Neutral Citation Number: [2019] EWHC 106 (QB)

Case No: TLQ17/1118
Claim No: HQ16C03906

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 25/01/2019

Before :

MRS JUSTICE YIP DBE

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Between :

HAZEL KENNEDY	**Claimant**
- and -	
DR JONATHAN FRANKEL	**Defendant**

- -
- -

Mr Jonathan Holl-Allen QC (instructed by **Anthony Gold**) for the **Claimant**
Ms Claire Toogood (instructed by **Clyde & Co**) for the **Defendant**

Hearing dates: 17,18,19,20,21 December 2018

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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.

....

MRS JUSTICE YIP DBE

Mrs Justice Yip :

1. Mrs Hazel Kennedy is a retired primary school teacher, now aged 56. She is married to Dr Philip Kennedy, who was a consultant neurologist until his retirement in 2006. In 2006, when aged 44, Mrs Kennedy developed a tremor in her left upper limb. Her husband was concerned that this was a sign of Parkinson's disease and arranged for her to see his former colleague, Dr Jonathan Frankel, a specialist in movement disorders. Dr Frankel saw Mrs Kennedy privately, but without charge. He diagnosed Parkinson's disease and advised on her treatment. Dopamine agonist medication, which the Claimant took on his advice, caused her psychiatric side effects, including an impulse control disorder (ICD) and eventually psychosis.

2. It is the Claimant's case that the Defendant failed to advise her of the risk of impulse control disorder associated with dopamine agonist medication and that he failed to respond in a timely or appropriate way when she developed the condition. She accepts that an appropriate warning would not have deterred her from taking the medication initially but contends that, properly advised, she would have ceased taking it far earlier and would have avoided the serious effects that developed. She therefore brings a claim for clinical negligence. It is an irony that it has since been discovered that she did not have Parkinson's disease at all. However, it is not alleged that this amounted to a negligent misdiagnosis.

3. Her claim relates to losses flowing from the ICD and psychosis. In addition to the more usual claims for treatment and care during her illness, she also brings claims relating to increased spending due to the ICD and for costs associated with separating from her husband as a consequence of her psychosis. Happily, the Claimant has now made a good recovery following cessation of the medication and her relationship with her husband has been restored.

4. The Defendant denies liability. He maintains that his treatment of the Claimant was reasonable at all times, based upon the information available to him at the time. Even if the Court finds that there should have been more detailed discussions about ICD and alternative medication, the Defendant denies that the Claimant's treatment would have been changed earlier than it in fact was.

5. There are live issues between the parties in relation to breach of duty, causation and quantum. Having exchanged skeleton arguments for trial, Ms Toogood for the Defendant sought to introduce an additional argument which had not previously been foreshadowed. Relying upon the recent decision of the Court of Appeal in *Khan v MNX* [2018] EWCA 2609, she contended that the Claimant's psychosis was a coincidental injury, falling outside the scope of the Defendant's duty, since the duty to warn related to the risk of ICD alone and did not extend to a risk of psychosis, which was an extremely rare complication.

6. A lively debate ensued as to whether the Defendant was entitled to raise that argument at trial and whether it required an amendment to the Defence. It is clear that if the Defendant is permitted to pursue the point, the Claimant will resist it. Mr Holl-Allen QC indicated that he did not accept that *Khan v MNX* had any material bearing on the principles applicable in this case. He does not accept that the development of a psychosis fell outside the scope of the Defendant's duty in any event.

7. Before I could rule upon the procedural arguments as to whether the Defendant was entitled to raise this issue, Counsel jointly proposed that I should defer consideration of all matters (procedural and substantive) relating to the Defendant's argument based on *Khan v MNX*, pending determination of the issues relating to breach of duty and causation as set out in the existing pleadings and the parties' primary skeleton arguments.

8. That was a sensible way forward. Hearing the arguments in full and ruling upon them risked delaying the trial, possibly to the extent that the evidence would not have been completed in the time available. Further, it was acknowledged that my findings on other issues *might* render the argument academic. The parties also indicated that they were hopeful, in view of the sums involved, that they might negotiate a resolution of the quantum issues once the primary arguments on breach of duty and causation had been addressed, without the need to determine this issue. Certainly, the time allocated for the trial would not have allowed for proper consideration of what was said by Ms Toogood to be a new point, arising out of the Court of Appeal's decision in *Khan v MNX*.

9. I have therefore adopted the parties' suggested approach. Accordingly, this judgment is limited to the issues of breach of duty and causation (excluding the 'scope of duty' argument). Quantum will be adjourned and, if necessary, will have to be determined by the court at a later stage. All arguments surrounding the Defendant's reliance on *Khan v MNX* (both procedural and substantive) are deferred to the quantum stage.

Legal Principles

10. Save for the point identified above, the applicable legal framework is essentially agreed.

11. A specialist is required to "exercise the ordinary skill of his specialty" (see *Maynard v West Midlands Regional Health Authority* [1984] 1 W.L.R. 634 at 638). Here, it is agreed that the standard of care to be expected of the Defendant was that of a consultant neurologist with a subspecialty in movement disorders including Parkinson's disease.

12. The allegation that the Defendant failed to warn the Claimant of the risk of ICD and to advise as to alternatives to dopamine agonists is to be judged according to the test in *Montgomery v Lanarkshire Health Board* [2015] AC 1430, as conveniently summarised by the Court of Appeal in *Duce v Worcestershire Acute Hospitals NHS Trust* [2018] EWCA Civ 1307, at paras 32 and 33:

> "32. The nature of the duty was held at [87] to be:
>
> > 'a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments.'
>
> 33. In the light of the differing roles identified this involves a twofold test:

> (1) What risks associated with an operation were or should have been known to the medical professional in question. That is a matter falling within the expertise of medical professionals [83].
>
> (2) Whether the patient should have been told about such risks by reference to whether they were material. That is a matter for the Court to determine [83]. This issue is not therefore the subject of the *Bolam* test and not something that can be determined by reference to expert evidence alone [84-85]."

