Please be aware that this is an anonymised copy of what was a real report and litigation has ended. The names in this report are all false.

Medical Report by Dr Alastair H Bint

Dated
22nd March 2010

Area of Expertise
General Practice

Acting as Single Joint Expert for;
Brighton County Court,
Law Courts, William Street, Brighton
County Court Claim number XXXXXXXX

Subject
Ms A Brown,
XXXXXXXX, Brighton, East Sussex, BN1 7HF

Written by
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Contents

Paragraph Number	Paragraph contents	Page Number
1	Introduction	3
2	The issues addressed and a statement of instructions	4
3	Examination of medical records	4
4	Examination of Miss Brown	6
5	Observation regarding mental health	10
6	Answers to specific questions from Smith Gadd Solicitors (Defendant)	11
7	Answers to specific questions from Edward Harte Solicitors (Claimant)	16
8	Statement of compliance	19
9	Statement of truth	19

Appendices

1	My experience and qualifications	20
2	List of documents I have examined	21
3	Explanation of medical terms	22
4	Blood test results	23-27

Report

1. Introduction

1.01 The Expert

I am Dr Alastair Halford Bint. My specialist field is General Medical Practice. Full details of my qualifications and experience entitling me to give expert opinion evidence in this case are in appendix 1.

1.02 Summary background of the case

Miss A Brown is the Claimant in proceedings brought under the Inheritance (Provision for Family & Dependants) Act 1975, concerning the Estate of her mother, xxxxxxx Brown deceased. The claim is opposed by her three brothers, who are the Defendants to the proceedings, xxxxxxxx Brown. Miss Brown is arguing that she should be allowed to remain in the old family home due to disabling medical conditions.

1.03 Summary of my conclusions

Miss Brown undoubtedly has large fibroids, which cause some problems for her, although less so now than they used to. She has dangerously high blood pressure and is not on any treatment for this. Some, if not most, of her dizziness symptoms are probably currently related to her uncontrolled and very high blood pressure. Her refusal to entertain treatments for her fibroids and her puzzling and inconsistent descriptions of herself are likely to be symptomatic of an underlying psychological illness which may be depression or may be a personality disorder, or a mixture of both. In my opinion, the degree of disability that Miss Brown claims is inconsistent with the clinical findings and I advise that a Psychiatric evaluation be made prior to the Court Hearing.

1.04 The parties involved

Miss XXX Brown; Claimant
Mr XXX, XXXX and XXXX Brown; Defendants

1.05 Technical terms and explanations

I have indicated any technical terms in **bold type**. I have defined these terms when first used and included them in a glossary in appendix 3. I have explained common medical abbreviations in brackets within the text of the report. Direct quotes from records are in *italic* script.

2 The instructions and issues raised

2.01 To assess Miss Brown with regards the existence or non-existence and severity of her medical conditions as listed and to answer specific questions as detailed in sections 6 and 7 of this report. The medical conditions are;

Uterine fibroids
Anaemia
Meniere's disease
Arthritis
Bowel incontinence
High blood pressure
Gout

3 Examination of medical records

A full copy of the GP records was received and the salient details are as follows:

3.01 Regarding the uterine fibroids, according to the GP records, these were diagnosed in April 2002, and were confirmed to be very large on ultrasound scan. She has been under the care of two Gynaecologists, Mr R Yellow and Mr A Turquoise. Surgery or minimal access embolisation were both offered to Miss Brown, but she has declined each of these treatment options on more than one occasion. As a consequence she lives with the symptoms of the fibroids. The main symptom is daily pain and they also cause heavy menstrual bleeding, which has caused her to develop anaemia. In correspondence, Miss Brown refers to her fibroids as her '*massive tumours'*.

3.02 Regarding the anaemia, this was first noted by the GP in April 2006 and a full blood count showed a significantly low haemoglobin level of 7.6 grams per decilitre (lower limit of normal for a female is 11.5 g/dl). It was felt that the anaemia was caused by her heavy menstrual bleeding, which was caused by the uterine fibroids. Miss Brown was given iron supplements and the last time her haemoglobin level was checked by the GP, was in May 2007 and it was entirely normal. She therefore no longer has anaemia. In correspondence with her GP, dated 15th July 2008, Miss Brown refers to her anaemia as '*this blood disease'* that she feels she has to live with.

