilkinson H. Diagnosis and management of ectopic pregnancy. BMJ 2011; 342:d3397.
- Sivalingam V et al. Diagnosis and management of ectopic pregnancy. J Fam Plann Reproduc Healthcare 2011; 37(4): 231-240.
- NICE guidelines CG154. Ectopic pregnancy and miscarriage: diagnosis and initial management. Published Dec 2012.
- Royal College of Obstetricians and Gynaecologists guideline no. 21: the management of tubal pregnancy. Published May 2004, reviewed 2010.
- Clinical knowledge summaries, NICE. Ectopic pregnancies. Published July 2013. <http://cks.nice.org.uk/ectopic-pregnancy#!scenario:1> accessed 26th June 2016.

Appendix 3

Glossary of terms used

diagnostic laparoscopy: keyhole surgery where small cameras are put into the abdomen to look around and find out what is wrong.

ectopic pregnancy: an abnormal pregnancy where the foetus grows in the wrong place. It then can't develop normally and causes problems if it isn't treated.

fallopian tube: the tube leading from the womb across to the ovary. There are two fallopian tubes: one on each side.

laparotomy: open surgery in the abdomen involving a scar either vertically or horizontally.

methotrexate: a medication used to treat a variety of medical conditions including rheumatoid arthritis and psoriasis; but in ectopic pregnancy it is used to kill the abnormally placed foetus.

salpingectomy: an operation to remove one of the fallopian tubes.

trimester: a third of the pregnancy, so approximately 13 weeks.