IN THE EASTERN CARIBBEAN SUPREME COURT
IN THE HIGH COURT OF JUSTICE

SAINT LUCIA

CLAIM NO. SLUHCV 2003/0557

BETWEEN:

JOSEPH REECE MANGAL

Claimant

AND

(1) DR. BOTTENGADA PONNAPPA
(2) THE HOSPITAL ADMINISTRATOR OF VICTORIA HOSPITAL
(3) THE ATTORNEY GENERAL OF SAINT LUCIA

Defendants

Appearances:
Mr. Alvin St. Clair for Claimant
Mrs. Georgis Taylor – Alexander in association with
Mr. Leslie Prospere for Defendants

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2006: April 4
2007: July, 12, 18
August, 31
September, 3
November 5

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JUDGMENT

Mason J

[1] It was agreed by the parties at the pre trial review on 16th July, 2004 that the sole issue to be determined at trial would be whether the Defendants were negligent in their treatment

of the Claimant.

Facts

[2] On 18th January 2003, the Claimant, a 72 year old self employed businessman, after complaining of constipation, intermittent colicky pain and vomiting was brought by his wife to the Victoria Hospital where he was admitted. After examination by the first Defendant, the Claimant was found to have a slightly distended abdomen and a diagnosis was made of a sub acute intestinal obstruction. The first Defendant also determined that there was no need for surgery.

[3] The Claimant remained under hospital care until his discharge on 22nd January 2003, a discharge which he protested on account of not having "eased his bowels", the reason for which he had gone to the hospital. On discharge he was advised to take a barium meal test (which at the time the hospital was not equipped to carry out) and to return to the hospital's outpatient clinic in three (3) weeks time. He was also advised to consume a high fibre diet.

[4] On his return home on 22nd the Claimant attempted the diet prescribed, experienced extreme discomfort and vomited. He did not return to the hospital. Instead he contacted Dr. Christy Daniel and explained his predicament. Dr. Daniel offered to see him two (2) days later on 24th January 2003. The Claimant's condition persisted throughout 22nd and so on 23rd January he attended the office of Dr. Alphonsus St. Rose who immediately prescribed a barium enema x ray. The Claimant on 24th January again consulted Dr.

Daniel who was in agreement with Dr. St. Rose's prescription. On review of the results of the test, Dr. Daniel suggested surgery while Dr. St. Rose proposed a colonoscopy. The Claimant and his wife opted for a colonoscopy which was scheduled for 28th January. Meanwhile the Claimant continued to suffer severe discomfort and on 27th January he consulted Dr. St. Rose who scheduled emergency surgery. Since that first operation, the Claimant has had to undergo several tests, further surgeries, extreme discomfort and inconveniences, the result of all of which he has now been fitted with a colostomy bag for disposal of bodily waste and with which he will have to contend for the rest of his life.

CLAIMANT'S CLAIM

[5] The Claimant now claims that the Defendants by :

a) failing to diagnose or suspect that his injuries were of such severity as required immediate attention and or surgery;
b) wrongly discharging him despite his objections, when it was not proper so to do and thereby aggravating the injury even further so that any proper treatment could not have been done in a timely manner;
c) wrongly discharging him at a time when it was not proper so to do and so falsely conveying to him that there was nothing to worry about when in fact there was;
d) failing to detect or suspect that his injuries were of such severity as required immediate or urgent surgery;

e) *failing to observe or to heed or take any heed or take any reasonable steps to investigate his complaints and objections; and*

f) *failing to properly treat and advise him so that proper treatment was delayed in* ***establishing a definitive diagnosis in order to administer definitive treatment for his condition***

were negligent and failed to use reasonable care and skill in the treatment and advice which they gave to the Claimant. As a result the Claimant claims that he underwent pain and suffering which he would otherwise not have endured, that his injuries were greatly aggravated and that the consequences thereof were prolonged. He further claimed that he suffered severe injuries and physical deterioration and consequential loss and damage. The claimant has also made a claim for special damages for his nursing care, his medical expenses and for his loss of income as a bus tour operator.

[6] The Defendants conversely state that the Claimant's diagnosis and course of medical treatment throughout the period of hospitalization were appropriate, adequate and conformed to the prevailing standard of medical diagnosis and treatment in the medical profession.

[7] The Defendants are also of the view that the Defendants' duty of care to the Claimant never persisted beyond the Claimant's period of hospitalization since the Claimant consciously sought alternative medical treatment and in any event there was nothing that prevented the Claimant from returning to the Victoria Hospital had his condition

deteriorated before his scheduled outpatient visit.