3.03 Regarding the Meniere's disease, this was a postulated diagnosis during 2001 to 2003 in response to Miss Brown suffering bouts of dizziness, which at times were disabling. After a normal MRI brain scan, a review by Mr Pink, Consultant ENT Surgeon, and a positive **Hallpike test** (although only weakly positive), it was felt the symptoms were more in keeping with Benign Paroxysmal Positional Vertigo (BPPV). However, there were some inconsistencies, in that Miss Brown did not develop nystagmus (an abnormal eye movement in keeping with BPPV) nor vomiting, and a senior audiologist, Mrs Purple, suggested in a letter to Mr Pink, in 2002, that Miss Brown did not describe rotational vertigo, but did have episodes that appeared to relate more

to anxiety. Miss Brown has not been reviewed by the ENT team for seven years and has only tried one medication for the problem, which she felt did not work. Miss Brown is disputing the diagnosis and severity as assessed by Mr O'Connell and has stated that because she would not open her eyes during the test, despite being instructed to do so, then they could not have assessed for nystagmus.

3.04 Regarding the arthritis, there are no GP medical records detailing a diagnosis of arthritis. Miss Brown has described neck, upper back and shoulder pains, although I cannot see any consultation with a GP regarding these specifically. There is a consultation with a GP dated 25th April 2002 but this was for low back pain and was felt to be '*appears simple muscular'* pain.

3.05 Regarding the bowel incontinence, there are no GP records to suggest that Miss Brown has consulted a GP regarding this problem. There is a suggestion in correspondence that the iron supplements she takes for anaemia have caused some bowel upset.

3.06 Regarding the high blood pressure, there are GP records showing that Miss Brown had high blood pressure noted in April 2007. There is no evidence in the medical records that this was causing any symptoms and she is not on any medication for this. There is a report from Dr Beetroot, GP at XXXX Medical Centre dated 6th May 2009 which states, '*I have advised her to attend surgery for rechecking of her blood pressure but to date she has not done so*.'

3.07 Regarding the gout, there is a barely legible hand written GP entry in 1983 relating to a pain that Miss Brown was suffering recurrently in her big toe. It may be that this was postulated to be gout, although I can see no evidence that there were any definitive tests to confirm this. There are no further GP records showing that Miss Brown has seen a GP with regards to attacks of gout. There is a report from GP Dr Beetroot dated 9th February 2009, which states that Miss Brown advised Dr Beetroot that her last attack of 'gout' was 4 years ago. A serum urate level was taken in July 2006, which showed a marginally raised result. This would be in keeping with a minimal susceptibility to gout but by no means a guaranteed susceptibility. Miss Brown is not receiving any treatment for gout.

3.08 There are a multitude of hand written letters in the GP records, from Miss Brown to various GPs, over the past few years. Many of the letters extend up to four pages of A4 sized paper in length, with crowded and often illegible writing. One letter, addressed to GP Dr Green, dated 23rd January 2006, was 9 pages of A4 sized paper in length. The general impression from these letters is that Miss Brown has had several complaints relating to prescriptions not reaching her, not being delivered on time, no one coming to visit her, not being able to get evening primrose oil on prescription, being given too much iron and not enough gaviscon, her GP records not being an accurate representation of her problems, problems with being dismissed from her employment, problems with her family, no one doing her shopping for her and that no one understood the disabling dizziness she suffers.

4 Examination of Miss Brown

4.01 An examination of Miss Brown took place at her home on 11th March 2010. Blood tests were taken and the results are filed in Appendix 3, with the salient and relevant results mentioned in the body of this report.

4.02.1 Regarding the social situation, Miss Brown is a 54 year old spinster who lives alone in her childhood home. She has a weight of 94 kilograms and a height of 161 centimetres, giving a Body Mass Index of 36, which is classed as moderately obese. She describes an extremely sedentary life, having not left the house for considerable time and only very occasionally venturing into the small garden.

4.02.2 Miss Brown has carers to wash her hair, to cut her toenails and wash her feet. She has a carer to do her shopping and a helper to open her post. She has not worked for fifteen years and was on incapacity benefit for ten years but this was stopped two years ago, a decision she is appealing. She does not use any kitchen equipment except a microwave. She has no hot water in the house and does not bathe, using a damp cloth to wash herself down. She describes days when she feels so exhausted that she struggles to get out of bed. She used to suffer periods of insomnia but she now finds herself excessively sleeping. When she is up and about, Miss Brown describes her day as '*just pottering'*. Miss Brown told me she has no friends except for the carers who she employs.

4.03 Large uterine fibroids were palpated and Miss Brown referred to them several times as her '*massive tumours'*. She told me that the discomfort she got from them was much less than it used to be, but later on in the conversation she changed that to say that they were constantly painful. Miss Brown told me that she had not wanted an operation on her fibroids because she expected them to shrink after menopause. She also advised that she thought of the womb as a '*secretory organ that helps takes poisons out of the body'*.