13. The advice which the Defendant gave is to be considered according to the well-known test set out in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582. The advice will be considered reasonable if it was in accordance with a responsible body of consultant neurologists with a subspecialty interest in movement disorders, even though other neurologists may have given different advice, provided that the advice had a logical basis (*Bolitho v City and Hackney Health Authority* [1998] AC 232).

14. If breach of duty is made out, it remains for the Claimant to establish causation. Mere failure to warn of a material risk as defined in *Montgomery* is not sufficient to give rise to liability. See *Duce* at paragraphs 69 and 92 and *Diamond v Royal Devon & Exeter NHS Foundation Trust* [2017] EWHC 1495 (QB). The Claimant must establish that if she had been given the appropriate warning / advice she would have come off or reduced the dopamine agonist medication earlier, thereby reducing the severity and/or duration of the side effects.

<u>The involvement of Dr Kennedy</u>

15. The relationship between the Defendant and the Claimant's husband is an unusual feature of the case. The Defendant agreed to see the Claimant privately and did so without charge as a favour to his recently retired colleague.

16. Until his retirement, Dr Kennedy was a general neurologist. He would see patients with Parkinson's disease in his clinics but, unlike Dr Frankel, he did not have a sub-specialism in movement disorders. He had identified Dr Frankel as an appropriate specialist for his wife to see because he was a specialist in the field.

17. Dr Kennedy was involved in making appointments for the Claimant. It was he who first suspected Parkinson's disease. He made suggestions for changes in her drug regime and provided information about her condition. However, Dr Frankel does not suggest that Dr Kennedy's involvement altered the doctor-patient relationship, or in any way removed or reduced the duty of care he owed to Mrs Kennedy. He readily accepted that decisions about Mrs Kennedy's management and the advice he gave remained matters for him. In an email dated 20 March 2013, written to Dr Kennedy, he said "I can absolutely state that you never attempted to influence me in any way". That email can be read as a sensitive response to attempts by Dr Kennedy to resolve the marital difficulties. However, the clear impression I have is that Dr Frankel has never sought to shirk his responsibilities to the Claimant or to shift blame to Dr Kennedy. It is, however, contended on his behalf that Dr Kennedy's own experience

in treating patients with Parkinson's disease is relevant in considering the factual matrix.

18. In addressing the facts, I shall have to consider and comment on Dr Kennedy's involvement in the Claimant's management, including the information he provided to Dr Frankel. However, it is no part of the court's role to analyse his actions with a view to either attaching any blame to him or vindicating him. I make that point because it seemed to me that both the Claimant and Dr Kennedy were keen to stress that he was not responsible for what happened and that, at least at times, this shaded the evidence they gave.

The evidence

19. In addition to the evidence of the Claimant, Dr Kennedy and the Defendant, I heard from Mrs Heather May, who was called by the Defendant. She was, at the time of the events in question, a close friend of the Claimant. She became involved because the Claimant confided in her throughout the period from 2007 to 2013. A substantial volume of email correspondence was produced, which provides some useful contemporaneous evidence. In amongst news of family and daily life, the Claimant shared her shock and upset on receiving the diagnosis of Parkinson's disease and some details of her treatment and appointments with Dr Frankel. As the Claimant's psychosis developed, she shared with Mrs May concerns about her marriage. Mrs May was a patently honest witness and, where her evidence is relevant, I have no hesitation in placing reliance upon it.

20. I regret that I did not find the Claimant and Dr Kennedy to be particularly reliable witnesses. I make allowance for the fact that the Claimant has been through a significant trauma but generally found her to be a poor historian. She gave her evidence extremely confidently. On several occasions, she asserted things without any shadow of doubt that were then shown to be incorrect.

21. By way of example, she was asked about her use of rotigotine patches and an apparent reluctance to change to another drug despite having problems with the patches in 2008 – 2009. She stated that she was unaware of a problem with the patches crystallising until this was mentioned by her pharmacist in about March 2010. However, her GP records show that this very point was discussed with her in a consultation in April 2008. When the notes were put to her, she simply responded "OK". She then carried on in the same confident manner without any apparent concern that what she had previously asserted was wrong.

22. Mrs Kennedy's evidence about her husband's involvement in her medical care was inconsistent. It was put to her that she had stopped taking HRT on his advice. She denied that. She claimed that her HRT had been stopped by her GP, Dr Menin. However, her GP records clearly demonstrated that she had stopped taking her HRT on her husband's advice without consulting her GP.

23. I note that in a letter dated 1 February 2013, addressed to Dr Frankel and Dr Menin, Dr Kennedy suggested that the Claimant has always been a poor medical historian. While I recognise that this letter was written in the context of accusations about his conduct and at a very difficult time, it does refer to matters going back beyond this,

suggesting that the Claimant "always exaggerated seemingly simple everyday symptoms".

24. It was apparent that Mrs Kennedy feels real guilt over the accusations she made against her husband while she was unwell and the impact on their marriage. She displayed very real distress and sorrow about the hurt she had caused her husband. It seemed to me that she was motivated by a strong desire to vindicate her husband and that blaming Dr Frankel for all that happened formed part of that narrative. I did not think she had set out to mislead the court in order to advance her claim, but the inconsistencies in her evidence mean that I approach what she told me with some caution, and I have looked to the contemporaneous evidence rather than simply accepting the evidence that she now gives with hindsight.

25. Dr Kennedy presented as quite a difficult man. In her closing submissions, Ms Toogood described his evidence as "largely self-justificatory". I do not think that description is unfair. He appeared very keen to vindicate his own actions and to blame Dr Frankel. I felt that he descended into frank advocacy at times. Having seen him give evidence, I understood why those who knew him, including Dr Frankel and Mrs May, had not been wholly surprised when Mrs Kennedy began to complain about his controlling personality and to express concerns that he was interfering with her medical care.