EVIDENCE

[8] Pursuant to the case management order of 5th April 2004, a team of highly distinguished medical experts met to discuss the diagnosis and treatment of the Claimant in order to attempt to produce a joint report in accordance with Part 32.15 (5) CPR. Present were Dr. Christy Daniel, Urologist, and Dr. Alphonsus St. Rose, Internist and Gastroenterologist, on behalf of the Claimant and Dr. Romel Daniel, Cardiologist, and Dr. Andrew Richardson, Consultant Surgeon, representing the Defendants.

[9] At that meeting the team considered the notes from the Claimant's hospital chart and the "particulars of negligence" as contained in the Claimant's statement of claim. On conclusion Dr. Richardson was elected to prepare a draft report for the approval of the other experts. While not disputing the contents of the draft report with respect to the Claimant's hospitalization record, the experts for the Claimant were in only partial agreement with the conclusions on the particulars of negligence.

[10] The draft report reflected the evolution of the Claimant's case as documented in the hospital's chart:

> "*Mr. Mangal was admitted to the surgical ward of Victoria Hospital via the Accident and Emergency Department at 11:15 a.m. on*

January 18th 2003. He complained of constipation, intermittent, colicky abdominal pain and slight abdominal distension for one day. He had vomited three times and was passing flatus. His prior history included Diabetes Mellitus, controlled on diet for four (4) years and he had no history of prior surgery.

Physical examination revealed that there was no cardio Pulmonary distress his mucous membranes were pink and moist, there was no jaundice and his cardiovascular examination was normal.

His abdomen was slightly distended in the epigastrium, it was soft and there was no tenderness. There were no masses and his bowel sounds were no masses and his bowel sounds were diminished. On rectal examination the rectum was empty.

A diagnosis of Intestinal obstruction was made. His chest X Ray was normal. On the abdominal X Rays there were dilated small and large bowel loops with multiple air/fluid levels, compatible with bowel obstruction.

Initial treatment included intravenous fluids, nothing by mouth, a nasogastric tube was passed into his stomach and placed on drainage, and blood investigations were ordered. He was admitted to the department of surgery under the care of Dr. Bottengada Ponnappa.

By January 20th Mr. Mangal was passing flatus and there was improvement in his overall condition. His nasogastric tube was removed and he was started on oral fluids.

On January 21st Mr. Mangal was still complaining of abdominal discomfort, but he continued to pass flatus, abdominal examination was unremarkable, and bowel sounds were present. Abdominal Ultrasound examination showed only a simple liver cyst. His management was not changed.

On re-examination on January 22nd Mr. Mangal's condition was regarded as improved and he was discharged with an appointment for a Barium X Ray, and an appointment for review in the outpatient clinic in three (3) weeks. He was advised to take a high fiber diet.

[11] The evidence of the Claimant and his wife appears to conflict with the notes taken by the hospital personnel. The Claimant and his wife speak to the Claimant's almost constant discomfort during his hospital stay, to almost nonexistent bowel movement by the Claimant, to an inability to tolerate normal diet, to being able only to consume liquids. The Claimant and his wife relate that even after having been administered enemas on 18th and 19th January, the Claimant's condition did not improve: he still remained "choked", not being able to "ease his bowels" and passing only brownish water. They state that this was relayed to both the nurse and the first Defendant:

8) *On Monday 20th Dr. Ponnappa made his rounds, it was only then that I realized that he was my doctor. He came to my bedside and asked me how I was feeling. I told him that I was not any better because I was still choked. He examined me by touching my stomach, asked me to open my mouth, extend my tongue, and left.*

9) *Throughout the day on Tuesday 21st I went to the washroom on a number of occasions, I urinated but could not ease my bowels. I always indicated to the nurses that I had been to the washroom but had not passed anything.*

10) *Whilst at Victoria Hospital I had no solid food. I do not recall the Victoria Hospital asking me or bringing food to me. I only had milk and juice prepared by my wife.*

11) *On Wednesday the 22nd day of January 2003, when Dr. Ponnappa made his rounds he passed by my bed with Dr. Ugbo. He asked about my condition. I again indicated to him that I had not eased my bowels. He again examined me, opening my eyes and touching my belly. He then said to me that "there was no need for surgery. He then left my bedside to continue his rounds. A few minutes later when my wife came to visit me she told me that Nurse Fletcher told her that I had been discharged. I was surprised and shocked by this news firstly because Dr. Ponnappa never indicated this to me and*

also because I could not understand why I was being discharged when my problem had not been solved.

[12] The hospital notes on the other hand indicate a largely uneventful stay concluding that the Claimant's problem had been resolved. However it was to the expert evidence adduced by the doctors who were called, ostensibly in accordance with Part 32 CPR 2000, that the Court's attention was more particularly directed.