4.04 There were no clinical signs of anaemia and a full blood count test was taken, showing normal haemoglobin levels. Miss Brown told me her periods were now infrequent and light so stopped taking her iron supplements two months ago. Blood tests confirmed that Miss Brown is going through the menopause, with a Follicular Stimulating Hormone (FSH) of 56 iu/l and a Lutenising Hormone (LH) of 35 iu/l.

4.05.1 Regarding the dizziness, Miss Brown gave a good history of benign paroxysmal positional vertigo (BPPV) in that she described getting dizzy and nauseous when rolling over from right to left in bed and other intermittent dizziness events. However, when I tested this using the Hallpike test, which is the definitive test for BPPV, this was negative. The Hallpike test also did not elicit any nystagmus or nausea or dizziness. A negative Hallpike test makes BPPV less likely but does not rule it out completely. I also asked Miss Brown to move her neck in all directions, which she could do, without precipitating any dizziness. There was therefore no convincing evidence of BPPV on examination on this occasion.

4.05.2 It is entirely possible that Miss Brown did suffer some inner ear problems in the past and perhaps still does have a degree of BPPV in amongst all the other symptoms, although I note from the history, that this was never firmly established to be either Meniere's or BPPV. Miss Brown reported that her hearing was normal.

4.05.3 Miss Brown's main dizziness complaint at present, is a constant feeling of dizziness and '*swimming head'*. This description is very out of keeping for both BPPV and Meniere's disease. Miss Brown had an exceedingly high blood pressure as outlined in paragraph 4.08 and it is my opinion that her constant '*swimming head'* is more in keeping with symptomatic hypertension (high blood pressure) rather than an inner ear cause.

4.06 Regarding joint pains, Miss Brown advised that she suffered pain in her back, neck and shoulders. On clinical examination all these joints appeared normal and there was no sign of any inflammation. She was markedly **kyphotic**, with significant increased curvature of the back resulting in a hyper-extended neck, but she had a good range of movement of her neck, back and shoulders. I could find no clinical evidence of active arthritis. Inflammatory marker blood tests including **Erythrocyte Sedimentation Rate (ESR)** are normal. Miss Brown described crippling low back pain, which she says prevents her walking far and sometimes causes her to stay in bed all day, yet she takes virtually no pain killers for this, only occasionally taking a paracetamol. On examination, she had a normal range of movement of her back and was able to flex fully without any pain. She was constrained if anything, by her obesity and fibroid mass rather than any specific back problem.

4.07 Miss Brown described '*bowel incontinence'* but actually on direct questioning, she advised me that she opens her bowels normally once a day but that some time after that during the day, she occasionally gets a brown liquid discharge, which comes on with urgency, but she normally gets to the toilet in time. She told me she only eats a meal once a day and that is often something simple like rice or potato, mixed with tomato puree or garlic, which she can cook in the microwave. She told me that during the time that she took iron supplements, her bowels were much worse, but she has been off the iron medication for at least two months. It is also possible that the pressure effects of large fibroids against the bowel is interrupting their function and causing some loose stool. It is also possible that her diet is not very nutritious at all and lacks necessary fibre, which would also account for bowel disturbance.

4.08.1 Miss Brown had a dangerously high blood pressure of 187/118 and upon rechecking was even higher at 197/119. This is extremely high and is borderline malignant hypertension, which carries a high risk of stroke or heart attack and warrants immediate treatment with medication.

4.08.2 I advised Miss Brown that she needed hospital admission urgently for control of her malignant hypertension, however she refused to entertain this. I made her fully aware of the potentially lethal consequences of her ignoring this advice, and she did, somewhat reluctantly, agree to contact her GP surgery the following day to advise them of her blood pressure readings.

4.08.3 Miss Brown mentioned she had been getting some sharp left sided chest pain at night, which did not sound typical of angina but none the less also warranted urgent medical attention. She advised me, with importance, that she took a drop of garlic oil each day, which she felt would thin her blood and therefore help prevent heart problems.

4.08.4 Miss Brown told me that her GP had advised her to take some home recordings of her blood pressure a year or two ago. She had purchased a blood pressure machine and showed me it, but admitted to very rarely using it, if at all.

4.08.5 Although Miss Brown clearly understood the severity of her blood pressure and its potential consequences, her reply regarding the importance of the garlic oil and her rather non-committal response regarding seeking GP input concerned me, and suggests she has a reluctance to consider anything that may challenge her set pattern of beliefs.