26. I was troubled by evidence that Dr Kennedy had dissuaded the Claimant from reporting concerns about her driving to Dr Frankel. In July 2012, Mrs Kennedy attended an appointment with Dr Frankel. Before attending the appointment, she prepared a document recording her current symptoms, which included concerns about her safety when driving. After the Claimant had produced this document, Dr Kennedy went through it, editing her account of her symptoms and removing the concerns about driving. Dr Kennedy accepted that concerns about driving were important, given the treating doctor's duty when reporting to the DVLA but said that the Claimant's self-reported symptoms amounted to a "medical oxymoron". He had therefore taken out that which he considered to be oxymoronic. He said that he had seen his wife driving and assessed that she was able to drive safely. He had also discussed with his son who is a neurologist. He accepted that in relation to this issue, he had controlled the information that Dr Frankel had available. None of this sat easily with his repeated assertions that he had not interfered with Mrs Kennedy's treatment by Dr Frankel.

27. In his statement, Dr Kennedy stressed that he was not a specialist in movement disorders and that he had not previously come across ICD related to treatment for Parkinson's disease in his own practice. I felt that he was keen to play down his knowledge and understanding of the condition. However, there is ample evidence that Dr Kennedy was researching matters relevant to the Claimant's treatment. He discovered the recall of rotigotine patches and discussed taking rasagiline with her. I conclude that Dr Kennedy had a good understanding of the treatment options available for Parkinson's disease and of current practice surrounding the management of the disease. As such, he cannot explain away matters which he did not raise at the time simply by relying upon a lack of up to date or sufficiently expert knowledge.

28. As with Mrs Kennedy, I do not say that Dr Kennedy was deliberately misleading the court, although at times I thought he was evasive. I suspect that he was similarly

influenced by the distressing events which nearly led to the breakdown of the marriage. Regardless of the motivation, I was left with concerns about the reliability of some of his evidence.

29. Dr Frankel's evidence got off to a poor start when he appeared unwilling to accept that he had a sub-specialism in movement disorders, despite the admission to that effect in the Defence. This was rather an odd stance to take since, as I suspected and as proved to be the case, his hospital website entry showed his specialty as neurology with a sub-specialty in movement disorders. Dr Frankel claimed that he did not know what specialisms were listed for him.

30. Mr Holl-Allen suggested that the way in which he dealt with this point was striking and damaged his credibility. Certainly, it raised initial concerns in my mind. However, as Dr Frankel's evidence progressed, he appeared to be entirely open and frank. He readily made appropriate concessions. I concluded that the initial evasiveness about his specialism was an aberration. It perhaps resulted from nerves. In the end, I do not accept that his credibility was damaged.

The expert evidence

31. The Claimant called Dr Guy Sawle, a consultant neurologist with a sub-specialism in movement disorders. The Defendant relied upon the evidence of Dr CMC Allen, a recently retired consultant neurologist. Dr Allen was a general neurologist with experience of seeing and treating patients with Parkinson's disease. Unlike Dr Frankel and Dr Sawle, he does not have a sub-specialism in movement disorders.

32. I found Dr Sawle to be a balanced and fair expert. I thought Dr Allen's evidence was less impressive. It was apparent that he was less knowledgeable than Dr Sawle in this field. For example, he had erroneously referred in his report to the Claimant's ICD being a component of dopamine dysregulation syndrome (DDS). Following discussion with Dr Sawle, Dr Allen agreed that the Claimant did not have DDS. He was entirely frank about this in cross-examination, accepting that it was an error he could not defend. I felt that it was an illustration that he did not have the knowledge to be expected of a specialist in movement disorders. In the end though, I thought there was little of real substance between the experts in the evidence that they gave.

33. I bear in mind that the appropriate standard of care is that of a consultant neurologist with a sub-specialism in movement disorders and that Dr Sawle falls into that category, but Dr Allen does not.

Diagnosis and initial treatment

34. The Claimant first noticed a tremor in her left upper limb sometime in 2006. She mentioned this to her husband. He suspected it was a sign of Parkinson's disease and so arranged for her to see Dr Frankel. The first appointment was on 30 January 2007. Dr Frankel confirmed mild supportive findings compatible with a likely diagnosis of Parkinson's disease. He did not recommend any treatment at that stage.

35. By August 2007, Mrs Kennedy felt that her symptoms had worsened. She returned to see Dr Frankel on 14 August 2007. In a letter to her GP dated 24 August 2007, Dr Frankel wrote:

> "We had a discussion about a wide range of issues concerning Parkinson's disease including drug treatment. I think that she has reached the point where this would be helpful and I do not think there are any significant contraindications other than the common 'psychological' block that exists with regard to starting treatment for the first time."

He recommended starting with a drug like amantadine with the prospect of moving onto selegiline and after that a dopamine agonist. Dr Frankel advised that Mrs Kennedy should return to see him every three months.

36. The Claimant saw her GP and was initially prescribed amantadine. Selegiline was introduced but the Claimant's tremor appeared to worsen. When she returned to see Dr Frankel on 13 November 2007, she was taking 200mg of amantadine, which appeared to be more beneficial than expected. I note that no criticism is made in relation to the advice given through 2007.

The introduction of dopamine agonist medication

37. In early February 2008, Dr Kennedy wrote to Dr Frankel requesting another appointment due to a complaint of increasing pain. He saw her on 12 February 2008. Dr Frankel recorded that the Claimant had a little more tremor and noted some other symptoms. He recommended a "gentle introduction to dopaminergic medication" in the form of rotigotine patches (a new product).

38. The Claimant's pleaded case was that the Defendant was in breach of duty at this appointment in failing to warn the Claimant of a material risk of ICD and to discuss alternative treatment at this appointment. However, this part of her case is not supported by the evidence. Mr Holl-Allen did not formally concede this allegation (contained in sub-paragraph (i)(a)) of the particulars of negligence). However, his closing submissions acknowledged that any suggestion that there was a causative breach of duty in 2008 had fallen away.

