**PROF. PRIYANI SOYZA**

**v.**

**RIENZIE ARSECULARATNE**

SUPREME COURT
DHEERARATNE, J.
BANDARANAYAKE, J. AND
ISMAIL, J.
SC. APPEAL NO. 89/99
C.A. APPEAL NO. 173/94 (F)
D.C. COLOMBO NO. 13035/MR
3RD MAY 2000, 21ST, 24TH, 25TH, 26TH, 27TH, 28TH AND 31ST JULY 2000, 1ST, 2ND, AND 3RD AUGUST 2000, 6TH, 7TH, 8TH AND 10TH NOVEMBER 2000.

*Acquilian action - Father's claim for damages on account of death of child - Patrimonial loss - Medical Negligence - Necessity of a nexus between negligence and causation - standard of proof.*

Suhani, the daughter of the plaintiff was four years of age and considered to be a normal healthy child. She attended St. Bridget's Convent and was in Nuwara Eliya in mid April 1992 during the school vacation with the plaintiff - respondent (the plaintiff) and other members of the family where she appeared to be dragging a leg whilst walking; whereupon, Suhani was brought to Colombo. On 18.4.1992 she was committed to the care and treatment under the defendant - appellant (the defendant) a paediatrician who made a provisional diagnosis of her ailment as Rheumatic Chorea (R.C.) Thereafter she was treated at Nawaloka Hospital. The defendant ordered three tests ASOT, ESR and TELECHEST and prescribed valium, penicillin and multi-vitamin tablets. On 23rd April, the plaintiff had Suhani examined by Dr. J.B. Peiris a senior neurologist who confirmed that the symptoms showed some features of chorea but noted that there were some symptoms which did not confirm that view. He also made certain suggestions as to treatment which are not material to this case.

During the entire period Suhani was under the defendant's care, viz until 20.05.1992, the defendant did not maintain a proper record of the illness in the Bed Head Ticket (BHT). Most entries had been made by the house officer in charge. No symptoms discovered by the defendant and no results of her clinical examination of Suhani were reflected in the B.H.T. The defendant also failed to properly consult Dr. J.B. Peiris regarding the patient or the diagnosis of the illness.

On 20.05.1992 the plaintiff caused Suhani's treatment and care taken off from the defendant and given to another senior paediatrician Professor Lamabadusuriya. The same day he noted "clinical features suggestive of rheumatic chorea....." He prescribed epilin a drug in the same class of

valium but stronger. On the 21st night he observed the child asleep and did not disturb her. The parents thought she had improved. On the 22nd Professor Lamabadusuriya wrote "unable to sit, tenden jerks brisk" On the 23rd he wrote "More drowsy today Involuntary movements same..... Continue epilin" On the 24th he wrote "unable to sit up..... tenden jerks..... poor co-ordination" Dosage of epilin was increased. The same day he wrote to Dr. Newton Jayaratne, inter alia, "tenden jerks are very brisk and there is ankle clonus which is unusual for chorea." He, therefore, requested a CT scan to exclude SOL (space occupying lesion). The CT scan was done on the 26th which disclosed "enlargement of the brain stem from the pons down to the medula DIAGNOSIS Brain stem Glioma' (BSG). Thereafter, on the request of Professor, Lamabadusuriya, Dr. Gunasekera Consultant Neurosurgeon advised that the lesion was in the middle of the brain stem and inaccessible for biopsy - no surgery possible. He recommend Stereotactic Radiotherapy" available at Sheffield C/o Dr. Sri Lal Dias.

On 1st June Suhani was taken to U.K. and shown to Dr. Dias but no operation was performed. On 12th June she was brought back and admitted to the Neurosurgical Unit of the General Hospital under the care of Dr. J.B. Peiris. On the 18th she was examined by Dr. R.S. Jayatillake oncologist of the Cancer Hospital, Maharagama who found that BSG covered the entire brain stem from the mid brain to the medulla and inaccessible for surgery. The following day the child died.

The plaintiff instituted action against the defendant claiming damages in 5 lakhs including for loss of care and companionship by Suhani's death on the ground of the defendant's negligence to correctly diagnose Suhani's ailment. However, both the Trial Court and the Court of Appeal answered in the affirmative the following issues raised by the defendant :

24(a) was the said child found to be suffering from a rapidly progressive extremely malignant (cancerous) incurable tumour of the brain stem in an inaccessible site as pleaded in para 2 13(g) of the answer ?