4.08.6 When I spoke to Miss Brown on the telephone on 15th March 2010, she advised me, that despite her very high blood pressure and my advice to contact her GP urgently, she had not done so.

4.09 Regarding the possibility of gout, there was no clinical evidence of gout and a serum urate was within normal limits.

4.10 With regards the assessment for possible Bulimia Nervosa. Miss Brown denied ever inducing herself to vomit, denied binge eating and said that she ate normally. She advised that her weight was stable. She had several dental fillings but her dental enamel looked normal, but there was mild parotid swelling, which can be a sign of repeated vomiting, although it is a soft and non specific sign. Blood tests confirmed normal electrolyte with a normal serum potassium. There did not appear to be strong evidence of Bulimia however, should this remain a concern, a psychiatric evaluation should be sought.

4.11 Miss Brown described occasional severe headaches starting from the neck and radiating into the forehead. These sound like tension headaches, although they could also be a symptom of her malignant hypertension.

4.12 Miss Brown described episodic right eye inflammation, which has been diagnosed as Iritis, and occasionally requires medication in the form of eye drops. It is likely this will occasionally recur.

4.13 Miss Brown described getting occasional cramping pains in both hands after she has been doing anything for a period of time for example using shears to cut garden grass. There was no evidence of active arthritis in the hands and my opinion is that this is symptomatic of her extreme physical inactivity and exercise intolerance.

4.14 Miss Brown described episodic heartburn symptoms, which she described as '*her ulcers'*. The symptoms are controlled with the anti-acid medication ranitidine, and her appetite is unaffected. She says that if she misses a dose of ranitidine, the pain is so terrible it can cripple her. She used to take Gaviscon but that was not strong enough. It may well be that Miss Brown warrants a gastroscopy to look inside her stomach to see if there is ulceration, however, my feeling is that her symptoms are more in keeping with heartburn rather than any peptic ulceration.

4.15 Miss Brown described herself as suffering from '*severe light sensitivity'*. She told me that when she looks outside through the curtains, this made her feel dizzy. I saw no evidence of this and at one stage switched the room light on, which suddenly lit the room from very dim to very bright, without any reaction from Miss Brown.

4.16 Miss Brown told me that the only medication she takes is a very occasional paracetamol and her ranitidine for heartburn. She showed me a prescription slip from the GP, which confirmed this.

4.17 Later, in a telephone consultation on the 15th March 2010, Miss Brown told me she gets occasional outbreaks of facial psoriasis.

4.18 Miss Brown also advised me during this phone call that she believes her physical impairments are such that she has spent many years adapting to her current house and therefore should remain in this house.

4.19 I performed a depression screening questionnaire on Miss Brown and she scored positive on some aspects for depression, but was adamant that she was not depressed. She did tell me that she has moments of extreme anxiety and stress, often prior to seeing her brothers. She also told me that there had been a lot of difficulties looking after her elderly mother. Miss Brown had normal eye contact and a seemingly normal affect, although she had some pressure of speech, talking for long periods without stopping. I was struck by a number of inconsistencies in her descriptions. At one stage she told me that her fibroids did not cause much pain, but she changed that later in the conversation, saying that she woke up in constant pain. She advised that her back, neck, ankle, and shoulders were constantly painful yet then changed that to say her ankle had not been painful for years. For this reason and others that I will come on to, I am concerned that there is a deep-seated psychological problem present, which I will expand further in the next section of this report.

5 Observation regarding mental health

5.01 Although this was not part of my specific instructions, the mental health of Miss Brown is a concern for me and has direct bearing on the manifestation of her other symptoms and therefore on the case.

5.02 There are a couple of reports from a psychologist dated February and August 1974 to be found in the GP records. It appears that Miss Brown was referred to a psychologist as a child due to some suicidal behaviour and phobic symptoms. It was postulated that Miss Brown may have been suffering a '*hysterical neurosis'* or '*pseudoneurotic sychizophrenia'*. It was recommended that Miss Brown have counselling and further analysis but this does not appear to have ever been followed up and there is no further correspondence from any psychologist or psychiatrist in the medical records.

5.03 Throughout the GP records from 1977 until 2000, there are several consultations with GPs recorded, when Miss Brown has been tearful, suffering insomnia and various stresses relating to family problems and work problems. She was dismissed from work on disciplinary grounds and there were some problems with the Police and neighbours who felt she was being abusive to her mother. There are references throughout the GP records and hospital records which relate to Miss Brown suffering anxiety, a problem that Miss Brown has vehemently denied suffering, in her correspondence with me.