39. For completeness, I note that Dr Sawle was very clear that he was not critical of Dr Frankel's advice prior to 2010. Knowledge of ICD as a side effect of dopamine agonist medication evolved over time. The scale of the problem was not initially apparent. Dr Sawle indicated in his report that ICD had remained "clinically invisible" and was regarded as a very rare side effect for a number of years. While Dr Sawle and some other neurologists were routinely giving warnings about ICD at the time, others even in specialist movement clinics were not. Therefore, the Defendant cannot be considered to have been in breach of duty, applying the principles in *Bolam* and *Montgomery*.

Change to ropinirole - April 2010

40. Mrs Kennedy did not see Dr Frankel again until 26 April 2010. During 2008 and 2009, problems with the rotigotine patches (to which I have referred briefly above) were recognised. Mrs Kennedy wrote to her GP about these difficulties in October 2009, in the course of which she indicated a reluctance to change to another treatment as the rotigotine was otherwise working very well.

41. In April 2010, Dr Kennedy wrote again to Dr Frankel. He noted that Mrs Kennedy needed to see him to "get the OK for her driving". He also mooted the possibility of a change to Requip XL (ropinirole – an oral dopamine agonist) given the difficulties with the rotigotine patches.

42. Mrs Kennedy saw Dr Frankel on 26 April 2010. In the clinic letter sent to her GP afterwards, he recorded that he was delighted to find her looking so well. In view of the difficulties with the rotigotine, he recommended that she should start taking ropinirole. There is no mention in the notes or the subsequent letter of any discussion about ICD or behavioural issues generally. The Claimant and Dr Kennedy say that there was no mention of any such side effects at this stage.

43. In his statement, Dr Frankel said that he would have had a general discussion with Mrs Kennedy regarding side effects including sickness, dizziness and peculiar feelings and that he would have pointed out that some patients on ropinirole can develop behavioural symptoms. However, when questioned about this, he said that he could not say one way or another whether he gave any warning of the risk of behavioural symptoms in April 2010. The Defence had confirmed that the Defendant no longer had any direct recollection of the consultation.

44. Dr Frankel's evidence was that he did not routinely warn patients specifically of the risk of ICD until 2013. As the knowledge of the risk of ICD developed over a period of years, he said that it was difficult now to remember exactly what advice he gave at different times. He accepted it was not his practice in 2010 to quiz patients about any behavioural changes.

45. It is notable that there is no reference to the possibility of behavioural changes of any sort in the letter to the Claimant's GP. If the Claimant had been warned of such a risk, I would have expected Dr Frankel to mention this to the GP, being the doctor who was to prescribe the medication. This would have allowed the GP to be alert to any possible symptoms.

46. Having considered all the evidence, I conclude, on the balance of probabilities, that the Claimant was not given any warning about ICD or about behavioural changes at the consultation in April 2010.

47. Dr Sawle's evidence was that by April 2010, it was mandatory for specific warnings about ICD to be given. He said that it had been recognised by then that it was not enough merely to mention behavioural problems as patients would not necessarily perceive the sort of behaviours in ICD as being negative or linked to the drug. Reference should have been made to the risk of a variety of obsessional and/or addictive behaviours occurring. I see some force in this.

48. Dr Allen did not agree that a specific warning about ICD was required at that time. However, he did agree that a general warning about behavioural problems should be given. I do not need to dwell on the difference in expertise between Dr Sawle and Dr Allen since it seems to me that any difference in opinion as to the nature of the warning that should have been given in April 2010 is not actually material to the case.

49. Dr Allen told me that when the risk of behavioural changes was mentioned, patients would generally say "What do you mean by that?" That would lead to further

discussion in which additional detail of the sort of problems that might arise would be given. In this case, I am satisfied that the Claimant, an intelligent woman, and her neurologist husband would have asked for further details and would have learnt that the sort of behavioural problems the drug might produce included impulsive behaviour. Therefore, I am satisfied that had Dr Frankel mentioned a risk of behavioural changes, that would have led to discussion which would have resulted in her having the sort of information that Dr Sawle says she should have had.

50. The risk of developing compulsive behaviour was a material risk, as defined in *Montgomery*. I find therefore that the Defendant was in breach of duty in failing to give a warning at this time.

51. In his closing submissions, Mr Holl-Allen confirmed that it was not the Claimant's case that she would have declined ropinirole in April 2010 had she been warned about the risk of ICD. Rather, her case is that a warning given at that stage would have made her more alert to ICD behaviours as they became manifest in 2010.

52. The Claimant's evidence was that, with hindsight, she considered that her behaviour and personality altered before the change to ropinirole. She said that she had begun to display impulsive behaviour and her spending increased. In 2009, she discovered eBay and began ordering many items online. She had some orders sent to her mother's home so that her husband would not see how much she was ordering. However, the contemporaneous evidence suggests that any changes in the Claimant's behaviour were not troubling at this time.

53. Mrs Kennedy appears to have been extremely open in what she shared with Mrs May. The extensive emails passing between them provide an interesting record of what was going on in Mrs Kennedy's life. She shared concerns about her symptoms and her treatment. There is a fairly mundane exchange in January 2010 about an order for a particular type of bakeware which both women used. The supplier was ceasing shipping to the UK so there was a last chance to order. Mrs May indicated she was "going on a spree". Mrs Kennedy ordered just one baking tray as she did not need anything else at the time. This small example shows her exercising her usual good sense and frugality. Despite so much being shared between the two women, there was nothing to indicate any particularly unusual behaviour at this time.

54. Mrs Kennedy began to collect silver teaspoons and to do more crafting. However, she had always had an interest in and talent for crafts. Mrs May admired what she did. There was nothing obviously out of the ordinary or problematic. If the Claimant's spending increased at this time, she could well afford it. She was not getting into debt nor were any of her activities preventing her pursuing a normal family life.

