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Medical

Negligence

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Editor's Note

In this month's issue of the LST Review we look at the issue of medical negligence. Professional negligence has attracted public and media attention for many years, yet the law reports contain very few reported decisions on the matter.

Medical negligence attracted public attention recently when a lawyer from the Attorney General's Department sued a leading paediatrician on the grounds that her professional misconduct was one of the causes leading to the death of his four year old daughter.

The District Court held with the plaintiff and awarded Rs 5,000,000 damages against the paediatrician. This finding was confirmed in the Court of Appeal, although the judges differed on the extent of damages. The plaintiff agreed to accept the lower amount of damages so as not to prolong the final resolution of the case.

In appeal, the Supreme Court came to a different conclusion. While holding that the paediatrician was guilty of negligence, the Court found that there was no causal connection between the negligence of the paediatrician and the death of child. Moreover, the Supreme Court awarded legal costs against the plaintiff, despite making a finding of negligence against the paediatrician. In this issue we publish the decision of the Supreme Court.

The Law & Society Trust organised a public symposium on the case. Presentations were made by Professor Ravindra Fernando, Director of the Centre for the Study of Human Rights, University of Colombo, Rohan Edrisinha, Lecturer, Faculty of Law, University of Colombo, and Chandra Schaffter, President of the Insurance Association of Sri Lanka.

In this issue we publish an edited version of the presentation made by Mr Schaffter. Unfortunately we were not able to obtain copies of the presentations made by Professor Fernando and Mr. Edrisinha in time for publication in this issue. We also publish a powerful critique of the case by Dr Shivaji Felix, who finds the reasoning of the Supreme Court problematic.

Of Snakes and Ladders

One Down for the Roman-Dutch Law: One Up for the Medical Profession

Shivaji Felix*

1. Introduction.

The Supreme Court of Sri Lanka has, in an important judgment, with far reaching implications, taken the opportunity to review the law relating to medical negligence.[1] The court's decision has significant consequences for both medical professionals and members of the public. In this case the Supreme Court held that, despite the fact that negligence (on the part of the medical professional) was established, the failure to establish a causal nexus between the negligence and the death of the patient resulted in the plaintiff/respondent failing in his claim.

One of the important issues that arise, as a necessary consequence of this decision, is whether a person who attends on a terminally ill patient could ever be liable in a claim for negligence. It appears that a medical practitioner can be as negligent as he or she wishes provided that his negligence was not the operative cause of the patient's death.

This article seeks to critically evaluate the decision of the Supreme Court in terms of the court's reasoning in the instant case and its implications for the future. For this purpose this article will initially examine the facts of the case and will then proceed to critically analyse the court's determination. The implications for the future will, thereafter, be examined.

II Relevant Facts.

In this case Arsecularatne, the father of a deceased four year old child, had sued the appellant, Prof Priyani Soysa, a well known senior paediatrician, for damages

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[1] *Soysa v. Arsecularatne,* (2000) S. C. Appeal No 89/99.

occasioned by medical negligence in respect of the manner in which his daughter had been treated. It was the plaintiff's contention that his daughter had been entrusted to the care of the defendant and that the defendant owed a duty of care to the patient. It was alleged that the defendant was in breach of her duty of care to the patient and was negligent in the discharge of her duties as a medical practitioner. It was further alleged that, in consequence of the defendant's negligence, there was no diagnosis of the actual condition, namely Brainstem Glioma (BSG), and the child was not treated for the actual malady but was diagnosed as suffering from Rheumatic Chorea (RC). It was the plaintiff's case that the child died at a point of time when she need not have died and that the death of the child was directly attributable to the breach of the duty of care and negligence on the part of the defendant.

The District Court of Colombo upheld the plaintiff's claim and awarded damages in a sum of Rs 5,000,000/-. On appeal to the Court of Appeal, a bench of two judges decided to accept the findings of the trial judge on the question of medical negligence but differed in respect of the quantum of damages. It was the view of one judge of the Court of Appeal that the plaintiff was only entitled to medical expenses amounting to a sum of Rs 250,000/-. The other judge was of the view that the plaintiff was entitled to (i) medical expenses, (ii) damages on account of mental shock, (iii) damages for loss of future earnings and support, and (iv) damages for loss of care and companionship, amounting in total to a sum of Rs 5,000,000/-. However, damages were not quantified under the different heads and the judgment did not make it clear as to what legal principles were resorted to when arriving at this figure.

The plaintiff's counsel agreed to accept the lesser sum so as to avoid the need to have the case heard by a bench of three judges and to, thereby, obviate the delay in bringing the case to a finality. Counsel for the plaintiff, however, reserved the right to re-agitate the question of quantum if an appeal was lodged, by the defendant, in the Supreme Court.

The defendant, thereafter, applied for special leave to appeal to the Supreme Court and leave was duly granted on the following questions of law: (i) Did the Court of Appeal err in its finding on professional negligence (as averred in paragraph 12 of the petition of appeal)? (ii) Is the plaintiff – respondent entitled to be awarded damages other than medical expenses?

The appeal before the Supreme Court, which attracted wide publicity, was heard by a bench of three judges, comprising of Dheeraratne, J., Bandaranayake, J., and Ismail, J., for 15 days. The Supreme Court, in an unanimous judgment, delivered by Dheeraratne, J., held that the plaintiff's claim had failed and that the defendant, albeit guilty of negligence in her treatment of the deceased, did not cause her death and was, therefore, not liable to pay damages. The Supreme Court further held that the defendant was entitled to taxed costs in all courts.

The ensuing discussion critically examines the reasoning adopted by Dheeraratne, J., in the Supreme Court.

III. The Decision of the Supreme Court.

Dheeraratne, J., delivering the judgment for an unanimous Supreme Court, analysed the issues involved in terms of the following: (a) the nature of the plaintiff's action and the damages recoverable under the law; (b) the standard of care; (c) whether the defendant was negligent inasmuch as her conduct fell short of the required standard of care; and (d) causation. Each of these issues warrants detailed, and critical, examination.

IV. The Nature of the Plaintiff's Action and the Damages Recoverable Under the Law.

According to Dheeraratne, J., the action had been filed by the plaintiff not in a representative capacity, on behalf of the deceased child's estate, but on account of the damage suffered by him. Consequently, Dheeraratne, J., examined the claim for damages from two points of view, i.e., (a) whether the Roman-Dutch law permitted a claim for damages, other than for pecuniary loss; and (b) whether it was possible to change or modify the principles of Roman-Dutch law whenever the necessity arose.

(a) Does the Roman-Dutch law permit a claim for damages other than for pecuniary loss?

Dheeraratne, J., was firmly of the view that, in the instant case, the Roman-Dutch law did not permit a claim for damages other than for pecuniary loss. Referring to the basis of the plaintiff's claim, his Lordship said:

"It is axiomatic that today the delict known as damnum injuria datum created by [the lex Aquilia] has become a general remedy for loss wrongfully caused by another under the Roman Dutch Law. In contrast, under the English Law, the common law has developed a specific delict of negligence."[2]

Dheeraratne, J., cited Wickramanayake,[3] Mc Kerron[4] and Boberg[5] in support of the requisites of the lex Aquilia. According to Wickramanayake the requisites for an action under the lex Aquilia are as follows:

"(i) The plaintiff must show actual pecuniary loss. An exception is the award of compensation for physical pain suffered by a person injured through the negligence of another.

(ii) He must show that the loss was due to the unlawful act of the defendant or that the defendant was acting in excess of his rights.

(iii) He must show dolus or culpa on the part of the defendant. The burden of showing this is on the plaintiff."[6]

The views of Mc Kerron and Boberg, on the requisites of the lex Aquilia, are similar in substance to that of Wikramanayake, although there is some divergence in respect of the terminology adopted.[7]

The plaintiff had claimed, inter alia, damages for mental shock, damages on account of future earnings and support from the deceased child and damages for the loss of care and companionship of the child.

It was the view of Dheeraratne, J., that damages claimed by the plaintiff, under the head of mental shock, was recoverable only if it resulted in psychiatric illness.[8] Damages for

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[2] *supra.*, note 1, at p. 5.
[3] Wickramanayake, E. B., *The Law of Delict in Ceylon* (1946).
[4] Mc Kerron, *The Law of Delict* (6th edn.,1965).
[5] Boberg, P., *The Law of Delict* (Vol. 1, 1984).
[6] Wickramanayake, *supra.*, note 3, at p. 3 (footnotes omitted).
[7] Whilst Wickramanayake and Mc Kerron refer to the nature of the loss as 'pecuniary' Boberg prefers to use the term 'patrimonial'.
[8] *supra.*, note 1, at p. 6.

emotional shock, of a short duration, which failed to have a substantial effect upon the health of a person, were not recoverable.[9]

The Supreme Court expressed the view that in order that the plaintiff succeeds in his claim for damages, on account of future earnings and support from the deceased child, it was necessary for him to demonstrate his indigent circumstances which, in the present case, the plaintiff had failed to do.

Counsel for the plaintiff contended that he was entitled to recover damages, other than medical expenses, for the loss of care and companionship of the deceased child; it was further contended that the resilient nature of the Roman-Dutch law made it possible to extend its application to modern conditions. These contentions were rejected by Dheeraratne, J., who relied upon the dicta of Innes, J., in the case of Union Government (Minister of Railways and Harbours) v. Warneke,[10] to support his view that it was not possible to extend the scope of the lex Aquilia so as to accommodate a claim for damages other than for pecuniary loss.

Assuming, without deciding, that the lex Aquilia did not permit a claim for damages, other than for pecuniary loss, surely, at the very least, the plaintiff should have been entitled to be recompensed for the additional medical expenses incurred as a direct consequence of the negligence of the defendant. It is unfortunate, therefore, that the Supreme Court did not adequately consider this issue. It is submitted that the additional medical expenses incurred by the plaintiff on his child, as a result of the negligence of the defendant, should have been recoverable, albeit, the claim was denied by the Supreme Court.

> (b) Is it possible to change or modify the principles of Roman-Dutch law whenever the necessity arose?

Dheeraratne, J., was of the view that the judiciary was not empowered to change or materially alter the substance of the Roman-Dutch law. His Lordship made the following observation in this regard:

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[9] The following decisions were cited as authority for this proposition in South African: *N* v. *T*, *1994 (1) S. A. 862*; *Clinton – Parker* v. *Administrator, Transvaal & Dawkins* v. *Administrator, Transvaal, 1996 (2) S. A. 37*; *Bester* v. *Commercial Union Versekeringmaatskappy Van SA BPK, 1973 (1) S. A. 769*; *Gibson* v. *Berkowitz, 1996 (4) S. A. 1029*.

[10] *(1911) S. A. L. R. 657*, at p. 665.

"I think we are not entitled, as judges, to change the material of the Roman Dutch Law, but are only permitted to iron its creases, whenever, the necessity arises. Effecting structural alterations to the Common Law should be the exclusive preserve of the Legislature...."[11]

Dheeraratne, J., was greatly influenced by the views expressed by H. N. G. Fernando, C. J., in *de Costa* v. *Bank of Ceylon*.[12] In that case, Fernando, C. J., after examining the text of the Proclamation of 1799, as found in the Collection of Documents in Volume II of Dr G.C. Mendis's edition of the Colebrook – Cameron Papers, arrived at the following conclusion:

"The Proclamation of 1799 thus declared that the Administration of Justice shall be exercised by the Courts according to the Roman-Dutch Law, subject to deviations and alterations –

(a) in consequence of emergencies, or absolutely necessary and unavoidable, or evidently beneficial and desirable;

(b) by the Court of Directors of the East India Company or the Secret Committee thereof or the Governor of Fort William;

(c) by Proclamation of the Governor;

(d) by lawful authority ordained.