[13] Counsel for the Defendants suggested that the court should prefer as the more objective, consistent and logical the evidence as proffered by their expert witness while viewing that of the Claimant's with circumspection. At the same time Counsel is urging that the Court must refrain from using its preference for the practice of one body of responsible medical opinion over another as a basis for making a determination of medical negligence. But I am reminded by Bingham LJ in Eckersley v Binnie ((1988) 18 Con LR1 cited in the text Medical Negligence: A Practical Guide, Fourth Edition, by Charles J. Lewis at page 275:

"*In resolving conflicts of expert evidence the judge remains the judge, he is not obliged to accept evidence simply because it comes from an illustrious source, he can take account of demonstrated partisanship and lack of objectivity. But ,save where an expert is guilty of a deliberate attempt to mislead(as happens only very rarely), a coherent reasoned opinion expressed by a suitably qualified expert should be the subject of a coherent reasoned rebuttal, unless it can be discounted for*

other good reason".

[14] I have not been totally persuaded as to the objectivity of approach by the various expert witnesses but rather by the words of Lord Scarman in Maynard v West Midlands Regional Health Authority (1984) 1 WLR 634:

> *"It is not enough to show that there is a body of competent professional opinion which considers theirs was a wrong decision, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances ...Differences of opinion and practice exist and will always exist in the medical as in other professions. There is seldom any one answer exclusive of all others to problems of professional judgment. A court may prefer one body of opinion to the other ..."*

And also by Lord Bridge in Wilsher v Essex Area Health Authority (1988) AC 1074:

> *"Where experts witnesses are radically at issue about complex technical questions within their own field and are examined and cross examined at length about their conflicting theories, I believe that the judge's advantage in seeing them and hearing them is scarcely less important than when he has to resolve some conflict of primary fact between lay witnesses in purely mundane matters".*

LAW

[15] In order to establish his claim for negligence, the Claimant must prove that the Defendants were under a duty, that they broke that duty, and that as a result of that breach of duty he suffered the injuries alleged. The standard rule however is that it is not enough to show that the Defendant's conduct increased the likelihood of damage being suffered and may have caused it. It must be proved on a balance of probability that the Defendants' conduct did cause the damage in the sense that it would not otherwise have happened: per Lord Hoffman in Baker v Corus (UK) plc (2006) UKHC 20.

[16] A doctor's duty which arises from the relationship of doctor and patient and which extends to examination, diagnosis, advice and treatment, obliges him to take all due care necessary for the health of the patient. It what has become known as the Bolam test, whether or not the doctor has exercised that relevant care necessary is measured by the standard of the ordinary skilled man exercising and professing to have that special skill. He need not possess the highest expert skill but it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art: (per McNain J in Bolam v Friern Hospital Management Committee (1957) 1 WLR 582). Thus if his acts or omissions fall below that standard of the reasonably competent practitioner he will be adjudged to have been negligent. However:

He is not a clairvoyant nor if he tells his patient that he can find

nothing wrong is he liable if his patient has a condition which is not discoverable by competent examination. The public policy of limiting the liability of tortfeasors by the control mechanism of foreseeability seems to me as necessary in cases of medical as in any other type of negligence. I do not see on what policy ground it would be fair or just to hold a doctor to be in breach of duty who failed to diagnose an asymptomatic and undetectable illness merely because he was at fault in the management of a correctly diagnosed but unrelated condition. In short it must be shown that the injury suffered by the patient is within the risk from which it was the doctor's duty to protect him. If it is not, the breach is not a relevant of duty: per Beldam J in Brown v ***Lewisham and North Southwark Health Authority*** *(1999) Lloyds Rep. Med 110".*

ISSUES

[17] Having regard to the matters raised by the Claimant in his "particulars of negligence", I am of the view that the issues can be considered and considered under the heads of diagnosis, discharge and delay.

DIAGNOSIS

[18] The Claimant's claim is that the first Defendant failed to diagnose, detect or suspect that the Claimant's injuries were of such severity as required immediate attention and or urgent

surgery.

[19] The first Defendant's diagnosis on the admission of the Claimant of sub acute intestinal obstruction was one with which all of the experts were agreed. The first Defendant at that time and on discharge of the Claimant did not consider that surgery was necessary.

[20] In the draft report submitted ostensibly on behalf of the medical experts, it is noted:

> "*The progress notes on his treatment and the evolution of his condition in Hospital indicates that Mr. Mangal was attended in appropriate fashion. This is supported by the fact that his condition improved over the period that he was in Hospital as documented by assessments by the doctors and the nurses in his hospital chart. Further supporting this are the comments by Dr. Daniel in his report on Mr. Mangal (sic) condition in the Hospital".* **

[21] This seems to suggest that the Claimant's claim was not initially supported by his expert for in a letter to the Claimant's attorney at law as well as under cross examination, Dr. Christy Daniel indicated that when he saw the Claimant at the hospital on 18th and 19th January that he was satisfied that his condition had improved, that he was being managed satisfactory and that he was receiving treatment appropriate for his clinical diagnosis.