(c) was the death of the child necessarily a part of the nature of the disease which was never preventable at any stage with an inevitable fatal outcome ?

That view was also supported by recognized medical writings on BSG.

Until 20th May when Prof. Lamabadusuriya commenced investigations, medical evidence regarding symptoms and signs in Suhani was indicative of both R.C. and B.S.G.

According to settled principles of medical negligence, a deterioration in the patient's condition is probably the most important indication to do a scan and it would be negligent not to investigate a patient who is getting worse.

**Held :**

(1) Lex Acquilia permits the grant of patrimonial damage. If loss of care and companionship as such should attract compensation it is for the legislature to make necessary provision, particularly in view of the 1799 proclamation which permitted the administration of justice according to Roman Dutch Law subject to deviations and alterations to be made by certain authorities. That proclamation did not authorize deviations and alterations to be made by the Courts of Law.

*Per* Dheeraratne, J

"I think we are not entitled, as Judges, to change the material of the Roman Dutch Law, but are only permitted to iron out its creases, whenever the necessity arises. Effecting structural alterations to the common law should be the exclusive preserve of the Legislature....."

(2) 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. The ultimate question is whether the defendant's conduct 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.

(3) The defendant was remis in failing to record in the BHT any symptons discovered by her and the results of her clinical examination of Suhani. But it has not been established by a balance of probability that this remissness had a nexus with the non diagnosis of the malady. The defendant also failed to properly consult, Dr. J.B. Peiris. However, had she done so there was only a possibility as opposed to a probability in Dr. Peiris ordering a C.T. scan to be taken at that time.

(4) The defendant was negligent just prior to 20th May, 1992, in failing to order a CT scan which would have disclosed BSG. However, the plaintiff failed to prove on a balance of probabilities, that such negligence of the defendant caused or materially contrbuted to the death of Suhani on 19th June, 1992, and thereby caused patrimonial loss to him.

**Cases referred to :**

(1) *Mendis v. Dublin de Silva* (1990)2 Sri L.R. 249.

(2) *Innes v. Visser* 1936 WLD 44 at 45.

(3) *N v. T* 1994(1) S.A. 862.

(4) *Clinton - Parker Administrator, Transvasal Dawkings v. Administrator, Transval* 1996(2) SA 37.

(5) *Bester v. Commercial Union Versekeringmaatskappy Van S A BPK* 1973 (1) S A 769.

(6) *Gibson v. Berkowitz and Another* 1996 (4) S A 1029.

(7) *Alcock and Others v. Chief Constable of the Yorkshire Police* 1991 (4) ALL E.R. 907.

(8) *Gafoor v. Wilson and Another* (1990) 1 Sri L.R. 143.

(9) *Union Government (Minister of Railways and Harbours) v. Warneke* (1911) SALR 657.

(10) *Pauw v. African Guarantee and Indemnity Co. Ltd.* 1950 (2) SA (SWA) 132.

(11) *De Costa v. Bank of Ceylon* (1969) 72 NLR 457 at 461.

(12) *Kodeeswaran v. The Attorney-General* (1969) 72 NLR 337.

(13) *Chissel v. Chapman* (1954) 56 NLR 121 at 127.

(14) *Wilsher v. Essex Area Health Authority* (1986) 3 ALL E.R. 801; (1987) Q.B. 730.

(15) *Cassidy v. Ministry of Health* (1951) 2 K.B. 348 at 359.

(16) *Hall v. Brooklands Auto Racing Club* (1933) 1 K.B. 205.

(17) *Glasgow Corporation v. Muir* (1943) AC 488 (HL) at 457.

(18) S v. Burger 1975 (4) 877 (A).

(19) *Bolam v. Friern Hospital Management Committee* (1957) 2 ALL E.R. 118.

(20) *Maynard v. West Midlands Regional Health Authority* (1985) 1 ALL E.R. 635.

(21) *Sidaway v. Bethlem Royal Hospital Governor and Others* (1985) 1 ALL E.R. 643.

(22) *Administratrix of the estate of Bolitho-deceased v. City and Hackney Health Authority* (1997) 4 ALL E.R. 771.

(23) *Rogers v. Whitaker* (1992) 67 ALJR 47.

(24) *Van Wyk v. Lewis* 1924 A D 438 at 447.