But the Proclamation did not authorise any such deviations or alterations to be made by the Courts of law."[13]

Dheeraratne, J., was aware that a different formulation of the role of the courts had been accepted by the Privy Council, the, then, highest appellate court, in an opinion given seven days before the judgment of the Supreme Court in *de Costa*'s case.[14] Perhaps, H. N. G. Fernando, C. J., did not have the advantage of perusing the determination of the Privy Council, a decision by which he was bound, prior to giving his reasons in *de Costa*. Senior counsel for the defendant, who was well aware of the significance of the Privy Council decision, having been junior counsel representing the Crown in both the appeal to the Supreme Court and the Privy Council in the *Kodeeswaran* case, quite rightly,

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[11] *supra.*, note1, at p. 10.
[12] *(1969) 72 N. L. R. 457,* at p. 461.
[13] *ibid.*
[14] See, e.g., *Kodeeswaran* v. *Attorney General*, (1969) 72 N. L. R. 337. The Supreme Court delivered its judgment in the *de Costa* case on 18 December 1969 and the Privy delivered its opinion, in the *Kodeeswaran* case, on 11 December 1969.

allowed the matter to be brought to the notice of the Supreme Court. The Supreme Court, however, preferred to rely upon the dicta of H. N. G. Fernando, C. J., in the *de Costa* case.

It is unfortunate, however, that the Supreme Court chose to adopt this course of action. When the *Kodeeswaran* case was being heard before the Supreme Court, H. N. G. Fernando, C. J., did not refer to the version of the proclamation found in Dr G. C. Mendis's work in contra distinction to the version found in the legislative enactments (1956 edition). His Lordship was content to rely upon a passage from the judgment of the Supreme Court in *Fraser's case*[15] which referred to the original proclamation and its modification by Ordinance, No 5 of 1835.[16]

The Privy Council, the then highest appellate court, allowed Kodeeswaran's appeal. Lord Diplock, who delivered the opinion of the Privy Council, was not unaware of the original text of the proclamation; in fact, his Lordship did make specific reference to certain aspects of the original proclamation in its historical context.[17] It is submitted, however, that Lord Diplock was right to refer to the proclamation as found in the 1956 edition of the legislative enactments in order to ascertain the applicable law, at that point of time.

The official version of the legislative enactments, last published in 1956, was prepared, under and in terms of the Revised Edition of the Legislative Enactments Act, No 2 of 1956 (Cap 1), by the Commissioner appointed for the purpose, Mr. H. H. Basnayake, the, then, Chief Justice. Prior to the revised edition of the legislative enactments coming into force it had to be laid before the House of Representatives, by the Prime Minister, and laid before the Senate, by the Minister of Justice.[18] Thereafter, a resolution had to be passed by the Senate and the House of Representatives authorising the Governor General to publish a proclamation in the Gazette so that the revised edition of the legislative enactments could come into force.[19]

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[15] *Fraser v. Queen's Advocate, (1836-1868) Ram. 316.*
[16] *Attorney General* v. *Kodeswaran, (1967) 70 N. L. R. 121*, at pp. 124 – 125.
[17] *Kodeeswaran v. Attorney General, (1969) 72 N. L. R. 337*, at p. 340.
[18] See, section 12 (1).
[19] See, section 12 (2).

Once the revised edition of the legislative enactments came into force it was binding and was, for all purposes, to be treated as an Act of Parliament. Section 12 (3) of the Revised Edition of the Legislative Enactments Act, No 2 of 1956 (Cap. 1), was as follows:

> *"The revised edition shall, on and after the date on which it comes into force, be deemed to be and be without any question whatsoever in all courts of justice and for all purposes whatsover the sole authentic edition of the legislative enactments of Ceylon therein printed."*

Additionally, the Commissioner, appointed in terms of the Act, was empowered to make appropriate alterations to legislation prior to its inclusion in the revised edition of the legislative enactments.[20] More specifically, he was empowered to omit any preamble to any legislation, where such an omission could be conveniently made,[21] and to incorporate any legislative changes to the law.[22] Consequently, once the revised edition of the legislative enactments of 1956 were published it was not necessary to look beyond the Adoption of Roman-Dutch Law Ordinance (Cap. 12) in order to ascertain the applicable text of the Proclamation of 1799 (as amended by Ordinance, No 5 of 1835).

In any event, the Roman-Dutch law was not a dead system of law that had ceased to evolve. The essence of the common law, as opposed to statute law, is that it evolves on an incremental basis. This was recognised by Lord Diplock in Kodeeswaran's case. Equating the further evolution of the Roman-Dutch common law of Ceylon with the evolution of the common law of England, his Lordship observed:

> *"Like the common law of England the common law of Ceylon has not remained static since 1799. In course of time it has been the subject of progressive development by a cursus curiae .... as the Courts of Ceylon have applied its basic principles to the solution of legal problems posed by the changing conditions of society in Ceylon."*[23]

The growth of the Roman-Dutch law in Sri Lanka has been gradual, and evolutionary, rather than revolutionary. It has been cross-fertilised by both the indigenous legal systems and by English Law. This is something that has been acknowledged for a long

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[20] See, e.g., section 3.
[21] See, section 3 (1) (e) and (h).
[22] See, section 3 (6).

period of time by many judges and academics of Sri Lanka. According to Cooray,[24] "[n]o legal system is static. The Roman-Dutch law is a development from the Dutch law. And the Roman-Dutch commentators never envisaged that the Roman–Dutch law should stand still." Advancing an argument in favour of legal pluralism and the cross-fertilisation of the Roman-Dutch law with the other systems of law prevailing in Sri Lanka (Ceylon), Goonesekere[25] states as follows:

> *"If the early trend in our courts which was unsympathetic to the Roman-Dutch law can be criticised, it is submitted that the recent tendancy to emphasise the importance of the Roman-Dutch law, is not without its own limitations. Even adopting a conservative view of the role of the judiciary in "law making", it would seem that if Ceylon has a legal heritage derived from many systems it is worthwhile to draw on the vitalising elements of either system, to fashion a jurisprudence suited to the needs of our own society...."*

The fact that the Roman-Dutch law, as we know it, has evolved by being influenced by other systems of law has even been judicially recognised in Sri Lanka. Tambiah, J., in *Kamalawathie* v. *de Silva*,[26] observed that "[l]aw, like race, is not a pure blooded creature. English Law has been tacitly adopted in Ceylon in many branches of the law such as the Law of Persons, Property and Obligations, where, according to the traditional view, the Roman-Dutch Law should apply."

Consequently, the view of H. N. G. Fernando, C. J., that the judiciary is unable to modify and change the principles of Roman-Dutch law (except to "iron its creases" as suggested by Dheeraratne, J., in *Soysa* v. *Arsecularatne*), to meet the exigencies of the times, has failed to be widely accepted. Cooray,[27] critically analysing the dicta of H. N. G. Fernando, C. J., in *de Costa* v. *Bank of Ceylon,* states:

> *"A system of law must be a living system. The Roman-Dutch law in Voet's day is very different from the Roman-Dutch law hundred years earlier at the time of Grotius. The law had adapted itself during this period in keeping with changing needs and circumstances. The Roman-Dutch law died in Holland in 1809 when it*

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[23] Supra., note 17, at p. 342.
[24] Cooray, L. J. M., *An Introduction to the Legal System of Sri Lanka* (1992), at p. 97.
[25] Goonesekere, S., 'Damage by Animals' (1971) 2 *Colombo L. R. 50*, at p. 51.
[26] *(1961) 64 N. L. R. 252*, at p. 259.
[27] Cooray, L.J.M., *supra*., note 24, at p. 90.

was repealed by a Code. It is illogical to tie ourselves to the law enunciated by the Dutch commentators before 1809, and abdicate the power to mould and adapt the law, which the Dutch commentators would undoubtedly have done, if not for the abolition of Roman-Dutch law in Holland. It is therefore submitted that any approach which seeks to tie the courts of Sri Lanka down to the law of 1796 should be avoided."

The essence of a common law, as opposed to statute law, is that it should evolve and grow. Living law is neither written on stone nor frozen in time. A common law which fails to be socially relevant fails to fulfill its purpose.

The Roman law, from which the Roman Dutch law was derived, was a very practical and reasonable system of law. It was a system of law that had an equitable core. Referring to the innate sense of justice of the Roman law, Grotius[28] states:

"Tam evidens ..... est ejus Juris in plerisque partibus, iis maxime, quae ad contractus aut damnum injuria datum pertinent, aequitas, ut, ad quos populos Romana arma pertingere nunquam potuerunt, ... eo leges Romanae sine vi ulla, justitiae suae vi triumphantes, pervenerint."

It has been accepted by writers of repute that the Roman-Dutch law, as it prevails in South Africa, has been influenced by other systems of law.[29] According to Wessels:[30]

"In some respects the introduction of English Law into South Africa has been slow and insidious; in other respects it has been rapid and overwhelming. The influence exerted by English textbooks and the decisions of the English Courts have tended gradually to modify the principles of Roman-Dutch Law and to bend them as to assume the form of similar English principles."

Lee,[31] commenting on the influence of the English law of torts, as far as the Roman-Dutch law was concerned, states:

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[28] Grotius, Hugo, *Epistolae ad Gallos, CLVI* , (Hamburgi, XVI. Novemb. 1633): So apparent is the equity of that law (i.e. the Roman law) in its several parts, but especially in those which pertain to contract and unlawful damage, that it prevails even among those peoples whom the Romans could never conquer by arms, and it does so without any force, triumphing merely by virtue of its innate justice.

[29] See, e.g., Lee, R. W., "The Roman Law and Common Law elements in the Law of South Africa and Ceylon" *(1959) Acta Juridica 114,* at p. 115.

> *"In the Roman-Dutch Colonies the English law of torts has imposed itself upon the Roman-Dutch law of delict much as the Roman law of delict imposed itself upon the native law of Holland. The adoption of English nomenclature has accompanied the adoption of much of the substance of the English Law. The process has gone further in some colonies than in others, but in all the influence of English Law has been very great. South Africa, here as elsewhere, is most retentive of the Roman-Dutch common law. In Ceylon and in British Guiana the reception of English Law has gone further."*

Thus, both the Roman law and the Roman Dutch law were very reasonable and practical systems of law. They were fully capable of meeting with new situations and adapting to changing circumstances.

It is submitted, therefore, that the Supreme Court should have taken the opportunity to reason by analogy, taking into account the changing social circumstances, and then decided whether the Roman-Dutch law, as modified by other systems of law, would have provided a sufficient rubric to found a claim for damages arising from the plaintiff's loss of care and companionship of his child. The Roman-Dutch law should never have been a stumbling block for reforming the law of negligence, if such reform was appropriate, in the current social context.

V. The Standard of Care.

Dheeraratne, J., in his judgment, expressed the view that the proper standard of care was that expected from a reasonable professional with the skill of the defendant. For this purpose, his Lordship relied upon the Bolam test[32] as formulated, by McNair, J., in that case. In terms of this test, "[a] doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art...."[33]

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[30] Wessels, J. W., *History of Roman Dutch Law in South Africa,* at p. 380.
[31] Lee, R. W., *An Introduction to Roman-Dutch Law* (1915), at pp. 268 –269.
[32] See, *Bolam v. Friern Hospital Management Committee, [1957] 2 All E. R. 118.*
[33] *ibid.*, at p. 122.

In order to illustrate the standard expected of a reasonable professional, Dheeraratne, J., referred, *inter alia*, to the cases of *Cassidy v. Minister of Health,*[34] *Hall* v. *Brooklands Auto Racing Club,*[35] *Glasgow Corporation* v. *Muir,*[36] *S.* v. *Burger,*[37] *Maynard* v. *West Highlands Regional Health Authority,*[38] *Sidaway* v. *Bethlem Royal Hospital Governor*[39] and *Bolitho* v. *City and Hackney Health Authority.*[40]

Dheeraratne, J., was correct to apply the Bolam test, as formulated by McNair, J., to ascertain the applicable standard of care. Similar principles are applicable in South Africa.[41] According to Macintosh and Norman-Scoble,[42] "[t]he liability of a medical practitioner for his own negligent acts depends upon a straightforward application of ordinary general principle. As he exercises a profession which demands both skill and capacity, he is bound to exhibit such skill and capacity; not the highest possible degree of skill, but a reasonable degree."