[22] However in response to the just quoted section of the draft report of the experts Dr. Christy Daniel wrote:

"I don't think he was adequately investigated before discharge. In a 70 year old man presenting with features of bowel obstruction the recommended minimum test on admission is a sigmoidoscopy because rectal/sigmoid malignancy is highly probable diagnosis. Even if the patient is sent for Barium enema a sigmoidoscopy is always mandated".

[23] It is to be noted that Dr. Daniel indicated that when he saw the Claimant two (2) days after discharge that he commenced his own investigations, performed a sigmoidoscopy and ordered a barium enema. After reviewing the results the barium enema x ray. It was revealed that there was a narrow stricture in the colon causing sub acute (partial) bowel obstruction. At the request of the Claimant and his wife, Dr. Daniel discussed the case with Dr. St. Rose who proposed a colonoscopy. Dr. Daniel advised that an operation would ultimately be needed but the Claimant and his wife wished to proceed with the colonoscopy. According to Dr. Daniel he accepted their decision since the Claimant was not completely obstructed.

[24] Dr. St. Rose for the Claimant for his part indicated that when the Claimant visited his office the day after discharge the Claimant outlined the complaints for which he had been admitted to the hospital and at that time, the Claimant was not "too clear" as to what his admitting or discharging diagnosis was. Dr. St. Rose's examination revealed a benign abdomen (non surgical), no manifestations of an acute abdomen. Consequently he saw no need for urgent admission.

[25] The evidence of the Claimant and his wife is that on 23rd he went to see Dr. St. Rose who instructed that the Claimant should take a barium enema. He continues "since I had an appointment to see Dr. Daniel on Friday 24th January 2003 I decided to visit him before taking the barium enema".

[26] It was five (5) days after discharge, when his condition deteriorated that the Claimant underwent emergency surgery.

[27] Under cross examination Dr. Daniel stated that he felt that surgery would ultimately be necessary but because there was not an acute blockage and because the Claimant was able to pass flatus that surgery was not needed at that stage. Dr. Daniel admitted that it was unlikely that the Claimant would have been discharged from the hospital with an acute blockage or that he would have left with the blockage cleared and two (2) days later when he saw him for there to have been a blockage.

[28] Dr. Richardson for the Defendants stated under cross examination that when the Claimant was discharged there was no evidence that he still had an intestinal obstruction and that the history of the evolution of the Claimant's hospital stay indicated improvement in his condition.

[29] Counsel for the Defendants submits that the first Defendant's actions in ordering a barium meal and prescribing for the Claimant a high fiber diet indicated first Defendant was

initiating a probe into the cause of his diagnosis, that this evidence was appropriate, adequate and consistent with the general and approved practice of the medical profession or a responsible body of medical opinion. Counsel further submits that the objective indicators of the Claimant's improved medical condition before and after his discharge from hospital militated against the requirement for emergency surgery.

> *In matters of diagnosis and the carrying out of treatment, the court is not tempted to put itself in the (surgeon's) shoes; it has to rely upon and evaluate expert evidence, remembering that it is no part of its task of evaluation to give effect to any preference it may have for one responsible body of professional opinion over another, provided it is satisfied by the expert evidence but both qualify as responsible bodies of medical opinion. Lord Diplock in Sidaway v The Board of Governors of the Bethleham Royal Hospital and the Mandsley Hospital (1985) AC 871".*

[ ] There is in my view no need for the Court to exhibit any preference with respect to the medical evidence on this aspect of the case for what has been revealed and made pellucidly clear is that the point at which the first Defendant determined that surgery was not necessary on admission and on discharge - his judgment was appropriate. While the medical experts on opposing sides appear to differ with respect to the cause of the eventual outcome of the Claimant's condition, it has been emphasized that surgery, although ultimately necessary only became absolutely necessary after discharge (five (5) days later) and after the Claimant had sought and been given alternate medical attention.

This seeming "intervening act" would in effect exonerate the first Defendant and in my judgment deny that there was failure to exercise reasonable care and skill.

[31] I am of the view that Dr. Christy Daniel's opinion that:

> "…….. *that the delay in establishing a definitive diagnosis in order to proceed (sic) definitive treatment for his condition has cause (sic) Mr. Mangal to undergo considerable pain and suffering, repeated operations and a very prolonged hospitalization and recovery period"*

has been arrived at as a result of the benefit of hindsight or the so- called "retrospectscope" as it is termed, and his knowledge of the outcome.

[32] I cannot conclude in the circumstances that the first Defendant was negligent because "the true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill will be guilty of acting with ordinary care". per Lord President Clyde in Hunter v Hanley referred to Lord Scarman in Maynard v West Midlands Regional Health Authority (1984) 1 WLR 634 and because the first Defendant in my judgment exhibited that appropriate ordinary skill.