55. Dr Kennedy's evidence is that he was well aware that dopamine agonist medication could cause impulse control behaviours even by February 2008. Therefore, unlike non-medical relatives who would probably not make a link between symptoms of ICD and the medication, he was very well-placed to observe and report any worrying signs.

56. He complains that he did not know at the time that patients with ICD could be secretive. He argued (and I use that word deliberately) that his views were worthless as he was not advised of the secretive nature of the condition which he said (with

reference to the experts' joint statement) was known in movement disorder specialist circles but not to him. I am bound to say I find this somewhat difficult to accept. It seemed to me that he was well-informed about ICD and could have discovered that which he says Dr Frankel should have known. In any event, it is not entirely clear how any additional knowledge about patients being secretive would have altered his view of the Claimant's behaviour.

57. The experts define ICD as "a behavioural disorder in which the patient fails to resist impulses to behave in ways that result in impaired social or occupational functioning". Even viewed with hindsight, I do not believe that there is any evidence that Mrs Kennedy's behaviour met that definition when she saw Dr Frankel in 2010. The concession made by Mr Holl-Allen that she is unable to maintain that she would not have taken ropinirole had she been properly warned is consistent with this.

58. The evidence does not establish that had Mrs Kennedy been warned about ICD she would have brought concerns to the attention of Dr Frankel sooner than they were in fact raised.

59. In all the circumstances, I do not consider that the failure to warn in April 2010 had any material impact on the course of the Claimant's symptoms or the treatment path.

The development of symptoms on ropinirole

60. In August 2010, Mrs Kennedy wrote to Dr Frankel updating him about her progress on the new medication. She indicated that the initial side effects had been much worse than when she started rotigotine. However, she confirmed that they had settled. She raised a concern about increased appetite. She observed that she had lost a lot of weight while on the rotigotine but that since changing medication her appetite had increased and she was gaining weight. Within the letter she said, "I feel as if I want to binge on food and am having to try very hard indeed to keep this in check …not easy!"

61. Dr Frankel responded indicating that weight gain or loss can occur in Parkinson's disease. He thought that it was possible that this was a reversal of the weight loss while on rotigotine. I note that Dr Sawle considered that to be a perfectly reasonable view for Dr Frankel to take. It would not necessarily have raised any concern about over-eating as a result of ICD.

62. In giving evidence, the Claimant told me that she first suspected that something was not right towards the end of 2010. She said that she was doing "silly things". The example she gave was that she paid for a meal for the Mays when they stayed with the Kennedys in their apartment in France. The arrangement had always been that the guests would pay for the meal out in return for their accommodation. That may have been unusual, but it is hardly something that would fit easily within the definition of ICD.

63. By late 2010, she was aware of what ICD was and that there could be a link between compulsive behaviour and the medication she was taking. By then, Dr Kennedy had formed the view that she had developed ICD. He is able to recall a discussion about it with his neurologist son when they attended a conference in September 2010. Dr Kennedy was aware that the Claimant was spending more time and money on her

hobbies. She sold her creations to raise money for charity. Dr Kennedy said that their home became "like a shop". He was aware of numerous deliveries being made to the house. However, he maintains that he was not aware of the full extent of his wife's spending due to her secrecy and the fact that their kept their finances separately.

64. Dr Kennedy did not immediately report his suspicions that the Claimant had developed ICD to Dr Frankel. He said that he did not regard it as a medical emergency. He did not think it was important at the time.

65. In January 2011, Dr Kennedy did write again to Dr Frankel, requesting an appointment. His letter is more in the nature of a medical report with various headings. The first was "pain control" and Dr Kennedy identified complaints of pain in the arms in relation to which Dr Frankel's opinion was sought. He then set out details of her current condition, noting that she had done very well given the time since the onset of symptoms. There was then a heading "impulse control disorder" under which Dr Kennedy noted "This has been recognised since we last met and has taken various guises." Further details were provided about weight loss; hobbies and impulse buying.

66. Dr Kennedy identified that there was nothing unusual in his wife pursuing hobbies such as making bears and re-upholstering chairs. However, he identified that this had become "pathological" in that she would continue through the night and the next day, meaning that she was working on bear-making for up to 48 hours at a time. He also noted that it had been a standing joke that an endless stream of delivery vans was coming to the house. Following the Claimant revealing that she had bid for 200 items on eBay one night, they had a talk. Dr Kennedy observed:

> "I thought she was able to keep it under wraps, she does control it, although she still says it is a struggle. As is typical of this condition, all of the above are in keeping with her character. She has not done anything out of the ordinary such as gambling."

<u>Appointment on 18 January 2011</u>

67. Dr Frankel saw the Claimant on 18 January 2011. There is reference in his clinical notes to "pain; hobbies, weight; impulse". Dr Frankel's evidence was that he made these notes as he discussed the points with the Claimant.

68. The experts agree that Dr Kennedy's letter put the Defendant on notice that the Claimant had ICD. In those circumstances, they agree that it was essential for him to discuss discontinuing the dopamine agonist medication. Dr Sawle's view, expressed in the joint statement, was that the Claimant should have been told that her ICD was due to her medication and that the options included stopping that and taking another drug (levodopa) which was likely to abolish the ICD symptoms without any deleterious affect on her Parkinson's symptoms. Dr Allen agreed with this in cross-examination.

69. Both experts were clear that there were unlikely to be any negative effects of moving from ropinirole to levodopa. There had been changes in thinking about the appropriate drugs for young patients with Parkinson's disease but in January 2011

levodopa was considered a good choice. There were no contra-indications for the Claimant. On the other hand, given the apparently very good control of Parkinson's symptoms, a change in medication would only be considered for good reason.

70. It is clear from the joint statement (see para 15) and the evidence the experts gave at trial that the appropriate approach once ICD had been recognised was to drill down into the account of symptoms to determine the scale of the problem. It is recognised that this is not always easy as patients may deny symptoms and family members may not be aware of them. Where the behaviour was not unwelcome and was not causing problems, similar treatment would usually be continued. If further increases in doses were required, patients and their families would be told to report back if symptoms increased. If symptoms were becoming troublesome, the dopamine agonist dose would be reduced and commonly stopped. Levodopa would usually replace the dopamine agonist.