More specifically, a medical practitioner will not be liable for an error of diagnosis unless the error was so palpable as to be proof of negligence. In Mitchell v. Dixon,[43] Innes, C. J., had occasion to refer to the applicable standard in respect of an error of diagnosis. His Lordship made the following observation:

> *"A medical practitioner is not necessarily liable for a wrong diagnosis. No human being is infallible; and in the present state of science, even the most eminent specialist may be at fault in detecting the true nature of a diseased condition. A practitioner can only be liable in this respect if his diagnosis is so palpably wrong as to prove negligence, that is to say, if his mistake is of such a nature as to imply an absence of reasonable skill and care on his part, regard being had to the ordinary level in the profession."*

Consequently, the Supreme Court was correct in its determination that the standard of care expected was that of a reasonable professional in the position of the defendant.

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[34] *[1951] 2 K. B. 348.*
[35] *[1933] 1 K. B. 205.*
[36] *[1943] A. C. 488.*
[37] *1975 (4) S. A. 877.*
[38] *[1985] 1 All E. R. 635.*
[39] *[1985] 1 All E. R. 643.*
[40] *[1997] 4 All E. R. 771.*
[41] *Mitchell v. Dixon, 1914 A. D. 519; Coppen v. Impey, 1916 C. P. D. 309.*
[42] Macintosh, J. C., and Norman-Scoble, C., *Negligence in Delict* (4th edn., 1958), at p.101.

However, the decision as to what is reasonable, in a given context, is for the court to decide.[44]

VI. The Negligence of the Defendant.

The next issue, considered by Dheeraratne, J., was whether the defendant was negligent inasmuch as she had misdiagnosed the child's malady as Rheumatic Chorea and failed to diagnose Brainstem Glioma which were both neurological diseases. It was alleged, by the plaintiff, that the non-diagnosis of Brainstem Glioma (BSG) resulted in the deterioration of the deceased child's condition ultimately leading to her untimely death. There was no doubt that the child died as a result of BSG on 19 June 1992 although she did receive treatment in the hands of the defendant for Rheumatic Chorea. Dheeraratne, J., analysed the issues involved under the following heads: (i) whether there was a failure to properly attend upon the child; (ii) whether there was a failure to properly investigate the child's illness.

Referring to the first matter, i.e., whether there was a failure to properly attend upon the child, Dheeraratne, J., held that defendant had been remiss inasmuch as no record had been maintained of the patient's symptoms whereas medical opinion was unanimous that a proper record of the illness should have been maintained in the bed head ticket.[45] Having thus held that the defendant was remiss, Dheeraratne, J., then goes on, surprisingly, to hold that the plaintiff had failed to prove, on a balance of probability, that remissness on the part of the defendant had a nexus with the non-diagnosis of the remedy.

It is submitted, with respect, that once the court arrives at the conclusion that the defendant had been remiss in not recording the symptoms, then, it stands to reason that any other person subsequently treating the patient would be deprived of the knowledge of vital elements of the case history so as to be in a position to make an accurate and speedy clinical diagnosis.

Dealing with the issue of whether there was a failure to properly investigate the patient's illness, Dheeraratne, J., referring to the conduct of another person exercising special skill in the position of the defendant, expressed the view that the failure of the defendant to

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[43] *supra.*, note 41, at p. 526.
[44] See, e.g., *Van Wyk* v. *Lewis, 1924 A. D. 438, per* Innes, J., at p. 447.
[45] Refer p. 19 of the judgment.

order a CT scan, when it was reasonably required by a specialist paediatrician to reach a differential diagnosis, fell short of the required standard of care and, therefore, resulted in the defendant's conduct being negligent.[46]

VII. Causation.

After holding that the defendant was remiss on both counts, namely by failing to properly attend on the child and by failing to properly investigate the child's illness, Dheeraratne, J., then, arrived at the conclusion that the death of the child had not been caused by the defendant's negligence and, therefore, held that the plaintiff's claim failed.

It is in respect of the application of the test of causation that the decision of the Supreme Court is likely to attract criticism. Obviously the child, if suffering from Brainstem Glioma, would have died, in any event, unless the condition had been diagnosed at an early stage (in which case it would have been possible to prolong her life). The negligence of the defendant, if not the operative cause of the patient's death, would have, at the very least, led to additional expenses having to be incurred in respect of obtaining a second opinion. Additionally, the plaintiff bore an unnecessary cost in respect of the expenses incurred for the treatment of the child when the defendant persisted in treating her for Rheumatic Chorea (when any other reasonable medical practitioner, with the skill of the defendant, should have come to the conclusion that the symptoms demonstrated by the child were inconsistent with her initial diagnosis).

The Supreme Court should have taken the opportunity, presented by the instant case, to review the law relating to causation. Assuming without deciding that the child would have died, irrespective of the negligence of the defendant, then, does it mean that the plaintiff's claim fails? Putting the issue in its proper perspective, what should have been examined was whether any consequences arose as a result of the defendant's negligence – additional medical costs is a clear example. If there were any consequences which arose from the defendant's negligence, and the plaintiff sought to recover damages for such consequences, then, to that extent at least, his claim should have been successful.

It should be noted that one of the questions of law, on which the defendant was granted leave to appeal to the Supreme Court, was whether the plaintiff was entitled to damages

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[46] See, p. 28 of the judgment.

other than for medical expenses. It is implicit, therefore, that the question of law was formulated in such a manner that even the defendant was prepared to accept that, if negligence was established, then, she would be liable for medical expenses. Yet, the Supreme Court failed to award damages for medical expenses despite the fact that it held that the defendant was negligent.

It would be relevant, at this stage, to cite the reflections of Zimmermann'[47] on the weaknesses of the modern law of causation:

> *"Does one have to focus on the purpose of the rule violated and eliminate all those consequences that are not covered by its protective scope? Or would it be more appropriate in this context to activate the requirements of wrongfulness and fault and to ask not (as has traditionally been done) whether the defendant's conduct was wrongful and culpable in abstracto, but whether it was wrongful and culpable in relation to the harm complained of? Does one have to establish (and limit) two causal connections: namely that between the defendant's conduct and the harmful result (existence of liability) as opposed to that between the harmful result (for instance: the injury to bodily integrity or life) and the resulting damages (extent of liability)?"*

It is suggested that the proper test for causation would have been to examine the harmful outcome that arose, as a result of the defendant's negligence, and, then, assess the extent of damages. It is the writer's view that the plaintiff, albeit not entitled to expect Rs 5,000,000/-, as damages, should have been fully entitled to recover the medical expenses incurred as a direct result of the defendant's negligence.

In the circumstances, it would seem to have been unduly harsh on the plaintiff, whose child was the victim of negligence, to have been further penalised by an adverse costs order.

VIII. The Implications for the Future.

Soysa v. *Arsecularatne* has significant, and far reaching implications for the future. In the first place, due to the nature of the test of causation adopted by the Supreme Court, it

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[47] Zimmermann, Reinhard, *The Law of Obligations* (1990), at p. 990.

would mean that no one could sue a negligent medical specialist on behalf of a patient who was terminally ill.

Secondly, it means that a parent cannot sue for damages due to the loss of his or her child unless that parent was in indigent circumstances. This is a highly unlikely situation if the parent is a professional or any other person who can afford to have his or her child treated at a private hospital.

The Supreme Court has rapped the plaintiff on the knuckles, for attempting to vindicate his rights, by having him saddled with an adverse costs order. Not only has the plaintiff to bear the additional medical expenses, occasioned by a negligent diagnosis, but he also has to bear the burden of the costs of his own litigation and will now be liable to pay the taxed costs of the defendant. It will not be a surprise to anybody if victims of medical negligence are dissuaded from vindicating their rights as a result of this decision of the Supreme Court. It appears that one has to bear the effects of medical negligence with Stoic calm because the law will not be on your side if you seek to complain. It's one up for the medical profession: heads they win; tails you lose.

IX. Conclusion.

It is hoped that the Supreme Court will soon have an opportunity to further review the law relating to medical negligence, perhaps by a fuller bench, so that we keep abreast with the changing environment. Medical costs have escalated; methods of diagnosis and treatment have dramatically improved. In the circumstances, the law must recognise the changes in the ground situation; it must mirror social change and act as a vehicle for growth and reform.

A person should not be allowed to suffer a wrong without a remedy. The Roman law was never an unreasonable system of law. It offered victims of wrongdoing a wide spectrum of remedies. The modern Roman-Dutch law must also keep abreast with the changing social ethos. With the rapid expansion, and availability, of insurance for professionals, it is in everyone's interest that the highest professional standards are maintained. Consequently, the law of negligence must progress and cannot be locked in a time capsule of 1799.

Insurance Cover for Professional Negligence.

Chandra Schaffter

Anybody who renders a service, usually for a fee, or free of charge is subject to the danger of a claim being made for his errors or omissions whether of himself or of his employees. Any loss or damage, which results from such negligence or error, could be the subject of a claim in negligence where the injured party sues the other for damage suffered.

In most cases an out of court arrangement is arrived at and a settlement is made, particularly if the defendant feels that he will not win his case or if the plaintiff feels that he will not have the resources to carry out an expensive trial.

In order to meet the very high expenditure on litigation which a defendant will have to meet and in this case it is the doctor, insurance steps in to manage the risk.

Negligence claims are faced by anybody who holds himself out as an accountant, as a doctor, a lawyer, an architect, and engineer, or by anybody who provides any professional service. The insurance company helps to mitigate the loss, or to meet the loss in full by issuing a policy of insurance for the amount which the professional or the insured feels he should be covered. It is the decision of the professional to decide for how much he should take out his policy. The insurer would then pay that amount in meeting the claim. If the claim is less, then it is all right. But if the claim is more, then the professional has to meet the shortfall. If the policy taken covers the professional fully, the insurer undertakes to meet in full not only the amount awarded by court but also the legal fees provided the aggregate of such amounts are within the sum insured. This is a great advantage to professionals in having a professional indemnity policy.

The *Priyani Soysa case*, is a straightforward case of presumed professional negligence, which is also called medical malpractice. It is a kind of personal injury, which is caused due to someone else's negligence. Professional indemnity claims are few and far between in Sri Lanka but in countries like the U.S. they are very common and the damages awarded are astronomically high. Generally speaking a person must have suffered bodily injury as a result of a medical person's negligence. Negligence in this case would mean that the medical professional failed to live up to the standard of care reasonably expected

of a professional. The specialist is held to a higher standard of care than a non-specialist. The neuro-surgeon who holds himself out as a specialist and provides service in his specialty, must possess and apply the knowledge and use the skill and care ordinarily used by a reasonably well qualified specialist practicing in the same or similar locality under circumstances similar to those shown by the evidence.

In addition to doctors, medical professionals may include among others, psychiatrists, physiotherapists, medical technicians and even ambulance personnel. They can all be brought in within the ambit of medical negligence. Examples of negligence are physician malpractice; (where the physician does not properly diagnose or he is neglectful in his treatment of the patient), hospital negligence; (where the hospital as an organisation is neglectful, which means its servants or its systems are such that there has been a negligence on the part of the hospital), pharmacist related injury; (that is where the pharmacist has been careless in the dispensation of drugs), and nurses' negligence.

All these come within the ambit of professional negligence or medical malpractice. Of all health care professionals, medical practitioners are the most likely to be sued for malpractice. Consequently the issues of compensation and indemnity in health care are more acute for medical practitioners. In U.K. or U.S.A., it is the doctors who are sued more than any other professionals.

The social and legal context in which medical practitioners undertake their work is unique. Medical practitioners carry an almost unparalleled responsibility for the welfare of their patients and a similar expectation of responsibility from the community at large. While a range of other professional groups such as airline pilots and traffic controllers operate in a similar environment of responsibility and accountability, they are usually not accorded the distinctive degree of autonomy experienced by the medical practitioner in the clinical management of their patients.

The actions of those other professional groups are usually prescribed by precedent or established protocols with opportunities for the exercise of personal judgment or autonomy, which is minimised. The position of responsibility coupled with high community expectations of care and an environment of clinical autonomy means that not only do medical practitioners face a greater likelihood of being associated with adverse patient outcomes, but that patients are more likely to hold medical practitioners accountable for their outcomes. While team based care is occurring more frequently in

many health care settings even in such situations medical practitioners are assumed to be the pinnacle of the chain of responsibility or care. Therefore doctors are endowed with a special position in medical care and have to bear the brunt of any action taken.