DISCHARGE

[33] The Claimant also claims that the first Defendant wrongly (prematurely) discharge him thereby causing further aggravation of his condition and falsely conveyed that the Claimant had nothing to worry about, that the first Defendant was negligent in requesting the Claimant to take an inappropriate test and to return three (3) weeks after discharge.

[34] The Claimant and his wife gave evidence of the display of a supercilious attitude by the first Defendant, that he paid no heed to their protests at the Claimant's discharge when he was still suffering discomfort and the problem for which he had been hospitalized had not been resolved.

[35] The opinions of the panel of experts on the issue of the discharge of a patient are somewhat divergent.

For the Defendants it was stated:

> *'The decision to discharge a patient from the Hospital is the admitting/treating doctor's decision not the patient's. There is no dispute that Mr. Mangal may have thought that he was not ready for discharge, but on review of the chart, the objective indications were such that it would appear that the decision to discharge Mr. Mangal at that time was appropriate".*

Dr. Daniel for the Claimant observed:

> *"The patient was obviously not feeing well when he was discharged. Although it is the admitting physician's right, most of us will listen to the patient. Even if we go ahead and discharge will give them the opportunity to return as soon as possible if anything develops. Mr. Mangal was discharged with instructions to have a higher fiber diet before any attempt to diagnose his problem as well as a request for an inappropriate investigation".*

[36] Dr. St. Rose also on behalf of the Claimant opined that he held a somewhat different view from the Defendants' experts for:

> *"While the decision to discharge a patient is initiated and executed by the attending physician, this does not represent and "all or nothing phenomenon" done in isolation of other considerations particularly if the patient makes repeated representation <u>that he feels unwell</u>. What might I ask could be so wrong with keeping such a patient in hospital for another 24 or even 48 hours of observation (even if the clinical parameters suggested otherwise)? And knowing what we know now the final outcome might have been drastically different. That is precisely what a judgment call is all about particularly in the circumstances where there is diagnostic and outcome uncertainty I think it pays to give the*

patient the benefit of the doubt".

[37] Counsel for the Defendants submitted that the First Defendant's decision to discharge the Claimant should be assessed only within the context of the objective indicators available to him at the relevant time which included an improvement in the Claimant's overall condition at the time of discharge coupled with the resolution of his acute intestinal obstruction. The Claimant's protests may have been considered by the First Defendant but it is clear that he (the First Defendant) felt that overall these indignations should not appear to trump the objective indicators that ultimately informed his decision.

Counsel also contended that the court must also remain cognizant that the First Defendant's conduct in discharging the Claimant must be assessed within the ambit of the sole issue in this matter which is whether the Defendants were negligent in their treatment of the Claimant. In the context of the sole issue on trial in the instant matter, it is submitted that the events that transpired after the Claimant's discharge from hospital cannot form a basis for a finding that the First Defendant's decision to discharge the Claimant was negligent. The First Defendant's decision can only be assessed by the objective indicators available at the time of the Claimant's discharge from hospital.

[38] The Claimant contends that the First Defendant ought to have detained the Claimant's in care and had the barium test done (the results are produced in a few hours) so that the problem could have been definitively diagnosed before discharge. The first

Defendant would then be "clothed" with a comprehensive knowledge of the Claimant's condition and so be able to properly advise and treat the Claimant.

[39] The overwhelming evidence is that at the time of the Claimant's discharge his problem had been clinically resolved. It was upon this basis that the First Defendant was prompted to discharge the Claimant. In my judgment there is no evidence that has the barium test been taken and the results the same as produced two (2) days after discharge that the Claimant would have react differently from how he reached then and been propelled to elect to expeditiously undergo the surgery that was found to be ultimately needed.

[40] I am in agreement with the submission of Counsel for the Defendants that it would be unjust to judge the actions of the first Defendant using the benefit of hindsight. I therefore endorse the statement by Mustil LJ in Wilsher v Essex Area Health Authority, (1987) 4B 730 as quoted by Counsel:

> *"The risks which actions for professional negligence bring to the public as a whole, in the shape of an instinct on the part of a professional man to play for safety, are serious and now well organized. Nevertheless, the proper response cannot be to temper the wind to the Professional man. If he assumes to perform a task, he must bring to it t he appropriate care and skill. What the court can do, however, is to bear constantly in mind that in those situations which call for the exercise of judgment, the fact that in retrospect the choice made can be shown*

to have turned out badly is not in itself proof of negligence, and

to remember that a duty care is not a warrant of a perfect result".

[41] I cannot therefore conclude that the first Defendant by discharging the Claimant when it was evident to him that the Claimant's problem had been resolved that the Defendant acted in breach of his duty to the Claimant.

[42] It is uncontroverted that the first Defendant on discharging the Claimant requested him to take a barium meal test, advised a high fibre diet and to return to outpatient's clinic in three (3) weeks. It is also in evidence that in the opinion of the experts that each of these requests was inappropriate and in the main accepted as such. But can it be said that the first Defendant was negligent in giving such directions or was it that the first Defendant was merely exhibiting as error of judgment.