71. Dr Frankel's notes of consultations are brief. His explanation was that he makes only a few notes while with the patient and then immediately dictates his clinic letter before seeing the next patient so that the letter stands as the contemporaneous record.

72. There is no specific reference to ICD symptoms. The letter concludes

> "We had a chat about other matters surrounding her disease all of which I think are under control. She knows that she can always contact me here if she does have any problems or concerns but for the time being I have recommended she remains on the same anti-parkinsonian medication …"

Dr Frankel accepted that, with hindsight, it would have been better if he had spelt out that the discussion of "other matters" was about symptoms of ICD. He said that the Claimant and Dr Kennedy would know what he was talking about but accepted the GP would not.

73. While he did not pretend to recall the discussion verbatim, he could remember discussing the ICD symptoms with the Claimant and Dr Kennedy. He said that his advice to continue with ropinirole was the result of assimilating all the facts, including the contents of the letter and what he was told in the consultation. He was adamant that he would not have been comfortable with the Claimant continuing on that medication if concerns remained in the room or if he had not been satisfied with what he was being told.

74. This accords with Dr Kennedy's recollection of the consultation. He said that it was striking that he had written the letter that he did in advance and had suggested that Dr Frankel might wish to seek another opinion from a specialist in ICD, yet he left the consultation reassured and content with the advice given.

75. This, in my view, supports the notion that there was a full and appropriate discussion about the Claimant's symptoms. Dr Kennedy was plainly well-informed about the condition and the link to the medication. He knew alternative drugs were available, indeed he had regularly prescribed levodopa. While that in no way removed the need for Dr Frankel to explain the options to Mrs Kennedy, it suggests that he explored the

possible need for a change in medication in a way that appeared appropriate to a well-informed and concerned observer.

76. The evidence as to whether levodopa was specifically discussed at this consultation is uncertain. The Claimant and Dr Kennedy said in their statements that alternative medication was not discussed. Dr Frankel did not state whether he had referred to levodopa. When cross-examined, the Claimant said Dr Frankel might have mentioned levodopa in 2011. It was clear from Dr Kennedy's evidence that he had levodopa in mind at this time but considered the decision about medication to be entirely for the treating physician. A letter from Dr Kennedy to Dr Frankel dated 20 March 2013 acknowledges that levodopa was discussed as being an acceptable therapy "in later consultations".

77. On balance, having considered all the evidence, I find that Dr Frankel probably did not clearly explain to the Claimant that levodopa was likely to abolish her ICD symptoms while still providing good control of her Parkinson's symptoms. However, he did canvass the possibility of a change in medication before making a positive recommendation that she remain on the medication she was on (as reflected by his clinic letter). I am satisfied that the Claimant was aware that other medication was available to control her Parkinson's symptoms and that it was the specific medication that she was taking that had caused her ICD symptoms. I find that the Defendant made a judgment to advise the continuation of the dopamine agonist having sufficiently explored the ICD symptoms and having been reassured by the Claimant and by Dr Kennedy that the symptoms were not then out of control.

78. The evidence available to Dr Frankel at the time did not suggest any marital discord or reason not to rely on Dr Kennedy's observations. The symptoms reported at the time could not necessarily be said to be causing a major problem for the Claimant. She was pursuing her crafting hobbies vigorously and to an extent that might be considered excessive. Mrs May regarded the extent of her craft activities as "bemusing" but plainly did not think it alarming. Mrs Kennedy was buying more, and her spending had increased but she was certainly not spending beyond what she could afford. Later (in 2012), Mrs Kennedy shared her concerns that she was spending too much time and money on eBay. Mrs May made the perfectly sensible point in response that she had been through a spell of heavy use of eBay and therefore that this might have happened to some extent even without the medication.

79. Mrs Kennedy was spending rather more of her own money and dedicating a lot of her time to craft hobbies. She was still involved with her family; enjoyed a social life and had regular holidays. I understand that, looking back, she may consider that her symptoms were a problem, but I am entirely satisfied that she did not give that impression at the time, either to Dr Frankel or to others.

80. Dr Sawle acknowledged that there is a balance to be struck between the control of motor symptoms and unwanted side effects. That must depend upon impression and judgment and, inevitably, there is room for differences of opinion. Dr Sawle accepted that the advice that should be given upon disclosure of ICD symptoms is very fact dependent. The literature confirms that around 20% of patients taking a dopamine agonist will experience changes in behaviour of an addictive and/or obsessional nature but that a much smaller percentage (less than 5%) experience symptoms which require withdrawal of the drug. It is therefore far from the case that dopamine agonist

medication should immediately be withdrawn upon any symptoms of ICD being reported.

81. On the facts as I have found them to be, I am satisfied that it was reasonable at that time for Dr Frankel to recommend the continuation of the dopamine agonist medication which was apparently providing excellent control of symptoms of Parkinson's disease.

82. Insofar as Dr Frankel did not sufficiently discuss levodopa as an alternative, as the experts agree he should have done, I find that this was not causative of any loss. This is because I find that, even with additional information about levodopa, Mrs Kennedy would still have followed Dr Frankel's advice to continue with her existing medication because:

    i) Her Parkinson's symptoms were very well controlled.

    ii) In the past, she had expressed some reluctance to change a treatment that was working well in controlling the disease. She also expressed reluctance to change her medication in April 2011.

    iii) She did not feel her ICD symptoms were out of control or a significant problem at the time.

    iv) Even if levodopa had not been specifically discussed, she was well aware that alternative drugs were available, and was happy to continue on her existing medication on that basis.

    v) Dr Kennedy was well aware of levodopa as an option and had been ready to recommend alternative treatment previously, but he considered the advice reasonable at the time.

83. It follows that I find that any breach by Dr Frankel up to and including January 2011 did not materially affect the course of the Claimant's treatment.