The risk of being sued is influenced by the nature of the medical practice undertaken by individual practitioners. Cardiology, psychiatry, gastro-enterology, and nephrology, are areas of medical specialty which are considered to be low risk. Organisations which provide professional indemnity to the medical profession therefore would charge them a lower premium than they would by comparison with areas such as anesthetics, urology, surgery, accident and emergency intensive care and obstetrics, which are considered high risk.

An insurer would judge as to what should be charged as the premium. While the risk of litigation may be relatively small in absolute terms, if it occurs, the consequences for an unindemnified doctor can be catastrophic.

Litigation involves considerable stress and anxiety for the defendant practitioner, and will often entail considerable expenses in legal fees. It may also result in a liability of tens of thousands or millions of rupees. It is not everyday that professional indemnity claims are made by patients. But the fact is that when they do arise the liability on the part of the doctor is very heavy. It is for these reasons that many medical professionals in developed countries recognise the need to have a professional indemnity cover in the event of being sued for negligence.

They either have their own mutual associations or they go to an insurance company. Insurance is a means resorted to by the medical practitioner to mitigate the damaging effects of consequential legal action.

There is also the question of how the state should deal with this problem. There are controls on practice and disciplinary mechanisms. Health care professions for which registration is necessary as a condition of practice should also be subjected to the scrutiny of a body with investigative and disciplinary powers. Usually these powers are vested in a board which is also responsible for determining applications for registration and maintaining a register for those professionals registered in practice. E.g. a Nursing Board should have a range of objectives which can be categorised as control of nurse education schools, registration of nurses, research and administration.

Inherent in these objectives are the following functions - advising the state and ministers of health, publishing and distributing information, holding examinations and determining their character and subjects, and suspending or cancelling registration to practice where necessary.

Compulsory Professional Indemnity Cover - Professional indemnity cover could be compulsory for all medical practitioners through the holding of appropriate professional indemnity covers. At present with the exception of insurance brokers, the law does not compel any professional to take this cover. It is a matter which the state should consider. What is the remedy for the somewhat difficult situation in which the medical practitioners, nurses and others are placed vis a vis claims for professional negligence made by patients or their legal representatives.

In an actual case, a seven year old child with a fever was taken to a doctor in the Emergency Room. Almost immediately complications arose. The child had trouble with breathing and the doctors had to intubilate her. Within seven hours the girl's life changed and she became brain damaged because the air tube went into her stomach and not to her lungs. Her brain was deprived of much needed oxygen as a result of this negligence. This is a typical case of professional negligence on the part of the doctor. That is why a claim for injuries arising out of a medical accident will be very different from other personal injury claims.

Good samaritan acts – These acts are not usually considered to be within the course of employment unless the performance of such acts are in the terms of the contract. Accordingly an employee will not normally be protected from the financial consequences of such an act by vicarious liability. In other words if you work for a hospital and if you performed something outside the hospital as a good samaritan act the hospital's insurance will not protect you nor will the hospital protect you. This would include for example an employee doctor with no right of private practice rendering assistance at an accident outside her or his working hours or a General Practitioner delivering a baby in an emergency. They will not be covered by the hospital's insurance.

Health care professionals normally owe no duty in accident scenes. However, once they go to the assistance of a person in distress they place themselves under a duty of care and may thus be held liable for damages. In other words though they do not have to go to the aid of a patient outside the hospital, if they do that then they would be held liable under

the duty of care. The principle of no requirement of intervention has been legitimately modified in some countries to impose a duty on health care professionals to provide assistance in emergency situations.

The law compels you to provide health care assistance in emergency situations. Once involved a professional owes a duty of care to the person being rescued probably only so far as not making the condition worse, although the common law is far from clear in these circumstances. Although health care professionals fear liability for rendering aid in an emergency it is also claimed that the risk of being sued by an accident victim is the biggest myth health workers have about the law.

There are practical impediments to suit in such situations for e.g. in a case of an emergency the law does not expect the same standard of care from a health care professional as expected from an employee working in a hospital with appropriate equipment. Even in the US where such suits have arisen, commentators say that inspite of the widespread fear among physicians of being sued for malpractice in volunteer situations, there is only one reported case in which a physician was sued for malpractice for rendering emergency treatment outside of a hospital. St. John's Ambulance has reported that over the past ten years qualified volunteers have treated approximately one million casualties throughout Australia and that during this time there have been six incidents of alleged negligence none of which concluded in a finding against St. John's Ambulance.

Remedies are also available to guard against the dangers which doctors and lawyers and other professionals face in claims for medical negligence made by their patients.

Firstly in regard to the hospitals which have a wide-ranging sphere of activities. Not only do they have doctors who treat patients, they have X-ray machines, they have CT scan machines and so many other things which are available for patients to use. If there is negligence in the use of any of those machines or in the performance of any of those machines the patient has a claim against the hospital for negligence. There are hospitals such as Durdans, Nawaloka and Asha Central. They employ a large staff in various capacities and the hospital faces possible claims against any one of those employees for negligence or omissions. To that extent a hospital has a very great exposure in the field of medical malpractice. Sometimes the patient asks for a specialist and at other times the specialist is recommended by the hospital or provided by the hospital itself. In either

situation the hospital places itself in a precarious position.

Questions arise as to the position of the doctor, the capacity of the patient's doctor or the hospital's doctor. When the doctor is brought in by the patient then he becomes the patient's doctor and the action is against the doctor himself. But if he is brought in by the hospital the hospital becomes responsible. Primary protection which a hospital should take is a professional indemnity policy covering not only its employees but its premises, its equipment, pharmacies and virtually every aspect of its operations.

Regarding individual medical practitioners, primarily in this country the danger is faced more by individual medical practitioners rather than by nurses, physiotherapists and others, although theoretically every one of them renders a service and is open to danger. Every member of the medical profession is open to the danger of claims for medical malpractice arising from willful negligence or otherwise. Doctors who run dispensaries, could face claims for incorrect dispensation, as a result of an incorrect reading of their bad handwriting which could result in serious injury or the death of patients.

Individual practitioners such as surgeons and physicians who dispense medical advice to carry out operations or provide a wrong diagnosis following an inadequate test, also face serious legal liability. The best method of protection for the medical profession is to take out a suitable medical indemnity policy with an insurance company. The alternative is to have your own medical organisation a mutual society which provides benefits which alternative is possible in some countries.

Basically the policy of insurance would undertake to meet the doctor's legal liability against claims made for errors and omissions committed by the person concerned and for which the doctor is found to be legally liable in a court of law. The insurance company will only pay if the doctor is found to be legally liable.

The patient or legal representative must take the matter to court as happened in the recent *Priyani Soysa case*, and prove negligence of the doctor concerned. Insurers will not otherwise pay. The quantum of insurance which a doctor should take would depend on what the doctor considers to be the maximum amount for which he would be held liable. It would depend on the financial potential of his patients concerned. The advantage of having a legal liability policy is that the insurer meets not only the amount awarded by court, but the legal costs as well, provided the amount insured is adequate.

The Assessment of Damages - These are usually assessed on the cost of care during the balance life time of the victim if he is disabled in any way permanently. If death results, the loss of income to the dependents is used to calculate damages. In the case of permanent injury the pecuniary loss resulting from inability to work, the cost of maintenance, the loss of enjoyment of life, the curtailment of longevity, all those are taken into account but they are not easy to assess and will largely depend on the advocacy of the people who act on behalf of the plaintiff and of the judge.

In the Supreme Court of the Democratic Socialist Republic of Sri Lanka

SC. Appeal No. 89/99
CA. Appeal 173/94 (F)
DC. Colombo 13035/MR

Professor Priyani Soysa,
25, Valukarama Road,
Colombo 3.

Defendant - Appellant

v

R.A.F. Arsecularatne,
51/4, Halpe Road,
Kandana.

Plaintiff – Respondent

Before : Dheeraratne J.
Bandaranayake J.
Ismail J.

Counsel : H.L. de Silva PC, R.K.W. Goonesekere, S.C. Crossette Thambiah, Hugo Antony, and A. Athurupana for Defendant – Appellant.

Romesh de Silva PC, Palitha Kumarasinghe, Harsha Amerasekera and Sugath Caldera for Plaintiff – Defendant.

Argued on : 3rd May; 21st, 24th, 25th, 26th, 27th, 28th, and 31st July; 1st, 2nd, and 3rd August; 6th, 7th, 8th and 10th November 2000.

Cur. Adv. Vult.

Decided On : 11th December 2000.

DHEERARATNE J.

Introduction

This case has attracted much publicity and public attention as it relates to the unfortunate death of a child and everyone who hears or reads about it cannot but be moved by the tragedy which befell on the plaintiff and his family. This is not surprising, as in the eloquent words of Edmund Burke, expressed many years ago, "Next to love, sympathy is the divinest passion of the human heart." However, sympathy is not the valid basis for determination of the important issues in this case and as judges it is our responsibility to do justice between the parties according to law. The facts of the case are briefly these. The plaintiff - respondent (the plaintiff) along with his wife and two children, was holidaying at Nuwara Eliya in April 1992; one of the children was the then four year old Suhani, who was considered quite a normal and healthy child. She attended St. Bridget's Convent till the school was closed for the April vacation. After a few days stay at Nuwara Eliya, it was observed that Suhani was dragging a leg while she walked and she was brought to Colombo by her parents, to be shown to a paediatrician. On the 18th April 1992, she was taken to Professor Priyani de Soysa, the defendant – appellant (the defendant), a well-known senior paediatrician, who examined the child at her consultation room at St. Michael's Nursing Home, Kollupitiya. The defendant made a provisional diagnosis of Suhani's malady as Rheumatic Chorea (RC) and she was referred to the Nawaloka Private Hospital (Nawaloka). In her referral note to the admitting medical officer at Nawaloka three tests, ASOT, ESR and Telechest were ordered to be taken and penicillin, valium and multi-vitamin tablets were prescribed to be given to Suhani. From 18th April to 19th May 1992, Suhani was under the care of the defendant. On 23rd April, as arranged by the plaintiff, Suhani was examined by Dr. J.B. Peiris, a senior neurologist. On 18th and 19th May as the defendant was not available in Colombo, she arranged Dr. D.R. Karunaratne, Director Lady Ridgeway Hospital, another senior paediatrician to attend on Suhani in her absence. On the 20th May, the plaintiff caused Suhani's treatment and care to be taken off from the defendant and given over to another senior paediatrician Professor Lamabadusuriya. On the 24th a CT scan was requested to be done by Professor Lamabadusuriya, which was done on the 26th, and Suhani's malady was diagnosed as a Brainstem Glioma (BSG) by Dr. N. Jayaratne, radiologist. On the 27th, Professor Lamabadusuriya wrote to Dr. Lal Gunasekera, consultant neurosurgeon, seeking his surgical opinion about further management of the malady. Dr. Gunasekera replied the same day to say that the lesion in the middle of

Suhani's brainstem was inaccessible even for a biopsy and as such no surgery was possible. He suggested that Stereotactic Radiotherapy was best available at Sheffield, under the care of Dr. Sri Lal Dias, a neurosurgeon. Suhani was then taken to the UK on 1st June and shown to Dr. Sri Lal Dias; but no operation was performed on her. On 12th June she was brought back to Sri Lanka and on the 16th she was admitted to the Neurosurgical Unit of the General Hospital, Colombo, under the care of Dr. J.B. Peiris. On the 18th, Suhani was examined by Dr. R.S. Jayathilaka, oncologist and Director of the Department of Clinical Oncology of the Cancer Institute, Maharagama, who found that the BSG covered the entire brainstem extending from the mid brain to the medulla and was inaccessible for surgery. The child was then at the death's very door and the following day she succumbed to her illness.

On 17th August 1992, the plaintiff wrote to His Excellency the President, complaining that the defendant's negligence and incompetence in the diagnosis of his child's sickness, brought about her untimely demise. He requested that an inquiry be held into that matter. He also urged him to "give due consideration to her (defendant's) actual competence and her fitness to be a member of the noble profession in considering her for future appointments" and "even consider appropriate to review the appointments already made because of the danger of allowing such an irresponsible person to hold public office discharging public functions." When the plaintiff received a letter asking him to attend an inquiry on the 9th October in response to his request made to His Excellency, he attended the inquiry but asked for a postponement of the same on three grounds, one of which being, since sending the letter to His Excellency, he had "decided to institute legal proceedings and wanted to seek legal advice."