[43] From the medical experts it was elicited that a barium enema is ordered to make a diagnosis where a patient has experienced altered bowel habits, lower abdominal pain or has passed blood, mucus or pus in his stool. The barium meal on the other hand while it also can make or confirm a diagnosis, is employed where a patient experiences problems swallowing or has unexplained pain and vomiting. It provides useful information about the condition of the patient's gullet and stomach.

[44] Dr. Richardson for the Defendant is of the view that because of equipment failure the timing of the test would not be under the control of the hospital since the Claimant would

have had to have the tests done outside the hospital. He also pointed out that should there be a recurrence of the problem or complication as a result of the problem, the patient usually returns to the hospital for treatment. He observed that the Claimant did not return and so it would not have been possible for the first Defendant to follow up the condition of the Claimant.

[45] Dr. St. Rose for the Claimant in response suggested that while the timing of the Claimant's x ray was not under the control of the hospital, given the seriousness of his medical problem, that responsible representation could have been made to facilitate investigations being done outside the hospital in a timely and appropriate manner.

[46] I feel constrained to make the following observation: while I agree with Dr. St. Rose that if ought not to be unusual for anyone to expect of a national hospital that in the event of equipment failure that there should exist adequate policy arrangements to provide or procure important services from outside providers, it seems that the local population has resigned themselves to expect and accept such shortcomings from the hospital. It appears too that Dr. St. Rose's suggestion cover only very ill patients for there is evidence from the Claimant himself about a situation which he experienced and about which he appears not to have made any complaint or resisted. On admission to the hospital a nasogastric tube was passed into his stomach and placed on drainage. When an ultra sound was ordered by the hospital, because of equipment failure, the tube and drips had to be removed so that the Claimant could go into Castries and have the test done. He states that on his return to the hospital the drips and tubes were inserted.

[47] It seems to me that it cannot be ignored that whether or not the request was for a barium meal or a barium enema, (1) it could not have been carried out at the hospital because of equipment failure but it was available elsewhere and (2) as subsequent events indicate, the Claimant did not immediately undergo the test, not because of its inappropriateness, but because he chose to seek alternate medical opinion. This in my opinion cannot be adjudged to be on account of any negligence on the part of the first Defendant.

[48] As stated previously the experts agreed that the direction by the first Defendant for a high fibre diet was inappropriate.

[49] The Claimant indicated that he discontinued the diet after the first helping because he experienced extreme discomfort and vomiting. Although Dr. Christy Daniel intimated that because of the Claimant's age the instruction for a high fibre diet ought not to have been given before an attempt to diagnose the problem was made, no evidence was adduced to show that this single consumption subsequently affected the Claimant, increased the risk of injury or as stated by Dr. Richardson made the situation more acute.

[50] The opinion in the draft report was that having decided that the patient had a bowel obstruction, although it had resolved, it might have been more appropriate to see the Claimant sooner than three (3) weeks in the outpatients clinic. Dr. Richardson and Dr. Romel Daniel termed it the "only questionable action" on the part of the first Defendant while making the observation that there was always the option available to the Claimant to

return to the hospital had his problem recurred or had complications arisen.

[51] Dr. St. Rose suggests otherwise:

> *"There must have been a reason why Mr. Mangal did not return to Victoria Hospital to allow Dr. Ponnappa the opportunity "to follow up on any subsequent recurrences or complication". Mr. Mangal expressed his annoyance and dissatisfaction at the manner in which he was treated (rightly or wrongly so and in particular the circumstances surrounding his discharge) by the surgical team at Victoria Hospital. It is therefore not difficult to appreciate a patients fear and/or reservation under these circumstances and thus preferring to exercise other existing options. Mr. Mangal expressed and chose Dr. Daniel as the surgeon and Tapion Hospital as the institution where he felt he would get the best level of care and service".*

[52] While this may be an attractive and logical reasoning in favour of the Claimant, I cannot but be persuaded by the argument of Counsel for the Defendants that it was a conscious decision on the part of the Claimant to disregard the option of returning to the hospital before his scheduled appointment instead seeking alternate medical assistance, that the directions given by the first Defendant were necessary to determine a course for his earlier diagnosis because a determination of the cause for his diagnosis would invariably

enhance his ability to effectively continue the medical management of the Claimant's condition.

[53] In my opinion these three (3) directions by the first Defendant – the direction for a barium meal, the direction for a high fibre diet and the direction to return to outpatients clinic in three (3) weeks – can be categorized as errors in judgment which the legal authorities suggest do not amount to negligence.