Developments during 2011

84. The emails between the Claimant and Mrs May do not evidence any difficulty in the marriage at this time. Later, such problems were shared with Mrs May. However, it is the Claimant's case that she was feeling irritated with her husband and that she was becoming more argumentative.

85. In April 2011, she went to see her GP, Dr Menin. In evidence, she told me she was feeling down at the time. Dr Menin suggested that she should see the specialist Parkinson's nurse, Sheena Morgan. He wrote a referral letter. Dr Frankel had suggested that the Claimant see Nurse Morgan after the initial diagnosis, but the Claimant had not thought that necessary then.

86. In August 2011, the Claimant went to see Nurse Morgan alone. She told me that she became distressed and was in tears for much of the consultation. She shared more with the nurse than she had with Dr Frankel. She says that Nurse Morgan asked more detailed questions and that she was less inhibited in answering because her husband was not present. Nurse Morgan told the Claimant that she thought she was suffering

from ICD and should come off the drug. The Claimant said she was loath to do that, as in other ways she felt good on the drug. The nurse impressed upon her that she should see Dr Frankel upon her return from a forthcoming holiday and asked her permission to write to him about their discussion.

87. Sheena Morgan's letter is significant. She recorded that the Claimant appeared to have developed an ICD in the form of compulsive buying, which had caused discord with her husband. She highlighted sleep disturbance due to the need to complete tasks. Nurse Morgan noted that "her current behaviour, that she is struggling to control, is out of character." She also mentioned weight gain, while acknowledging that might be unrelated. She informed Dr Frankel they had discussed decreasing or withdrawing the dopamine agonist, but that Mrs Kennedy was reluctant to consider that as her motor function was so stable. She then said this:

> "She has given permission for me to highlight her current problems to you, but does have concerns about focusing on this herself, during clinic appointments as her husband is finding it difficult to come to terms with them but she still wishes him to be present."

88. Dr Frankel indicated that he had spoken to Sheena Morgan about Mrs Kennedy before the letter reached him. Therefore, he knew what was coming. When he received the letter, he knew that Mrs Kennedy was to make a further appointment with him and considered that he would need to revisit the ICD symptoms when she came to clinic. He read the letter and directed it should be filed so that it would be in her notes when she came. He acknowledged that the letter suggested the need for careful handling of Dr Kennedy's position.

<u>Consultation 25 October 2011</u>

89. On 15 October 2011, Dr Kennedy wrote to Dr Frankel asking for a further appointment, which took place on 25 October 2011. The Claimant's recollection is that they did not discuss her behaviour or spending in any detail. Dr Kennedy said in his statement that he and the Claimant both discussed their concerns about ropinirole on her behaviour, particularly her spending. Dr Frankel recalls asking about behavioural changes but that neither the Claimant or Dr Kennedy thought it was a significant problem.

90. Following the consultation, Dr Frankel wrote to Dr Menin. He confirmed that he had recommended an increase in the dose of ropinirole. The letter contained the following paragraph:

> "She had been a little concerned about the effects of ropinirole on her behaviour in terms of buying things and she did discuss this with me last time she came. Both she and Philip did not think it was a significant problem or that they would not be able to detect it if it was increasing or changing. There have been a fair number of personal stresses and concerns recently that will have contributed to the overall mix."

91. There is no record of that letter being copied to Sheena Morgan. Mr Holl-Allen suggests that the inference from that combined with the terms of the letter is that Dr Frankel overlooked the letter from Nurse Morgan at the consultation, or at least that it was not in the forefront of his mind at the time.

92. I consider that this is a reasonable inference. The letter from Sheena Morgan gave a clear account of ICD causing disturbance of sleep, behaviour that was out of character and marital discord. The letter to the GP identified only a little concern about buying things, which had been discussed on the last occasion. There was no advice to the GP to keep an eye on ICD symptoms nor any suggestion that the Claimant should be reviewed by Nurse Morgan. The specialist nurse had advised that she thought the dopamine agonist medication should be decreased or withdrawn. Dr Frankel's advice was to increase the dose. That was an important decision in light of what Nurse Morgan had said, about which very little was said.

93. Dr Sawle said, and I accept, that a specialist receiving the letter from Nurse Morgan would have started with the expectation that a change of drug was required. He said that to be persuaded otherwise, there would need to be a real drilling down into the symptoms and for something compelling to emerge from the discussion such as would justify not making a change. Dr Allen indicated in cross-examination that he did not disagree.

94. Ms Toogood's submissions that there were risks associated with changing to levodopa are not supported by the expert evidence. Both experts were clear that there were no contraindications to changing to levodopa if there was a reason for a change. They did agree though that patients are often reluctant to change to levodopa if they feel their symptoms are well-controlled on a dopamine agonist.

95. Nurse Morgan had specifically identified that the Claimant was reluctant to discuss matters relating to her ICD in front of her husband. Her account was important. As a specialist nurse, Dr Frankel was able to place reliance on her reporting of symptoms. Clear concerns were being raised. It is difficult to see how such concerns could easily be overcome with a relatively short discussion when it was known that Mrs Kennedy may not be entirely open in front of her husband.

96. If there had been a drilling down into the details of the Claimant's ICD producing a picture that contradicted that in Nurse Morgan's letter, that ought to have been properly documented. The information should also have been shared with the GP and Nurse Morgan. The justification put forward on the Defendant's behalf for not recommending a change in medication in October 2011 is that Dr Frankel was told that the ICD was not a significant problem and/or that Mrs Kennedy was reluctant to change.

97. In my judgment, the brief discussion, conducted in Dr Kennedy's presence without any proper documenting of what was discussed was not sufficient to displace what emerged from Nurse Morgan's letter.