In January 1993, the plaintiff filed this action against the defendant claiming damages on the ground of medical negligence on her part. It was alleged that Suhani was entrusted to the care of the defendant and that the defendant owed a duty of care to the patient; that the defendant breached that duty and was negligent in the discharge of her duties as a medical practitioner. It was alleged that in consequence of the defendant 's negligence, there was no diagnosis of the actual sickness and the child was not treated for the actual malady. It was alleged that the child died at the point of time when she need not have died and the death of the child was directly attributable to the breach of the duty of care and negligence on the part of the defendant. The District Court awarded the plaintiff a sum of Rs. 5,000,000 as damages. On appeal to the Court of Appeal, heard before a bench of two judges, both judges agreed on the finding of the trial judge on the question

of medical negligence; but on the question of damages they differed. One judge was of the view that the plaintiff was only entitled to medical expenses amounting to a sum of Rs. 250,000, and the other was of the view that the plaintiff was entitled in addition to medical expenses, (1) damages on account of mental shock, (2) damages for loss of future earnings and support and (3) damages for loss of the care and companionship, all amounting to a sum of Rs. 5,000,000. Damages were not quantified under the different heads and we do not have the benefit or knowing what legal principles were applied to arrive at that figure. Learned counsel for the plaintiff agreed to accept the smaller amount of damages, in order to obviate the delay in bringing the case to a finality, which would have been otherwise caused, by the case having had to be re-argued before a bench of three judges of the Court of Appeal; learned counsel "reserved the right to re-agitate the question of the quantum, in the event of the defendant preferring an appeal to this Court," whatever he may have meant by that expression. The defendant was granted special leave to appeal by this Court on the following two questions; namely:

(1) Did the Court of Appeal err in its finding on professional negligence as averred in paragraph 12 of the petition of appeal; and

(2) Is the plaintiff – respondent entitled to be awarded damages other than medical expenses.

Nature of the Plaintiff's action and the damages recoverable under the law

It is convenient to deal with the second question relating to damages initially, by examining the nature of the plaintiff's action alone and that requires no reference to the voluminous evidence led in the case. The question is purely academic, as no appeal has been filed by the plaintiff; he could not have appealed because he was no *aggrieved party*, his counsel having consented to accept the smaller amount of damages (see re aggrieved party, *Mendis* Vs. *Dublin de Silva (1990) 2 SLR 249).* The action has been filed by the plaintiff not in a representative capacity on behalf of the child's estate, but as the father of the deceased child on account of damages suffered by him. It is axiomatic that today the delict known as *damnum injuria datum* created by the *Lex Acquilia* has become a general remedy for loss wrongfully caused by another under the Roman Dutch Law. In contrast, under the English Law, the common law has developed a specific delict of negligence (See the History of Negligence in the Law of Torts – Winfield 1926 42

LQR 184). Requisites of an action under the *Lex Aquilia*, have been expressed by different text writers in different ways; but substantially they are the same. Wickremanayake, gives the requisites as (i) The plaintiff must show actual pecuniary loss. An exception is the award of compensation for physical pain suffered by a person injured through the negligence of another. (ii) He must show that the loss was due to the unlawful act of the defendant or that the defendant was acting in excess of his rights. (iii) He must show *dolus or culpa* on the part of the defendant (The Law of Delict in Ceylon 1949). McKerron, states the essentials of liability in the Aquilian action are (i) a wrongful act, (ii) pecuniary loss resulting to the plaintiff, and (iii) fault on the part of the defendant (The Law of Delict 1965). Boberg, enumerates four requirements, which are (a) wrongful act or omission; (b) fault, which may consist in either intention or negligence; (c) causation, which must not be too remote (unless this limitation is subsumed under the fault element); and (d) patrimonial loss. (The Law of Delict Vol. 1, 1984). I am concerned here with the nature of the loss, which the two authors call pecuniary, while the other calls patrimonial. In the process of deciding what damages are legally due to the plaintiff in the action, I must remind myself of the words of Greenberg J. in the case of *Innes* Vs. *Visser 1936 WLD* 44 at 45, said of course in a different context, that "The of Justice carries a pair of scales not a cornucopia."

Damages claimed by the plaintiff under the head of mental shock, appear to be recoverable under the Roman Dutch Law as well as the English Law (if the test of reasonable forseeability is satisfied), only if that results in psychiatric illness. Damages on account of emotional shock of short duration, which has no substantial effect on the health of a person are not recoverable. See *N.* Vs. *T 1994 (1) SA 862, Clinton – Parker* Vs. *Administrator, Transvaal & Dawkins* Vs. *Administrator Transvaal 1996 (2) SA 37. Bester* Vs. *Commercial 769; Gibson* Vs. *Berkwitz and another 1996 (A) SA 1029; and Alcock and others* Vs. *Chief Constable of the Yorkshire Police 1991 (4) AER 907.*

As regards damages claimed on account of future earnings and support from the deceased child, it is incumbent on the parent claiming such damages, to prove his indigent circumstances warranting such support. "Contrawise *needy* parents also must be maintained by their children" – Voet XXV – 3 – 8. Amerasinghe J. has exhaustively dealt with that aspect of the matter in the case of *Gafoor* Vs. *Wilson and another,* 1990 (1) SLR 143 and it hardly requires any labouring at my hands.

Learned President's Counsel for the plaintiff strenuously contended that the plaintiff is entitled to claim damages for loss of care and that, firstly, if the principles of the *Lex Aquilia* are properly applied, damages other than medical expenses are recoverable by the plaintiff. Secondly, he contended that the resilient nature of the Roman Dutch Law is such that it is within the power of this court to extend the application of that law to modern conditions and thereby grant the plaintiff damages on account of loss of care and companionship of the child. He contended that *damnum* within the meaning of the *Lex Aquilia* encompasses every type of damage caused by the injurious act and that in the religious and social context of Sri Lanka where intra – family ties are treasured and cherished, loss of care and companionship of a child should attract compensation today.

What damages were recoverable in an action based on the *Lex aquilia* was carefully considered in the case of *Union Government (Minister of Railways and Harbours) v. Harneke (1911) SALR 657,* and it was held that the loss of the comfort and society of the plaintiff's wife did not constitute calculable pecuniary loss. At page 665 Innes J. said ".... It becomes necessary to consider the fundamental features of this form of action, which have a bearing upon the matter before us. And we are at once faced with the fact that it was essential to a claim under *Lex Aquilia* that there should have been actual *damnum* in the sense of loss to the property of the injured person by the act complained of (Gruber, p. 233). In later Roman Law property came to mean *universitas* of the plaintiff's rights and duties, and the object of the action was to recover the difference between that *universitas* as it was after the act of damage, and as it would have been if the act had not been committed (Gruber, p. 269). Any element of attachment or affection for the thing damaged was rigorously excluded. And this principle was fully recognized by the law of Holland. As pointed out by Professor de Villiers (Injuries, p. 182), the compensation recoverable under *Lex Acquilia* was only for patrimonial damages, that is, loss in respect of property, business, or prospective gains. He draws attention to the clear cut distinction between actions of *injuria* (where the intent was of the essence), and actions founded on *culpa* alone. In the former case compensation might be awarded by way of satisfaction for injured feelings. In the latter all that could be claimed was patrimonial damage, which had to be explicitly and specifically proved. The difference between the two forms of relief is emphasized by Voet (44.7.16), who states that where one and the same act gives ground for both actions, the receiving of satisfaction for the injuria does not bar the claim for patrimonial loss resulting from culpa. The award of compensation for physical pain caused to a person injured through negligence, which was recognized by the Law of Holland, constitutes a notable exception to the rule in question.

Professor de Villiers has some interesting remarks upon this position, which was probably the result of the influence of Germanic upon Roman Law. But however that may be, there is no warrant for any such exception in the case of mental distress or wounded feelings causing no physical injury. Damages calculated in that basis were wholly outside the scope of the Aquilian procedure..."

Of course compensation for injured feelings arising out of and flowing naturally from physical hurt done, could be claimed under the *Lex Aquilia.* See *Pauw* Vs. *African Guarantee and Indemnity Co. Ltd. 1950 (2) (2) SA (SWA) 132.*

I find a further constraint on me to grant damages on account of loss of care and companionship. That is, after the administration of the Island changed from the Dutch to the British rule, on a settled principle of English Law and policy, that colonies acquired by cession or conquest, retain their old law, so long and so far as it remained unaltered by the new ruling power, the system of law that prevailed in the Island at the time of the capitulation of the maritime province to the British, was made to continue. This continuance was later guaranteed by the Proclamation issued by the British Governor on 23rd September 1799, making Law, subject to such "deviations and alterations" as the specific authorities might determine; but those authorities did not include the Courts. In *De Costa* Vs. *Bank of Ceylon (1969) 72 NLR 457 at 461,* H.N.G. Fernando CJ. Having closely examined the Proclamation of 1799, observed as follows:

"The Proclamation of 1799 thus declared that the Administration of Justice shall be exercised by the Courts according to the Roman Dutch Law, subject to deviations and alterations:

(a) in consequence of emergencies, or absolutely necessary and unavoidable, or evidently beneficial and desirable;

(b) by the Court of Directors of the East India Company or the Secret Committee thereof or the Governor of Fort William;

(c) by Proclamation of the Governor;

(d) by lawful authority ordained.

But the proclamation did not authorise any such deviations or alterations to be made by the Courts of Law."

Fernando CJ, having thereafter considered the repeal of the Proclamation of 1799 with certain exceptions by Ordinance No. 5 of 1835 stated at 462, "What is important for the present purposes is that the Proclamation of 1799 and the Ordinance of 1835 did not authorize *the Courts* to alter or deviate from the Roman Dutch Law or to apply in Ceylon principles of English Law which conflict with the Roman Dutch Law. From 1835 at least such deviations or alterations could be effected only by Ordinance."

Learned President's Counsel for the plaintiff drew our attention to the Dicta of Lord Diplock in the Privy Council judgment in *Kodeeswaran* Vs. *The Attorney General (1969) 72 LR 337,* where a different view was taken. Lord Diplock equated the common law of this country to the common law of England and stated that it has not remained static since 1799. Unfortunately, the text of the 1799 Proclamation referred to by Lord Diplock in *Kodeeswaran's* case (at page 339), was that which was reproduced as the Adoption of Roman Dutch Law Ordinance (Chapter 12) of the 1956 Revision of the Legislative Enactments and not the text of the original 1799 Proclamation which judges in *De Costa's* case (at page 461) referred to, having obtained it from Dr. B.C. Mendis' work on the Colebrooke – Cameron Papers. In the 1956 version of the 1799 Proclamation referred to by Lord Diplock, in the Preamble cum the first clause, the crucial words *"subject to such directions, alterations, and improvements, as shall be directed or approved by the Court of Directors of the United Company of Merchants of England trading to the East Indies, or the Secret Committee thereof, or by the Governor-General in Council of Fort William in Bengal,"* were missing. For that reason I would respectfully adopt the views expressed by Fernando CJ in De Costa's case, which have been reached after a careful analysis of the complete provisions of the 1799 Proclamation.

Much earlier Gratiaen J. in *Chissel* Vs. *Chapman, (1954) 56 NLR 121 at 127* was constrained to remarks as follows: "But those who administer the Roman Dutch Law cannot disregard its basic principles although (on the grounds of public policy or expediency) we may cautiously attempt to adapt them to fresh situations arising from the complex conditions of modern society. But we are powerless to alter the basic principles themselves, to introduce by judicial legislation fundamental changes in the established elements of an existing action."

I think we are not entitled, as judges, to change the material of Roman Dutch Law, but are only permitted to iron its creases, whenever the necessity arises. Effecting structural alterations to the Common Law should be the exclusive preserve of the Legislature and such alterations have been done by the Legislature from time to time as the occasion arose, in several fields like for instance, in landlord and tenant, inheritance and sale of goods. I entirely agree with learned President's Counsel for the plaintiff that in the socio – religious backdrop of Sri Lanka, loss of care and companionship should attact compensation. The Legislature should take such a policy decision and lay down guidelines on which courts should calculate and assess the quantum of compensation. Those guidelines should indicate, for example, in the case of a child attributable to a tortuous act, whether compensation should vary according to the age of a child: whether brother or sister could claim compensation; whether the father or mother is entitled to claim more than the brother or sister, or should loss of the only child attract more compensation; and the like.