[54] Lord Denning MR in Hucks v Cole (1993) 4 Med LR 393 stated:

> *"With the best will in the world, things sometimes go amiss in surgical operations or medical treatment. A doctor is not to be held negligent simply because something has gone wrong. He is not liable for mischance or misadventure, or for an error of judgment. He is not liable for taking one choice out of two or favouring one school rather than another. He is only liable when he falls below the standard of a reasonably competent, practitioner in his field so much that his conduct may be deserving of censure or inexcusable:.*

[55] See also the statement of Lord Fraser in Whitehouse v Jordon (1981) 1 WLR 246:

> *"Merely t describe something as an error of judgment tells us nothing about whether it is negligent or not. The true position*

is that an error of judgment may, or may not be negligent, it depends on the nature of the error. If it is one that would not have been made by a reasonable competent professional man professing to have the standard and type of skill that the defendant held himself out as having, and acting with ordinary care, then it is negligent. It, on the other hand, it is an error that such a man, acting with ordinary care, might have made then it is not negligent".

[56] In all of this it has been established that the Defendant has only to show that at the time of the alleged negligence that there was one body, albeit a minority one, of reasonable medical opinion that would have approved the Defendant's actions. In other words not what the medical expert himself would have done but rather what a reasonable doctor would have done. "The court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis: per Lord Browne – Wilkinson in Bolitho v City and Hackney Health Authority (1997) 4 AER 771.

[57] I must state that I have been so satisfied by the arguments and observations of the Defendants and consider the first Defendant not to have been negligent by discharging the Claimant from the hospital when he did.

DELAY

[58] It is the Claimant's contention that because the first Defendant failed to properly treat and advise him, there was delay in establishing a definitive diagnosis thereby causing a delay

in definitive treatment for his condition.

[59] According to the legal authorities, in order to succeed with this contention the Claimant must first show on a balance of probabilities that the delay in treatment was "at least a material contributing cause" of his resulting condition.

[60] This issue entitled "loss of a chance" was considered in a number of cases. One of these was Hotson v East Berkshire Area Health Authority (1987) AC 750. In that case the Defendant failed to diagnose the plaintiff's injury and he was sent home where he remained for five (5) days in severe pain. On his return to the hospital the correct diagnosis was then made. As a result of the defendant's failure to treat the plaintiff at a proper time, be developed a disability. The plaintiff claimed that he had been deprived of the chance of recovery. The trial judge found on the evidence that even if he had been properly treated there was a three (3) to one (1) chance that the disability would still have resulted and concluded that the plaintiff had not proved on a balance of possibilities that the treatment would have avoided the injury. With this the House of Lords unanimously agreed, stating that the inescapable issue of causation had first to be resolved. Lord Bridge of Harwich had this to say:

> "*The plaintiff's evidence, at its highest, was that the delay in treatment was a material contributor cause. This was a conflict, like any other, about some relevant past event, which the judge could not avoid resolving on a balance of possibilities. Unless the plaintiff proved or a balance of*

possibilities that the delayed treatment was at least a material contributing cause of the avascukar necrosis, he failed on the issue of causation and no question of qualification could arise".

[61] In the more recent case of Gregg v Scott (2005) 2 AC 176 where the circumstances are somewhat similar to the case at bar, there too it was pointed out that the causal connection between a tort and consequential loss of any kind has to be proved or a balance of possibilities before the question of compensation could be considered. The House of Lords was divided on the question of whether the diminished chance of recovery should result in damages. The majority decided inter alia that a claim for damages for clinical negligence required proof or a balance of probability that the negligence was the cause of the adverse consequences complained of:

In the words of Lord Hoffman:

"Everything has a determinate cause, even if we do not know what it is .... It was for the plaintiff to prove that it was an act or omission for which the defendant was responsible ……..The fact that proof is rendered difficult or impossible because no examination was made at thee time…….or because medical science cannot provide the answer ……makes no difference.

There is no inherent .uncertainty about what caused something

to happen in the past or about whether something which happened in the past will cause something to happen in the future. Everything is determined by causality. What we lack is knowledge and the law deals with lack of knowledge by the concept of the burden of proof".

[62] The headnote to that case reads in part:

"In 1994 the claimant developed a lump under his left arm. He attended the defendant general practitioner's surgery and was told that it was a benign collection of fatty tissue and that no further action was called for. In 1995 the defendant moved home and registered with another general practitioner. This doctor, upon seeing the lump, referred him to a hospital for examination, where the condition was diagnosed as non-Hodgkin's lymphoma. By that time, the tumor had spread into the claimant's chest. Treatment led to a remission in the condition but the claimant suffered a relapse and, after further treatment, a second relapse which left him with a poor prospect of survival. The Claimant brought an action against the defendant for damages for negligence, claiming that had he been referred to hospital when seen by the defendant there would have been a high likelihood of cure whereas by the time treatment commenced his chances of recovery, defined as surviving for a period of ten (10) years, had fallen to below 50%".