98. I find that Dr Frankel should have advised the Claimant about levodopa and that switching to that drug would probably remove the ICD symptoms while still giving good control of the Parkinson's symptoms. I consider that in light of the additional information received from Sheena Morgan, Dr Frankel ought to have made a clear

recommendation to reduce or discontinue the dopamine agonist so as to control the ICD. His recommendation to increase the dose cannot be considered reasonable on the evidence before me. I therefore find that the Defendant breached his duty to the Claimant in failing to properly advise her in October 2011.

99. Given the real concern expressed to Sheena Morgan about her ICD and her distress when discussing it, I am entirely satisfied that the Claimant would have chosen to change to levodopa if Dr Frankel had properly advised her that her Parkinson's symptoms were likely to be controlled but her ICD would cease.

100. It is agreed that a change in medication at this time would have led to the Claimant recovering quickly from the ICD and not going on to develop the psychosis.

Events after October 2011

101. I shall deal with this period briefly, given the effect of my finding above and since no specific breach is maintained after this time.

102. The Claimant and Dr Kennedy recall worsening problems from the end of 2011. They recall a car accident (they thought in November 2011 but in fact January 2012) after which Mrs Kennedy expressed concerns about her husband. The contemporaneous emails do not evidence any significant change until June 2012. However, by then, there had been a distinct change in tone. Mrs Kennedy had begun to express very negative views about her husband. Over time, their relationship became more strained.

103. A further appointment with Dr Frankel took place on 17 July 2012. Following the consultation, the Claimant emailed Dr Frankel in confidence (as he had invited her to do). She complained about her husband and said she feared him. She did not wish any of the information she gave Dr Frankel to be divulged to him.

104. The experts say that it is difficult to say for sure when Mrs Kennedy first showed features consistent with a psychosis but agree she may have been developing psychosis by July 2012. If not by then, the psychosis was probably developing later in 2012, and certainly by early 2013.

105. The psychosis was very distressing for the Claimant and for Dr Kennedy. She made serious unfounded allegations against him. She was very convincing, and the Mays were led to believe what she was saying. In January 2013, the Claimant left the marital home and instructed solicitors to begin divorce proceedings. I am satisfied that this stemmed from her psychosis and the resultant delusional beliefs about her husband.

106. I agree with Ms Toogood's submission that there is no evidence that the Claimant's ICD worsened after October 2011. I also agree that the events of 2012/2013 caused the Claimant significantly more distress than her ICD did. This has undoubtedly coloured her recollections about her ICD and I have taken that into account when making the findings above about the consultation in October 2011.

107. Dr Sawle was not critical of the Defendant's actions from 2012. He accepted that once the psychosis began to develop it became much more difficult for Dr Frankel to

work out what was going on. He confirmed that the combination of ICD and a psychotic reaction in a patient on a dopamine agonist was extremely rare. He could not recall ever seeing such a combination. He highlighted that it is very difficult to look inside a marriage and know what is truly happening. The fact that Dr Kennedy was a former colleague cannot be ignored in this context. There is no doubt that Dr Frankel was put in a very difficult situation.

108. He dealt with the developments in 2012 appropriately. In February 2013, he advised the reduction of ropinirole and a second opinion. He appears to have dealt with this sensitively, advising Mrs Kennedy that dopamine agonists were best avoided by patients where there were any features suggesting that the drugs were affecting their underlying behaviour. Dr Frankel's last appointment with the Claimant was on 19 February 2013. He advised an appropriate plan for her to come off ropinirole.

109. The Claimant had an unpleasant time coming off the drug but went on to make a good recovery. Her ICD and psychosis resolved completely, and she and Dr Kennedy were able to save their marriage. Upon withdrawing from ropinirole, she did not develop the motor symptoms that would have been expected, leading to the suspicion that she did not in fact have Parkinson's disease. Dr Gibb, the neurologist from whom she sought a second opinion, confirmed in April 2013 that she did not have Parkinson's disease.

110. Neither expert is critical of the Defendant's response from July 2012 and beyond. In those circumstances and given the limited issues I am required to determine at this stage, it is unnecessary for me to say more now about this period

Conclusion and disposal

111. I therefore find that the Defendant should have warned the Claimant of the risk of developing ICD on ropinirole from April 2010. Further, when symptoms of ICD emerged, he should have clearly explained that taking levodopa instead was likely to abolish symptoms of ICD while still providing good control of the symptoms of Parkinson's disease. However, any breach prior to October 2011 did not cause any loss, since I conclude that, properly advised, the Claimant would have continued to take ropinirole until that time.

112. I find a material breach of duty in relation to the advice given in October 2011. I conclude that, at that time, the Claimant should have been properly advised about levodopa and that, given the evidence in the letter of Sheena Morgan, a reduction in dose and/or discontinuance of the dopamine agonist medication should have been recommended rather than an increase. The Claimant would then have agreed to her medication being changed. Therefore, but for the Defendant's breach in October 2011, the Claimant would have recovered from her ICD within a short time and would not have gone on to develop psychosis.

113. In finding the Defendant to have been in breach of duty, I acknowledge that this was not an easy case for him. Mr Holl-Allen acknowledged that he had acted in good faith. I consider that the involvement of Dr Kennedy did play its part and perhaps explains, although does not excuse, Dr Frankel's breach. I consider it unfortunate that, having acted with the best of intentions and without charging for his private services, he has found himself in the position he does. However, he readily

acknowledged his duty to Mrs Kennedy as his patient and, to the extent set out above, I have found that he fell below the required standard of care. When the psychosis developed, Dr Frankel faced a very difficult situation given the allegations his patient was making against his former colleague. It is notable that he discharged his duty of care appropriately and sensitively at this stage.

114. I have not yet heard submissions on quantum and invite the parties to seek to agree the appropriate valuation of the claim reflecting the above findings. The issue raised by Ms Toogood in reliance on the Court of Appeal decision in *Khan v MNX* has been deferred pending this judgment. If the parties are unable to agree how this should be resolved, the matter will have to be listed for a further hearing. The parties will need to have proportionality in mind given the sums likely to be involved. I would hope that they are at least able to narrow the issues and to agree sensible directions for the final resolution of the claim.