The Standard of Care

Admittedly, the defendant held herself out as a qualified paediatrician, to whose care and treatment the plaintiff entrusted his daughter Suhani; therefore, the defendant owed a duty to the plaintiff, to treat Suhani, exercising reasonable care and skill as a paediatrician, without causing patrimonial loss to him. Duty of care is not a warranty of a perfect result (Mustill J. in *Wilsher* Vs. *Essex Area Health Authority (1986) 3 AER 801; (1987) QB 730).* It transpired that the defendant has not charged any fee for her professional services, but that does not affect her duty of care to the patient, as that duty arises from the performance of the services. As stated by Denning LJ. In the case of *Cassidy* Vs. *Ministry of Health (1951) 2KB 348 at 359* "if a man goes to a doctor because he is ill, no one doubts that the doctor must exercise reasonable care and skill in his treatment of him; and that is so whether the doctor is paid for his services or not." When a person's conduct falls short of the standard of care the law demands from him, his conduct becomes negligent. The criterion of negligence is commonly described as the standard conduct of a reasonable man or *diligence paterfamilias* placed in the same circumstances as the person whose conduct is in question. In other words, negligence is, doing or omitting to do something, what a reasonable man would not do or would not omit to do, in a given situation. The standard of reasonableness is partly objective and partly subjective. In so far as the actor is expected to conform to a standard that takes no account of his individual ability, experience or temperament (his personal equation), it is

the practice of the peers of the skilled professional, whose action is impugned, becomes relevant. However, in my view, this does not mean that the Court should abdicate its determination of the standard of care required of the skilled professional, in favour of the opinions expressed by the peers of the skilled professional whose action is impugned.

The accepted test currently applied in the English Law to determine the standard of care of a skilled professional, commonly referred to as the Bolam test, is based on the dicta of Mc Nair J. in his address to the jury, in *Bolam* Vs. *Friern Hospital Management Committee (1957) 2 AER 118.* At page 121 he said "but where you get a situation which involves the use of special skill or competence, then the test whether there has been negligence or not is not the test of the man on the Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not posses the highest expert skill at the risk of being found negligent. It is well-established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art." Again, at page 122 he explained "A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible art ... Putting it another way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view." The Bolam test is a departure from the test of the hypothetical reasonable skilled professional. The former places emphasis on the standards, which are in fact, adopted by the profession, while the latter concerns itself with what ought to have been done in the circumstances. (For a critical discussion of the Bolam test, see Montrose, 'Is Negligence an Ethical or a Sociological concept [1958] 21 Modern Law Review 259). Certain glosses were added to the Bolam test by some subsequent judgments of the House of Lords to which I shall refer.

In *Maynard* Vs. *Midlands Regional Health Authority (1985) 1 AER 635,* (decided in May 1983) the House of Lords having considered the Bolam test, held that it had to be recognized that differences of opinion and practice existed in the medical profession and that there was seldom any one answer exclusive of all others to problems of professional judgment and therefore although the Court might prefer one body of opinion to the other, that was not a basis for a conclusion that there had been negligence on the part of the defendant doctor. In *Sidaway* Vs. *Bethlem Royal Hospital Governor and others (1985) 1ER 643* (decided in February 1985), while the Bolam test was approved by the House of Lords, it was held by a majority, that it applied not only to diagnosis and treatment, but

also to the doctor's duty to warn his patient of the risks inherent in the treatment recommended by him, Lord Scarman in his dissenting judgment formulated the Bolam test to mean "a doctor is not negligent if he acts in accordance with a practice accepted at that time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care; *but the standard of care is a matter of medical judgment."* (emphasis added). A further important refinement was added to the Bolam test by the House of Lords in the case of Bolitho *(administratrix of the estate of Bolith - deceased)* Vs. *City and Hackney Health Authority (1997) 4 AER 771.* It was held that "a doctor could be liable for negligence in respect of diagnosis and treatment despite a body of professional opinion sanctioning his conduct, where it had not been demonstrated to the judge's satisfaction that the body of opinion relied on was reasonable or responsible. In the vast majority of the cases the fact that distinguished experts in the field were of a particular opinion, would demonstrate the reasonableness of the opinion. However, in a rare case, if it could be demonstrated that the professional opinion was not enable of withstanding logical analysis, the judge would be entitled to hold that the body of opinion was not reasonable or responsible."

In my view, *Bolitho's* case probably brings the Bolam test fairly close to the test of the conduct of the notional reasonable skilled professional, in the assessment of the standard of care, by its emphasis that the medical opinion should not be solely determinative of the required standard.

In Australia, in the case of *Rogers* Vs. *Whitaker (1992) 67 A 47,* the High Court held, at least in relation to cases of non-disclosure of medical risks, the Bolam test should no longer be applied. He plaintiff in that case, decided to get her right eye which was injured in her childhood, operated by the defendant ophthalmic surgeon. There was no doubt that the operation was performed with the required skill and care, but the patient not only lost the vision of that eye, she became almost totally blind as a result of a condition known as sympathetic ophthalmia developing in her left eye. The question was whether the defendant was negligent in that he failed to warn the plaintiff of such risk of damage being caused to the left eye. If the Bolam principle was applied, even if a patient asks a direct question about the possible risks or complications, the making of that inquiry would be of little or no significance, because medical opinion would determine whether the risk should or should not be disclosed and the express desire of a particular patient for information or advice does not alter that opinion or the legal significance of that opinion.

The principal criticism for the application of the Bolam test appears to be that if a medical practitioner is able to get a responsible body of medical opinion, however small that may be, to say that the practice adopted by him was in their opinion, one which could be reasonably followed, then the court should adjudicate the medical practitioner not negligent, even though a vast body of medical opinion might take the opposite view. *(See Disclosure of Risks in Proposed Medical Treatment – F.A. Trindate (1993) 109 Law erly Review, where a suggestion is made for the abandonment of the Bolam test in England).* In view of the matters considered above, with regard to the determination of the standard of care, I would prefer to follow the dicta of Innes J in *Van Hyk* Vs. *Lewis 1924 AD 438 at 447* that "The testimony of experienced members of the profession is of the greatest value ... But the decision of what is reasonable under the circumstances is for the Court: it will pay high regard to the views of the profession, but it is not bound to adopt them."

The same idea was expressed more forcefully by King CJ, in the Full Court decision of the Supreme Court of South Australia in *F* Vs. *R (1983 33 SASP 189 at 194,* when he stated "the ultimate question, however, is not whether the defendant's conduct accords with the practices of his profession or some part of it, but whether it conforms to the standard of reasonable care demanded by the law. That is a question for the court and the duty of deciding it cannot be delegated to any profession or group in the community." I am in respectful agreement with that proposition.

Was the defendant negligent, in that her conduct did fall short of the required standard of care?

It was alleged that the defendant was guilty of several acts of omission and commission amounting to negligence, which caused the misdiagnosis of Suhani's malady as RC and the non-diagnosis of BSG, resulting in the deterioration of her condition, and ultimately leading to her untimely death. We were helpfully and carefully taken through for several days, the lengthy mass of evidence led and the medical literature produced at the trial, by learned President's Counsel who appeared for either side, to demonstrate that the defendant was either negligent or not. The evidence for the plaintiff came from the plaintiff himself, Dr. Sri Lal Dias, neurosurgeon, and M.G.G. Amarasinghe, radiologist. For the defendant, Dr. J.B. Pieris, neurologist, Dr. Shelton Cabral, Neurosurgeon, Dr. Joseph Fernando, Secretary of the Ministry of Health, Dr. R.S. Jayatilake, oncologist, Dr.

K.M. Velumylum, Director of Health Services, Dr. Harendra de Silva, professor of paediatrics, University of Ruhuna, and the defendant herself gave evidence.

There is no doubt that the BSG was the cause of Suhani's death on 19.06.1992, although she received treatment at the hands of the defendant for RC, which is also a neurological disease. In the statement made by the defendant on 05.10.1992 to the inquiring officer of the Minister of Health, in response to a petition sent by the plaintiff to His Excellency the President, as well as in her answer dated 15.01.1993, she stated that in the course of time she too would have ordered a CT scan on Suhani and her BSG could have been diagnosed. Her position when she gave evidence in the original court, was that Suhani was suffering from both BSG and RC, but the medical opinion ruled out the probability of the presence of both diseases simultaneously in one person. In any event, I am mindful of the fact that mere misdiagnosis or non-diagnosis of a disease, by itself does not amount to negligence. Attention of both the original Court and the Court of Appeal appears to have been diverted to many peripheral matters which had no nexus or relationship to the alleged culpable act of negligence namely, non diagnosis of the BSG, like for instance, the failure of the defendant to use the knee hammer or the ophthalmascope, for the clinical examination of Suhani, when no different results were yielded when other doctors used them on Suhani. For the sake of convenience and with a view to avoid repetition, I shall examine several items of relevant evidence led on behalf of the plaintiff to bring home the charge of negligence on the part of the defendant, *leading to non diagnosis of the BSG,* under two broad heads: (A) was there a failure to properly attend on Suhani? and (B) was there a failure to properly investigate Suhani's illness?

Was there a failure to properly attend on Suhani?

It was alleged that the defendant failed to elicit a full history of Suhani and the medical opinion was unanimous in the importance of eliciting the history of a patient as a precursor to effective treatment. It is significant to note that Suhani was presented to the defendant's examination as a child in normal good health who even attended school on the last day of the term before the April recess. Much weight was given to this allegation of not eliciting the history of the patient, because of the fact that the plaintiff while giving the history of Suhani to the Neurological Unit of General Hospital, on 16th June 1992, has stated in mid February 1992, he noticed in Suhani *'a funny way of looking'; 'once in a way head bend to the right side'* and end of February *'talking at night while sleeping';*

'couldn't wear slippers'; 'clumsiness of her limbs'; and *'when walks tendency to fall'.* At the time this history was recorded, the BSG in Suhani was diagnosed and admittedly the plaintiff had read medical literature on Suhani's malady. The child was presented to the defendant for examination as a girl in the pink of her health, except for the dragging of a foot. There was no critical examination by the Courts below as to whether the plaintiff gave that history to the Neurological Unit from hindsight or whether he was confused due to over-anxiety as to when those symptoms manifested. There is no evidence as to whether Dr. J.B Peiris or Professor Lamabadusuriya elicited those matters from the plaintiff after detailed questioning. I would consider it too much to expect a specialist to do 'extensive questioning' from parents who bring a normally healthy child for examination, on all symptoms of diseases in the book of paediatric pathology. Looking objectively, the inability of a busy specialist to indulge in the time consuming exercise of eliciting the history of a patient, must be viewed from the unfortunate Sri Lankan context, where a patient is permitted to rush to a specialist, by-passing his family general practitioner, and the specialist being licensed to readily attend on a patient without even a referral note from a general practitioner.

The purpose of a Bed Head Ticket (BHT) is to keep a medical record of a patient. Except for two entries, one calling the nurse to explain why her order to give Valium was not carried out, and the other requesting Dr. D.R. Karunaratne to look after the child in her absence, the defendant made no entries in the BHT. Most entries had been made by the house officer in charge and the defendant stated that she did not even dictate anything to be written on the BHT by the house officer. No symptoms discovered by the defendant and no results of her clinical examination of Suhani were reflected in the BHT. Although in the statement of the defendant dated 05.10.1992, forwarded to the inquiring officer of the Ministry of Health regarding the death of Suhani, she stated *'... on examination, I found weakness, involuntary purposeless movements, and brisk tendon reflexes which led to a provisional diagnosis of rheumatic chorea',* none of those symptoms were recorded or were caused to be recorded in the BHT by the defendant. Strangely, in that very statement to the inquiring officer, in relation to Dr. Lamabadusuriya taking over the treatment of Suhani, the defendant stated, *'he had the advantage of taking over the patient after my observations for a month in the same ward',* whereas absolutely no record of her observations whatsoever was available for the benefit of others. Medical opinion was also unanimous that the proper record of the illness should have been recorded in the BHT and it was clear that the defendant was remiss in that matter.