"The judge found that the defendant had been negligent in excluding the possibility that the growth might not be benign and so was in breach of duty but, on the question whether that negligence had been the cause of the claimant being unlikely to survive ten (10) years, held that since the claimant would on a balance of probability have failed to survive the ten (10) year period even if treated promptly, he had failed to show that the outcome for him would have been materially different had he been treated nine months earlier, and dismissed the claim".

[63] It is evident from the Claimant's contention that it is both events subsequent to his discharge that the court must look in order to judge whether the delay in treatment was the "material contributing cause" of the Claimant's condition, it having been determined that events prior to discharge were within the bounds of the Bolam test and therefore did not support a claim of negligence. It should be noted that the Bolam test is not applicable to questions of fact.

[64] The following statement by Stewart – Smith LJ in the case of Fallows v Randle (1997) 8 Med LJ quoted in the text Medical Negligence op cit at page 187 sums up that position:

In my judgment that principle has really no application where what the judge has to decide is, on balance, which of two explanations – for

something which has undoubtedly occurred which shows that the operation has been unsuccessful – is to be preferred. That is a question of fact which the judge has to determine on the ordinary basis on a balance of probability. It is not a question of saying whether there was a respectable body of medical opinion here which says that this can happen by chance without any evidence, it is a question for the judge to weigh up the evidence on both sides, and he is, in my judgment, entitled in a situation like this, to prefer the evidence of one expert witness to that of the other".....I do not think that the Bolam principle should be applied in a situation like this at all....".

[65] In our case, apart from the fact that the Claimant failed to exercise his option to return to the hospital when his condition resurfaced and opted instead to seek alternate treatment, even when attended by those physicians it is seen that he equivocated on the question of whether to follow his doctor's advice of surgery and chose instead to wait for a colonoscopy. He attributed this ambivalence to "confusion that two (2) days earlier he was told he was fine and suddenly he is being told that he needed surgery". In any event the specialist did not view his condition to be acute. Dr. St. Rose wrote:

"My examination at that time revealed a benign abdomen (non-surgical) as he certainly did not manifest at that time evidence to suggest an acute abdomen. This was perhaps one of the simple most important factors as to why I did not think he needed urgent admission".

[66] Counsel for the Defendants admitted that the first Defendant by ordering the barium meal test had initiated a probe to determine the cause of his diagnosis and that the delay in confirming this diagnosis was unavoidable due to the fact that the tests had to be taken outside the hospital.

[67] Dr. St. Rose for the Claimant suggests that had an urgent barium enema been done at the earliest avoidable time, that based on the result a referral would have been made to the appropriate surgical service for further management but the evidence discloses that even when performed two (2) days subsequent to discharge, the results of the barium enema did not elicit urgent action on the part of the Claimant's specialists or persuade the Claimant to undergo surgery.

[68] I am convinced however and choose to base my decision on the belief that had the correct test been ordered (barium enema rather than barium meal) and been urgently performed, that even if the results of that test showed the same condition as it did two (2) days after the Claimant's discharge, that even if the Claimant had returned to the first Defendant and the first Defendant had wanted to follow the same treatment path or had come to the same conclusion as the Claimant's medical team, it is possible that the Claimant and his wife would have prevaricated about which procedure to take in the same way that they did with their consulting specialists in whom they had repose confidence. This is because the results of the test would have shown what they did even at a later stage: that there was a narrow stricture in the colon causing sub acute (partial) bowel obstruction, a

condition which did not demand urgent surgery but would require an operation ultimately. It is probable that the Claimant's condition would still have deteriorated and therefore while I accept that the appropriate test or earlier treatment might have increased his chances of recovery, I am not satisfied that it would have prevented the outcome.

[69] It has not been definitively shown that the Claimant was actively made worse by the delay, e.g. whether the perforated bowel discovered during surgery was the result of the delay. This in the absence of the identification of any individual or specific disability that occurred or was increased, the Claimant's claim must fail because there was no evidence adduced that in this instance the first Defendant was negligent or that negligence, if there was any, caused the resulting damage.

[70] As pointed by Lord Hoffmann in Gregg v Scott and reproduced above at paragraph 61, all past events are treated as having a determinate cause whether or not the courts are in a position to know this cause. The progress of the Claimant's condition may have been caused by inherent factors in his genetic makeup or subsequent events outside the control of the Defendant. It is not enough to attribute the blame to the Defendant but it is incumbent upon the Claimant to prove the causal connection and I am not satisfied that he has so done.

[71] It is my judgment that the delay in seeking treatment after discharge was of the Claimant's own making and does not fit the label of " material contributory cause" to the development of his resulting condition which would support his claim for damages.

[72] In the circumstances, the Claimant claim is dismissed with prescribed costs to the Defendants.

SANDRA MASON QC

High Court Judge