5.04 Thereafter Miss Brown has not been to see her GP, as she has classified herself as disabled and housebound. However, there have been numerous hand written letters sent to various GPs over the last few years, which offer some insight into her mental health in that she has been an insomniac, is socially very isolated and has some very difficult family dynamics. The excessive length of some of her letters indicates a probable obsessive fixation with what she believes to be her disabling diseases.

5.05 Miss Brown views herself as 'disabled', and as such, she has built a life around that, becoming increasingly socially isolated, housebound and fixated by her illnesses, which dominate her life and have, in my view, become disproportionately intrusive. In my experience it is highly unusual for a patient who is suffering from symptomatic fibroids to refuse treatment and decide instead to suffer from them. In fact, I would go so far as to say that Miss Brown is the first patient I have met with such significant symptoms from fibroids but who is unwilling to entertain any treatment.

5.06 The depression screening questionnaire that I completed on Miss Brown suggests that she has some features of clinical depression although by no means is this clear-cut. She may have an obsessive or neurotic personality disorder. This may explain some of her puzzling behaviour, for example, her reluctance to have her fibroids operated on, her refusal to address her dangerously high blood pressure, and her exaggerated descriptions of her physical symptoms and diagnoses ('*these massive tumours'* and '*this blood disease'*, and this '*crippling back pain'*). One may explain some of this behaviour as a mix of hypochondriasis, reclusive eccentricity and inadequacy,

however I am of the view that there is enough doubt as to warrant a psychiatric evaluation. In my opinion, Miss Brown should be assessed by a Psychiatrist with a view to a diagnosis and any possible treatment. The psychiatrist should also be instructed to comment on the effects that a house move or indeed remaining in her current house will have on her mental health.

5.07 I have informed Miss Brown that I believe she has a significant psychological disturbance and that I am going to suggest she have a psychiatric evaluation. She denied feeling she may have a psychological problem but was in agreement to seeing a Psychiatrist.

6 Answers to specific questions asked by Smith Gadd and Co Solicitors (Defendant's Solicitor)

The questions as written in the joint letter of instruction are in bold type below and the answers are in normal type.

6.01 Whether each of the purported medical conditions is present or absent, the degree to which any are present and whether standard and definitive tests have been carried out for diagnosis.

Uterine fibroids; undoubtedly present and confirmed by clinical examination and previous definitive tests.

Anaemia; was present some years ago but most recent blood test confirms no present anaemia.

Meniere's disease / BPPV; there may be an element of inner ear disturbance which is probably BPPV, although at present, I suspect that her constant 'swimming head' is much more likely to be associated with her very high blood pressure.

Arthritis; There is no clinical or biochemical evidence of arthritis. The joint pains that Miss Brown describes are better known as arthralgia, which simply means 'joint pain'. There may be a degree of osteoarthritis, which is simply wear and tear of the joints. One could X-ray these joints, however I do not believe that they will yield anything helpful or diagnostic other than expected wear and tear. I should also comment Miss Brown's description of incapacitating and disabling pain is completely out of keeping with her minimal, if any, use of painkillers even plain paracetamol. In my experience, a patient in the amount of pain that Miss Brown claims to be in, would take regular painkillers.

Bowel incontinence; Miss Brown claims to suffer from this but there is no evidence of this in the medical records and what she describes is more in keeping with bowel urgency rather than true incontinence.

High blood pressure; Miss Brown does have a very high blood pressure which does warrant treatment.

Gout; there is no definitive evidence of gout either in the medical records, clinical examination or on biochemical measurement.

6.02 Whether Meniere's disease has ever been diagnosed and whether it is ruled out by a weakly positive test result for Benign Paroxysmal Positional Vertigo.

I believe paragraphs 3.03 and 4.05.1 to 4.05.3 have dealt with this.

6.03 The Defendants have reason to believe an extreme eating disorder, (perhaps best described as Bulimia Nervosa) has existed for a number of years. It is understood that this has not been investigated. If there are metabolic/endocrine tests (hypokalaemia ketone bodies) which it is felt might shed light on this then these should be carried out as well as comments offered upon the extent to which this might be a contributory factor in any of the claimed medical problems (Anaemia, menstrual dysfunction, bowel incontinence).

My assessment for this is detailed in paragraph 4.10

6.04 Whether appropriate treatments have been undertaken, or not, and a consideration of the efficacy of treatments available, but not yet used, for each of the purported conditions.

Uterine fibroids; Miss Brown has not pursued any of the treatment options available to her, which are very reasonable treatment options and which would cure her fibroids. There is no longer a need for hysterectomy for fibroids and there are minimal access operations (telescopic surgery), which have little risk and quick recovery times. Embolisation, as offered by Dr Walker in Guildford, is highly successful and often appeals to patients reluctant to undergo surgery. This has been offered to Miss Brown but she has declined the offer. There is an option that Miss Brown could be treated with hormone medication that may shrink the fibroids, however it has side effects and is not first line therapy.