However, I am unable to say that it has been proved by a balance of probability, that this remissness had a nexus with the non-diagnosis of the malady.

It is alleged that the defendant failed to properly consult and follow Dr. J.B. Peiris. The plaintiff arranged Dr. J.B. Peiris to examine Suhani on 18th April and it is right to say that the defendant quite reluctantly agreed with that arrangement. The house officer had to speak to the defendant over the phone and write a note in the BHT requesting Dr. J.B. Peiris to see the patient. Dr. Peiris having done a thorough neurological examination of Suhani, wrote in the BHT as follows in respect of her.

> *"Prof. Priyani Soysa - she has coarse multiplanar, non purposive movements of legs which have the features of chorea, but there are no confirmatory movements in arms or tongue, Knee Jerks brisk and pendular. Suggest Rivotril 0.5 Mg. EEG (Electro Encephalogram). X-ray skul - posterior - lateral. Shall review. Thanks".*

I shall refer again to the contents of this entry in the BHT later in another connection. The EEG was taken and a note was addressed in the BHT to the defendant again by Dr. J.B. Peiris to say that the EEG *'shows no significant paroxysmal or focal abnormality'*. Rivotril was not given and the skull x-ray was not taken; those may not have mattered. But the significant fact is that the defendant failed to have any dialogue whatsoever with Dr. J.B. Peiris regarding the patient, particularly about the neurological symptoms noted by him and the seeming reservations he had chosen to express; further no opportunity was given to him to review the diagnosis. The skull x-ray would have revealed nothing, as subsequently it was discovered that there was no hydrocephalus which would lead to intra-cranial pressure. Therefore, the Court of Appeal was clearly wrong in concluding that the scull x-ray would have shown intra-cranial pressure and finding fault with the defendant on that score. All I could say is that on the evidence led, although the defendant could be faulted for not properly consulting Dr. Peiris, only a possibility as opposed to a probability existed in Dr. Peiris ordering a CT Scan being taken, if he was properly consulted *at that time*.

It was also alleged that the plaintiff persisted in requesting the defendant to obtain a second opinion from another paediatrician but the defendant refused to do so. The plaintiff's evidence on this matter was devoid in detail. To the letter dated 17.8.1992 written by the plaintiff to His Excellency, he appended marked "A" an "account

pertaining to the death" of Suhani. Although reference is made in that statement to plaintiff's making arrangements to get Suhani examined by Dr. Peiris, not a word is mentioned about the alleged persistent requests made to the defendant to obtain a second opinion and the defendant's refusal to do so. The probabilities are that he did not make such a request.

Was there a failure to properly investigate Suhani's illness?

Powers and Harris on Medical Negligence (1994), under the subtitle "Space occupying lesion" at 778 states *"The commonest medico-legal problem in this category results from delay in diagnosis; the subsequent management is rarely a problem. Early cases of subdural haematoma or a glioma can be very difficult to diagnose and it is not negligent to be unable to reach a diagnosis at the initial consultation. However, it is important to consider this diagnosis even if it is only a remote possibility as it might be in the case of a patient with a single attack of epilepcy. With modern CT scanning a moderate sized tumour or subdural haematoma will be demonstrated but this does not follow for small lesions which can be missed. The injection of contrast material during the radiology increases the sensitivity of the test but does not make it fully reliable. In the absence of definite focal signs a normal CT scan may occur in the early stages of the lesion and therefore follow-up is important. (Bouchez, Assakar, Hautefeuille, Combelles, Arnott 1986). CT scans may not be quickly available and it can be important to judge the best time to do the scan. A deterioration in the patient's condition is probably the most important indication to do a scan or to repeat it and it would be negligent not to investigate fully a patient who was getting worse".*

Admittedly the only way of diagnosing the existence of a BSG is through a CT scan and the evidence of the plaintiff at the trial was that he was aware of this significant fact. One allegation made against the defendant was that she failed to order a CT scan when she was expressly requested to do so by the plaintiff. The Courts below have not considered in this connection, as to why the plaintiff failed to mention this significant fact in the petition he sent to His Excellency, and why he failed to make the same request to Dr. Peiris or to Professor Lamabadusuriya, whose disposition towards him was quite friendly, according to him. Viewed in the context of those circumstances, the probabilities are that the plaintiff did not make such a request, and the defendant cannot be faulted on that score.

There appears to be no negligence on the part of the defendant in arriving at the initial provisional diagnosis of Suhani's malady as RC. Chorea is described in Nelson's Essentials of Paediatrics (1999) at 744 as *"Hyperkinetic, rapid, unsustained, irregular, purposeless, non-patterned movement. Muscle tone is decreased. Choreiform movement abnormalities may be congenital, familial, metabolic, vascular, toxic, infectious, or neoplastic in origin. The movements may occur alone or as a part of more extensive disorder (eg. Sydenham chorea, Huntington chorea, celebral palsy, Wilson disease, reaction to toxins and drugs). Fidgety behaviour, inability to sit still, clumsiness, dysanthia, and an awkward gait may occur. The exact site of disfunction within the extra-pyramidal system is unknown".* Medical opinion is that it takes a minimum of six weeks for RC to run its course.

There is no question that the controlling of the involuntary choreiforum movements required the patient to be sedated and rested and the defendant prescribed Valium for Suhani. I am unable to agree with the finding of the Court of Appeal, a conclusion unsupported by any medical opinion, that the defendant was responsible for "masking" the symptoms of BSG by heavy sedation of the child. Medical literature shows that the BSG is presented with an insidious onset of symptoms and signs, therefore it is of utmost importance to observe what symptoms and signs manifested in Suhani, when she was under the care of the defendant. Both Courts below have proceeded to examine the question of negligence of the defendant on the basis that the following symptoms of the BSG were manifested in Suhani and they manifested almost simultaneously and were staring in the face of the defendant, who most callously overlooked them. As described by the Court of Appeal, they were:

> (i) Brisk knee jerks (ii) Ankle clonus (iii) Choriform movements (iv) Inability to walk - involving motor tract (v) Inability to sit up - involving the motor tract (vi) Inability to use arms (vii) Eyes becoming red - involving cranial nerves 4 and 6 (viii) Salivating - involving cranial nerve 7 (ix) Inability to hold head up - involving the motor tract (x) Slurred speech - involving cranial nerve 7; and (xi) Response to Babinski test.

As regards (xi) referred to above there is no evidence of anyone having done that test. Of the above symptoms, regarding (iv), (v), (vii), (viii) and (ix) only the plaintiff spoke of them and no confirmation of the presence of those symptoms came from the evidence of Dr. Peiris or from the notes of Professor Lamabadusuriya or from any other source. The

plaintiff's evidence as to when those signs he deposed to manifested, appears to be quite vague. Evidence disclosed that Suhani did have red eyes and that she was treated by the defendant for conjunctivitis. But, there was no evidence to show that the redness of the eyes persisted. Suhani did not have red eyes even at the time she was admitted to the Neurosurgical Unit of the General Hospital on 16th June. The only witness who could have positively spoken of what symptoms manifested at the time Professor Lamabadusuriya took over the care and treatment of Suhani on 20th May 1992, was Professor Lamabadusuriya himself and the plaintiff has starved the case of that vital evidence by not calling him to testify, although he was listed as his witness. It is right to presume, that this evidence which could have been and was not produced, would if produced be unfavourable to the party who withheld it, particularly, in respect of the symptoms which the plaintiff alone deposed to. (see section 114 illustration *{f}* of the Evidence Ordinance). In this connection, I am unable to subscribe to the view that generally, a member of the medical profession in Sri Lanka, is reluctant to give truthful evidence before a Court of Law, merely because such evidence, will conflict with the personal interests of a colleague. To take such a view of professional camaraderie, would probably be as unreasonable as to agree with George Bernard Shaw's hyperbole that "all professions are conspiracies against the laity" *(Sir Patrick in Doctor's Dilemma - 1906).* At the same time I think it is my duty, in that connection, to indicate the same concern expressed by Lord Wilberforce in the case of *Whitehouse* Vs. *Jordan and another (1981) 1 AER 267,* for the benefit of both the Medical and Legal professions. Lord Wilberforce said at 276 "while some degree of consultation between experts and legal advisors is entirely proper, it is necessary that expert evidence presented to court should be, and should seen to be, the independent product of the expert, uninfluenced as to the form or content by the exigencies of litigation. To the extent that is not, the evidence is likely to be not only incorrect but self defeating."

The evidence unequivocally points to the presence of the following symptoms and signs in Suhani, when she was under the care of the defendant (1) Brisk knees jerks (2) Ankle clonus (3) Choreiform movements which includes inability to use arms and (4) Slurred speech. As regards brisk knee jerks, both Dr. Peiris and Professor Lamabadusuriya noted them, but Dr. Peiris did not think they were inconsistent with RC. Dr Cabral and Dr. Sri Lal Dias were however of the view that they were indicative of the presence of a lesion in the brain. With regard to ankle clonus, it was the evidence of Dr. Peiris, that there was nothing diagnostic about clonus and at the same time its presence was unusual for RC.

The medical evidence regarding choreiform movements and slurred speech - dysarthia - is that they are symptomatic of both RC and BSG.

In addition to the eleven matters mentioned above, the Court of Appeal was of the view that there were several other features in Suhani's sickness which were **inconsistent** with the diagnosis of RC. They were: (a) the child being four years and one month old; (b) the absence of a history of rheumatic fever; (c) the ASOT being high; (d) sleeping pulse being high; (e) temperature of the child being normal; and (f) absence of confirmatory movements in arms and tongue as recorded by Dr. Peiris.

(a) There was no expert evidence to indicate that a child of four was immune from RC. According to the Oxford Text Book of Medicine (1988), RC affects children and adolescent between the ages of 3 and 20, (b) The Oxford Textbook of Medicine again show that rheumatic fever is rare in patients under four years of age, most cases occurring in the 6-15 age group, (c) According to Dr. Peiris, the raised ASOT was consistent with Suhani having had rheumatic fever as it was indicative of an earlier streptococcal infection. The enlargement of the heart shown in the Telechest was also according to him indicative of RC. However, the defendant herself admitted that the raised ASOT was **unusual** for RC, (d) The medical evidence regarding the raised sleeping pulse given by Dr. Peiris is equivocal and it cannot be said with any degree of certainty that his evidence supports that it was inconsistent with RC. But Professor Harendra de Silva has testified to the fact that in RC the sleeping pulse is normal, (e) The Oxford Textbook of Medicine states that in RC the child usually has no fever, although Dr. Peiris has expressed the view that it is inconsistent with RC. (f) As regards the absence of confirmatory movements in the hands and tongue as observed by Dr. Peiris on 18th April, although evidence disclosed that the child could not hold objects and her speech was slurred, there was no indication as to what Dr. Peiris meant by those observations and that Dr. Peiris was given an opportunity to review his diagnosis. At the most, therefore, there appears to have had some features unusual with diagnosis of RC, that being the raised sleeping pulse and raised ASOT; but there is no justification for the Court of Appeal to have come to the conclusion that there was evidence of the presence of several features **inconsistent** with RC, and therefore bring home the charge of negligence on the defendant on the basis that she overlooked them.

I find it difficult to accept the submission made on behalf of the appellant that Dr. Peiris confirmed the diagnosis of Suhani's malady as RC, firstly, because of the reservations he

had chosen to express on the BHT and secondly, because he got no opportunity to review the diagnosis as suggested by him. That accounts for why Dr. Peiris told the plaintiff that it was "probably rheumatic chorea". As far as Dr. Karunaratne was concerned, he came to medically look after the child, in the defendant's short absence, at her request, with no observations of the symptoms of the disease recorded by her on the BHT, but with the firm request "to look after the child with rheumatic chorea". In those circumstances one can hardly contend that Dr. Katrunaratne too confirmed the diagnosis made by the defendant.

I shall now recount briefly the events leading to the discovery of the BSG in Suhani. On 20th May 1992, the plaintiff wrote the letter produced marked P10, to the sister-in-charge of the paediatric unit of Nawaloka, conveying his decision to transfer the care of the child from the defendant to Professor Lamabadusuriya since his daughter "has not made much progress since her admission to Nawaloka on 18.04.92". Learned President's Counsel for the defendant made a point of this plaintiff's statement, quite rightly, to submit that the child's condition had not dramatically deteriorated, as it was attempted to be made out by the plaintiff, warranting the defendant to order a CT Scan. As observed earlier Professor Lamabadusuriya was not called as a witness, nevertheless, what he did as regards the treatment and management of Suhani from the 20th May, in my view assumes great significance in the determination of the question of the defendant's negligence.

I shall set out the important entries made by Professor Lamabadusuriya in the BHT at Nawaloka from the 20th. On the 20th, he wrote *"Clinical features suggestive of rheumatic chorea. All tendon jerks very brisk with ankle clonus"*. He prescribed Epilin, a drug in the same class as Valium, but stronger. On the 21st night, when he saw the child, she was asleep and he did not want to disturb her, but he wrote *"Parents think involuntary movements are less and speech is better"*. On the 22nd, he wrote *"Condition same as yesterday. Hypotonia + speech same, unable to sit. Tendon jerks brisk"*. On the 23rd, he wrote *"More drowsy today and less alert. Involuntary movements same. Pupils (normal). Continue Epilin"*. On the 24th, he wrote *"Involuntary movements less. Speech same. Unable to sit up. Fundi - cannot visualise the optic discs. Tendon jerks - could not elicit knee jerks. Poor co-ordination"*. Dosage of Epilim was increased. On the same day Professor Lamabadusuriya wrote to Dr. Newton Jayaratne, consultant radiologist say that *"This patient is under treatment for Rheumatic Chorea since mid April '92. I took over the patient only few days ago. Her tendon jerks are very brisk and there is ankle clonus which is unusual for chorea. I cannot visualise the optic discs to see whether*

there is papiledema. Could you please do a CT Scan of the brain to exclude the possibility of a SOL (Space Occupying Lesion)."

The CT Scan was done on the 26th and according to the report sent by Dr. Jayaratne addressed to Professor Lamabadusuriya *"The size shape and position of the ventricles are normal. There is enlargement of the brain stem from the pons down to the medulla. An irregular enhancing mass is seen in the brain stem. Appearances are most likely due to a brain stem glioma. The possibility of a tuberculus infection is less likely. DIAGNOSIS, Brain Stem glioma".* On the 27th Professor Lamabadusuriya wrote to Dr. Lal Gunasekara, consultant neurosurgeon to say that *"This patient who has been treated as a case of rheumatic chorea for one month, came under my care last week. In addition to choreiform movements, I noticed that all tendon jerks were brisk and there was ankle clonus. As the brisk jerks persisted and the response to sodium valporate was not optimal a CT Scan was done yesterday, which revealed a S.O.L. in the brainstem suggestive of a glioma. I would very much value your surgical opinion about further management".* The same day Dr. Gunasekara replied *"The lesion is in the middle of the brainstem and inaccessible for a biopsy. No hydrocephalus. As such no surgery is possible... "* He added a postscript to say that *"Stereotactic Radiotherapy which is the best is available at Sheffield c/o Dr. Srilal Dias".*

We are thus in possession, as to why Professor Lamabadsuriya, a senior paediatrician himself ordered the CT Scan. True, he did not rush to order the Scan to be taken on the 20th itself or order that to be taken on the 24th "immediately", as he could have done. He watched for the response to sodium valporate (Epilin) as seen by his memorandum to Dr. Gunasekara. He belongs to the same class of medical specialists to which the defendant belongs and in fact succeeded the defendant as the professor of paediatrics at the Medical College. The reasons why he ordered the Scan is specified in his letter addressed to Dr. Jayaratne and that was to exclude the possibility of a SOL, because tendon jerks were brisk and there was ankle clonus, which were unusual for RC. Although the presence of ankle clonus is not recorded in the skimpy BHT at Nawaloka before the 20th of May, that symptom could not have suddenly sprung up on the 20th for the benefit of Professor Lamabadusuriya's examination of Suhani. I have already held that the defendant was remiss in not setting out or causing to set out symptoms of Suhani's illness in the BHT. Was the defendant negligent in not ordering the Scan either to confirm her initial diagnosis or to arrive at a differential diagnosis when those two symptoms were present in addition to choreiform movements? In my view what Professor Lamabadusuriya did

in the circumstances was demonstrative of the standard of care and skill required of an ordinary skilled person exercising and professing to have that special skill namely that of a specialist paediatrician. Ordering a CT scan be taken on Suhani was something reasonably required by a specialist paediatrician to reach a differential diagnosis at that stage. In my view, the defendant's conduct fell short of that standard of care and she was therefore negligent.

Causation

Nelson - Essentials of Pediatrics (1999) on oncology gives the following description at page 601:

"Tumor/Site - Brain stem glioma

Manifestations - Onset between 5 and 7 year of age; traid of multiple cranial nerve deficit (vii, ix, x, v, vi) pyramidal tract, and cerebellar signs; skip lesions common; Increased Intra-cranial Pressure is late.

Treatment - Excision impossible; radiotherapy is palliative; corticosteriods to reduce tumor edema; experimental chemotherapy.

Comments - Small size but critical location makes the tumor highly lethal".

The mere proof of the fact that the defendant was negligent in not ordering a CT scan on Suhani, (which led to the non-diagnosis of the BSG), does not make the plaintiff become entitled to damages. The plaintiff must further prove that such non-diagnosis caused or materially contributed to the deterioration and death of Suhani which caused wrongful loss to him. If the death would have occurred in any event unconnected with the defendant's breach of duty, the defendant is not liable in damages. In other words, the plaintiff must prove on a balance of probabilities the existence of the causal connection between the defendant's breach of duty and the damages he suffered. In this connection, there were certain specific issues raised at the trial on behalf of the defendant, and they were:

Hospital Management Committee (1968) 1 AER 1068, it was held that the hospital's casualty officer was negligent in his failure to see and examine the deceased, but even if the deceased was examined, medical evidence showed on the balance of probabilities, that he would still have died; and negligence was not the the cause of death. In the more recent case of *Kay* Vs. *Ayrshire and Arran Health Board (1997) 2 AER 417,* a child who suffered form meningitis was negligently injected thirty times the correct dose of penicillin. Immediately remedial treatment was given when the mistake was realised. The child recovered from the short term toxic effects of the overdose, but was subsequently found to be deaf. In the action brought against the defendant for damages in respect of the deafness, evidence was led on behalf of the defendant to the effect that in no recorded case, had an overdose of penicillin caused deafness, while deafness was a common sequel of meningitis. In appeal to the House of Lords, it was contended on behalf of the child that the overdose had created an increased risk of neurological damage which in fact resulted in deafness. It was further contended on the child's behalf that the defendant was liable on the principle that if the defendant engaged in a conduct which created or increased the risk of injury, and the child was injured, the defendant was then to be taken as having caused the child's injury, even though the existence and extent of the contribution by the defendant's conduct to the child's injury, could not be ascertained. But the House of Lords held that, where two competing causes of damage existed, the law could not presume in favour of the patient that the tortuous cause was responsible for the damage, if it was not first proved that it was an accepted fact that the tortuous cause was capable of causing or aggravating such damage.

In Hotson Vs. *East Berkshire Area Health Authority (1987) 2 AER 909* it was held that the crucial question of fact which the judge had to determine, was whether the cause or the plaintiff 13 year old boy's injury, was his fall or the Health Authority's negligence in making an incorrect diagnosis and delaying treatment, since if the fall had caused the injury the negligence of the authority was irrelevant in regard to the plaintiff's disability. That question was to be decided on the balance of probabilities. Accordingly, since the judge had held that on the balance of probabilities, given the plaintiff's condition when he first arrived at the hospital, even correct diagnosis and treatment would not have prevented the disability from occurring, it followed that the plaintiff had failed on the issue of causation. The issue of quantification considered by the judge therefore never arose, because the question concerning the loss of a chance could not arise where there had been a positive finding that before the duty arose, the damage complained of had already been sustained or had become inevitable.

Learned President's Counsel for the plaintiff submitted that it was sufficient if it was proved that the tortuous act materially contributed to the damage or materially contributed to the risk of damage. He relied on the judgements of *Bonnington Castings Ltd.* Vs. *Wardlaw (1956) 1 AER 615 and Mc Ghee Vs. National Coal Board (1972) 3 AER 1008.* He submitted that although in *Wilsher* Vs. *Essex Health Authority (1988) 1 AER 873* it was held by the House of Lords, that *Mc Ghee* was wrongly decided regarding the shifting of the burden of proof to the defendant, it is still good law subject to the formal requirement that the burden of proof remains with the plaintiff.

If I may advert to the facts of those two cases, in *Bonnington,* the plaintiff workman sued his employer for damages caused by negligence. He worked for 8 years for the employer in the dressing shop of a foundry, producing steel castings and contacted the disease called pneumoconiosis through inhaling silica dust. The main source of this dust was from pneumatic hammers, one of which the plaintiff operated. There was no known protection against dust produced by this source. Part of the offending dust came from operations conducted at swing grinders, as a result of ducts of the dust extraction plant for those grinders not being kept free from obstruction by the employer, as provided for by law. It was held that the proportion of silica dust coming from the latter source and inhaled by the plaintiff, had been shown on the evidence not to have been negligible and had contributed materially for his contacting pneumoconiosis. In *Mc Ghee*, the plaintiff workman was employed by the defendant employer to clean out brick kilns and he contacted the disease known as dermatitis. The plaintiff claimed damages on the ground of negligence on the part of the defendant. Medical evidence disclosed that dermatitis had been caused by the working conditions in the brick kilns as the workman was exposed to clouds of abrasive brick dust. The evidence was that as the employer failed to provide the washing facilities, after work, the workman had to exert himself further by bicycling home, with brick dust adhering to his skin, which added materially to the risk of developing dermatitis. It was held that the defendant was liable in damages as the breach of duty by it materially contributed to the injury, notwithstanding that there were other factors for which the defendant was not liable, which had contributed to the injury. The principle laid down in both *Bonnington* and *Mc Ghee* was that if the defendant's negligence is partly contributory to the injury caused to the plaintiff, that part should materially contribute to the injury or the risk of developing that injury, for the defendant to be liable. That is undoubtedly good law, but the material contribution to the injury or the risk of injury should nevertheless be proved on a balance of probabilities.

condition of the child, but if surgery was contemplated at an earlier point of time surgery may have been done with success?

A. Yes.

Q. If the child was presented to you earlier when she was in a better state and the lesion less, if surgery was done you would have expected her to live for a period of time thereafter?

A. Yes".

Some details of the quality of life the child would have led, like attending school were elicited from Dr. Dias, on the hypothesis of the child being operated on when her condition was better and the lesion was less, and I fail to see the force of the probative value such evidence would carry to establish causation. Again the following question has been asked:

"Q. If the child was presented to you earlier when the lesion was less and the surgery was done the child would have lived for a particular period of time?

A. That is indeed true".

This answer was again following by the quality of life the child would have led, if surgery was done under those imaginary circumstances and conditions. Dr. Dias was rightly not cross examined on those matters, and the evidence if any on causation, rested purely in the realm of conjecture. This is in all probability, why the Court of Appeal observed, 'If treated in time, the medical evidence confirmed that there was a **possibility** of the child living for some more time'.

In view of this unsatisfactory evidence on causation, learned President's Counsel for the appellant submitted, that the defendant's liability for negligence should not be based on a mere possibility as distinct from probability and that allegation has to be established upon a preponderance of probability and not on a mere speculative theory. He is correct in that submission. I hold that the plaintiff has failed to prove on a balance of probabilities, that the negligence of the defendant just prior to 20th May 1992, caused or materially

contributed to the death of Suhani on 19th June 1992, and thereby caused patrimonial loss to him.

Conclusion

For the above reasons, I allow the appeal, set aside the judgement of both Courts below and make order dismissing the plaintiff's action. The defendant will be entitled to taxed costs of the action in all Courts.

Judge of the Supreme Court

I agree.

Bandaranayaka, J.

Judge of the Supreme Court

I agree.

Ismail J.

Judge of the Supreme Court.