Anaemia; appropriate treatments already been given that have worked.

Meniere's disease / BPPV; many treatments have not yet been tried for the dizziness including several medications e.g. betahistine. No ENT reviews have been performed for some years, with a view that they could re-perform the Epley manoeuvre or organise further vestibular retraining sessions. There are exercises which Miss Brown could perform herself (Brandt-Daroff exercises) which can be very successful in resolving BPPV. The current dizziness may be explained by her very high blood pressure but she is not on any treatment for this, and very much should be.

Arthritis; there is no definitive arthritis and no treatment needed for her joint pains other than painkillers, losing weight and consideration of some physiotherapy for her back and neck.

Bowel incontinence; has settled somewhat since stopping iron, likely having her fibroids removed and improving her diet would improve things further.

High blood pressure; Miss Brown should definitely be on medication for high blood pressure and urgently, however she has to date, not followed up the advice of the GP to have her BP rechecked. She should also have her episodic chest pain investigated.

Gout; no definitive evidence of gout attacks, no treatment needed other than painkillers as required.

6.05 What effect any existing medical conditions might have on the Claimant's ability to undertake paid work, and what effect the acceptance of appropriate medical treatments might have upon her ability to undertake work.

6.05.1 Miss Brown appears to be in some discomfort from her significantly enlarged fibroids although she describes an inconsistent amount of pain, to a degree that her pain level is almost impossible to accurately quantify.

6.05.2 She is also suffering from a constant feeling of dizziness, probably caused by malignant hypertension. I also have my concerns regarding her emotional and mental welfare. Having been out of work for fifteen years, statistically she is very unlikely to be able to return to work. Her physical symptoms do affect her ability to undertake paid work. However, with treatment for her blood pressure, adequate pain control and some major lifestyle changes, it would be physically possible for her to undertake paid work.

6.05.3 The biggest barrier, I fear, is her psychological state, in which she has become very socially isolated and has been unable to build any meaningful relationships or friendships. Her fixation with her symptoms means that unless she has significantly successful psychotherapy, I doubt that she is or will be employable.

6.06 Which conditions present might be expected to improve in time, either with treatment or without, and which conditions present might be expected to worsen without appropriate treatment

Uterine fibroids; if anything these will probably reduce in size over next few years as Miss Brown goes through the menopause, however the definitive cure is surgery. Blood tests have confirmed that Miss Brown is menopausal.

Anaemia; not present.

Meniere's disease / BPPV; There is little evidence of these being present but to answer your question; they are generally stable conditions which can improve with time. In my experience patients generally come to terms with their Menieres/BPPV, knowing what to do if they have an attack, and they go on to live normal lives. Any component of her dizziness that is related to her very high blood pressure will potentially worsen if left untreated but should resolve with adequate treatment.

Arthritis; not present, the arthralgia, especially back and neck pains will probably worsen unless she loses weight and increases her physical activity. With adequate pain control e.g. taking paracetamol regularly rather than very infrequently will probably ease her joint pain to a degree that she could, and should be, much more mobile.

Bowel incontinence; better now off iron, would be even better if she improved her diet and had her fibroids removed. Will probably remain much the same without treatment or lifestyle change. Could be improved with simple medication e.g. immodium or mebeverine.

High blood pressure; will probably worsen and could well lead to very serious, if not fatal consequences, unless treated soon. Radical lifestyle changes also need to be made.

Gout; no current evidence of gout and serum urate normal at present. There is some previous evidence to suggest she may be susceptible to it (due to high circulating urate levels), which may get worse over time unless she alters her diet, reduces her purine intake or considers prophylactic treatment if necessary (e.g. medication Allopurinol). Normally medication like allopurinol is only necessary if a patient is having frequent attacks of gout (not the case with Miss Brown) or if their serum urate is significantly raised (not the case with Miss Brown).

6.07 Whether, and the degree to which, the conditions found to be present might have been caused or worsened by her diet, obesity or lack of normal physical activity.

Her joint pains, high blood pressure, bowel problems and probably her dizziness would all improve were Miss Brown to undertake lifestyle changes. There is no doubt in my mind the severity of these symptoms are in part related to her poor diet, obesity and lack of physical exercise as well as her general mental health.

6.08 Whether any of the conditions present might be improved with the effective treatment of another of the conditions.

If Miss Brown were to have her uterine fibroids removed she would be in less pain and therefore more able to exercise and lose weight, which would help her joint pains and her blood pressure. Removing them would also likely be of benefit to her bowel irregularity. If she were to have treatment for her high blood pressure, then I suspect a lot of her 'swimming head' symptoms would settle and she should therefore be more able to get out of the house and exercise. Any intervention which physically allows her to get out the house and meet people is extremely important in helping her to re-engage with society and become less reliant on helpers who do most of her daily chores.

6.09 Whether any of the conditions are widespread and common.

Uterine fibroids; very common benign condition, most often unnoticed and asymptomatic, with the commonest symptom being heavy periods. Large fibroids cause pain and are commonly operated on and removed. In my experience it is highly unusual for a patient who is suffering from symptomatic fibroids to refuse treatment and decide instead to suffer from them.

Anaemia; very common, can be a consequence of heavy periods associated with uterine fibroids.

Meniere's disease ; very common with about 1 in 1000 people affected, often disabling at the time of the attack but frequently patients can go many months without an attack. Regular, frequent attacks are relatively rare. **BPPV**; also very common, often causes more frequent attacks than Menieres, with a very specific postural component. The constant 'swimming head' associated with malignant hypertension is the commonest symptom of this severely raised blood pressure.

Arthritis; Her condition can be better described as arthralgia, simply meaning pain in joints, and this may be related to a bit of osteoarthritis which is simply wear and tear of the joints, a very common finding in obese and inactive patients.

Bowel incontinence; she does not have true incontinence. Iron tablets commonly cause bowel upset, as would a large fibroid pressing against the colon.

High blood pressure; very common, especially in obese and inactive patients with poor diet. Quite rare to see patients with symptomatic malignant hypertension, as in this case, as most seek and accept treatment from their GP before it gets to the malignant phase.

Gout; very common problem but most patients get an occasional attack, which is relieved using anti-inflammatory medication.

6.10 Your opinion and prognosis as to the future including assessment as to when (if at all) and, if so to what extent, her symptoms and complaints might resolve with time and with proper medical treatments.

Uterine fibroids; The prognosis is that the fibroids may reduce in size a little once Miss Brown passes the menopause but the only way to cure the problem is for her to entertain the operative treatment options given to her.

Anaemia; no longer an issue

Meniere's disease / BPPV; 'swimming head' should resolve with blood pressure control. BPPV could resolve if had further ENT input and certainly should be very manageable with combination of exercises and medication.

Arthritis; arthralgia will probably continue to some degree.

Bowel incontinence; likely continue much the same.

High blood pressure; will probably worsen unless treated and will lead to very significant health risks for example heart attack or stroke.

Gout; no issue

7 Answers to specific questions asked by Edward Harte Solicitors (Claimant Solicitor)

The questions as written in the joint letter of instruction are in bold type below and the answers are in normal type.

7.01 Her current medical situation with specific mention of aforementioned matters.

I believe paragraph 6.01 answers this point.

7.02 The treatment received and whether any further treatment is appropriate

I believe paragraph 6.04 has dealt with this.

7.03 Consideration of Miss Brown's medical history as relevant to the above complaints.

I believe section 3 has dealt with this.

7.04 The affect, if any, that these complaints have had upon Miss Brown's ability to work to include her prospects on the labour market generally.

I believe paragraph 6.05 answers this.

7.05 The affect that these medical issues have had and may continue to have in the future on her social, domestic and recreation activities and upon her enjoyment of life generally.

Unless her fibroids are removed, I foresee that they will continue to be a problem. Once she is postmenopausal there will be no more heavy periods and no risk of recurrent anaemia but she is likely to continue to get some discomfort. Unless Miss Brown loses some weight by exercising and controlling her diet, her joint pains will remain, and will probably worsen. Her blood pressure needs urgent treatment, with medication and radical lifestyle changes. Although some of her physical issues could be impacting her social, domestic and recreational activities, it is my opinion that her current lack of social, domestic or recreational activities is more to do with her psychological problems rather than her physical disabilities.

7.06 Whether there are any medical problems or complications which might arise in the future so far as the above complaints are concerned or in relation to any other matter found upon examination.

Regarding problems that may arise in the future, I believe my comments in paragraphs 6.06, 6.08 and 6.10 have dealt with this. Regarding other matters found on examination, I believe my comments in paragraphs 4.10 to 4.17, and section 5 have dealt with this.

7.07 Your opinion and prognosis as to the future including assessment as to when (if at all) and, if so, to what extent her symptoms and complaints might resolve.

I believe paragraph 6.10 has dealt with this.

7.08 To conclude, Miss Brown undoubtedly has large fibroids, which cause some problems for her, although less so now than they used to. She has dangerously high blood pressure and is not on any treatment for this. Some, if not most, of her dizziness symptoms are probably currently related to her uncontrolled and very high blood pressure. Her refusal to entertain treatments for her fibroids and her puzzling and inconsistent descriptions of herself are likely to be symptomatic of an underlying psychological illness which may be depression or may be a personality disorder, or a mixture of both. In my opinion, the degree of disability that Miss Brown claims is inconsistent with the clinical findings and I advise that a Psychiatric evaluation be made.

8 Statement of compliance

(a) I understand that my overriding duty is to assist the Court in matters within my expertise, and that this duty overrides any obligation to those instructing their Clients or me. I confirm I have complied with that duty and will continue to do so, I am aware of the requirements set out in Part 35 of the Civil Procedure Rules and the accompanying Practice Direction, the Protocol for the Instructions of Experts to give Evidence in Civil Claims, and the Practice Direction for Pre-action conduct.

(b) I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert is required.

(c) I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters which I regard as relevant to the opinions I have expressed.

(d) I consider that all the matters on which I have expressed an opinion lie within my field of expertise.

(e) I have drawn to the attention of the court all maters, of which I am aware, which might adversely affect my opinion.

(f) In preparing and presenting this report I am not aware of any conflict of interest actual or potential save as expressly disclosed in this report.

(g) In respect of matters referred to which are not within my personal knowledge, I have indicated the source of such information.

(h) I have not included anything in this report which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.

(i) Where, in my view, there is a range of reasonable opinion relevant to the opinions I express, I have indicated the extent of the range in the report.

(j) At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any alteration, correction, or qualification.

(k) I understand that this report will be the evidence that I will give, if required, under oath, subject to any correction or qualification I may make before swearing to its veracity.

(l) I have attached to this report a statement setting out the substance of all the facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

9 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 matter to which they refer.

Signed by Dr Alastair Bint

Dated 22nd March 2010

Appendix 1

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GU1 3JH.

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Mobile: 07771 910198
email: alastairbint@nhs.net

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My experience and qualifications:

I am a full time NHS GP in a practice with a 10,000 patient population and I am a trainer of foundation doctors in General Practice. I am Chairman of the South West Thames faculty of the Royal College of General Practitioners and I sit on the executive committee for postgraduate General Practice education in Kent, Surrey and Sussex. I work as a clinical lead and have sat on the Guildford Practice Based Commissioning board, one of the roles of which is appraising clinical pathways and protocols. I am a commentator for the Royal College of GPs on professional regulatory and medico-legal issues.

With reference to the main issues raised in this case, I have postgraduate training in Gynaecology and in Ear Nose and Throat medicine. I also routinely treat patients with depression and the many manifestations of depression.

Qualifications:

- MBChB, Bachelor of Medicine and Bachelor of Surgery, Edinburgh, 1998
- Advance life support; ACLS (1999), ATLS (2000), PALS and APLS (2001).
- DGM, Diploma in Geriatric Medicine, Royal College of Physicians, 2001
- DRCOG, Diploma from Royal College of Obstetricians and Gynaecologists, 2002.
- DFSRH, Diploma from Faculty of Sexual and Reproductive Healthcare, 2002
- FRCGP, Membership of Royal College of General Practitioners, 2003, Fellowship elected 2009.
- MEWI, Membership of Expert Witness Institute 2008.

Memberships:

- General Medical Council number 4546883
- Medical Defence Union number 307265G
- Royal College of General Practitioners number 53602
- Faculty of Sexual and Reproductive Healthcare number D015276
- Expert Witness Institute number 1776

Appendix 2

List of documents examined

Full GP records.

Hospital records from Brighton and Sussex University Hospitals.

Letters of instruction from Smith Gadd and Co Solicitors and Edward Harte LLP Solicitors.

Appendix 3

Explanation of medical terms

Hallpike Test; a method for evaluating the function of the vestibule of the ear in patients with vertigo or hearing loss, particularly diagnostic in BPPV. The patient's position is quickly changed from sitting to lying down with the neck hyperextended and rotated to either side, and then returned to sitting. Nystagmus can then be evaluated, and specific disorders of the vestibule may be diagnosed.

Kyphosis; excessive forward curvature of the upper spine causing a bowing of the back otherwise known as a hump.

Erythrocyte Sedimentation Rate (ESR); non specific blood marker test which is raised in patients suffering from arthritis or an acute gout attack.

Appendix 4 Blood test results

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