(25) *F v. R* (1983) 33 SASR 189 at 194.

(26) *Whitehouse v. Jordan and Another* (1981) 1 ALL E.R. 267.

(27) *Fish v. Kapur* (1948) 2 ALL E.R. 176.

(28) *Barnett v. Chelsea of Kensington Hospital Management Committee* (1968) 1 ALL E.R. 1068.

(29) *Kay v. Ayrshire and Arran Health Board* (1987) 2 ALL E.R. 417.

(30) *Hoston v. East Birkshire Area Health Authority* (1987) 2 ALL E.R. 907.

(31) *Bonnington Castings Ltd v. Wardlaw* (1956) 1 ALL E.R. 615.

(32) *Mc Ghee v. National Coal Board* (1972) 3 ALL E.R. 1008.

(33) *Wilsher v. Essex Health Authority* (1988) ALL E.R. 873.

**APPEAL** from the judgement of the Court of Appeal.

H.L. de Silva, P.C., R.W. Goonesekera, S.C. Crossette Thambiah, Hugo Antony and A. Aturupana for defendant-appellant.

Romesh de Silva, P.C., Palitha Kumarasinghe, Harsha Amarasekera and Sugath Caldera for plaintiff-respondent.

*Cur. adv. vult.*

December 11, 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 aranged Dr. D.R. Karunarathne, 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 Gunesekara, consultant neurosurgeon, seeking his surgical opinion about futher management of the malady. Dr. Gunesekara 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 Deparment 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 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 a 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 of 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 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*[1]. 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 a 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. Wickramanayake, 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). Mc Kerron, 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 event of his succeeding in the action, I must remind myself of the words of Greenberg J. in the case of *Innes Vs. Visser*[2] said

of course in a different context, that "The figure 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*[3] *Clinton - Parker Vs. Administrator, Transvaal & Dawkins Vs. Administrator Transvaal*[4] *Bester Vs. Commercial Union Versekeringmaatskappy Van SA·BPK*[5] *Gibson Vs. Berkowitz* and *another*[6] and *Alcock and Others Vs. Chief Constable of the Yorkshire Police*[7].

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*[8] 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 companionship of the deceased child. He submitted 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 an 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 consisered in the case of *Union Government (Minister of Railways and Harbours) V. Warneke*[9] 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 recognised by the law of Holland. As pointed out by Professor de Villiers (Injuries, p. 182), the compensation recoverable under the *Lex Aquilia* 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 emphasised 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 recognised 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 on 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*[10].

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 the Common Law of the Island the Roman Dutch 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*[11] 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 authorise *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 Presient'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*[12] 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. G.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 Fenando CJ in *De Costa's* case (Supra) which have been reached after a careful analysis of the *complete* provisions of the 1799 Proclamation.

Much earlier Gratiaen J. in *Chissel Vs. Chapman*[13] was constrained to remark as follows:- "But those who administer the Roman Dutch Law cannot disregard its basic principles although (on 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 the Roman Dutch Law, but are only permitted to iron out 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 attract compensation. The legislature should take such a policy decision and lay down guideliness on which courts should calculate and assess the quantum of compensation. Those guidelines should indicate, for example, in the case of a death of a child attributable to a tortious 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*[14]. 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*[15] 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 objective; in so far 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 objective; in so far as the standard takes account of the circumstances in which the actor found himself, it is subjective." (Boberg Vol. 1 269).

The fictional paragon called the reasonable man, was invented by the Roman Law as well as by the English Common Law, to suit the requirements of the society. He appears so real in the life of the law, perhaps just like his better known fictional counterparts - I am Fleming's flamboyant James Bond or Sir Arthur Conan Doyle's discerning Sherlock Holmes. English judges described him as "the ordinary man", "the average man" or "the man on Clapham ominibus." See *Hall Vs. Brooklands Auto Racing Club*[16].

The attributes of the notional reasonable man have been the subject of many interesting and vivid judicial descriptions. Lord Mc Millan in *Glasgow Corporation Vs. Muir*[17] at 457, said he treads the middle path being "free from over - apprehension and from over - confidence." Holmes JA in S *Vs. Burger at 897* said of him "One does not expect of a *diligens paterfamilias* any extremes such as Solomonic wisdom, prophetic foresight, chamelionic caution, headlong haste, nervous timidity, or the trained reflexes of a racing driver. In short, a *diligens paterfamilias* treads life's pathway with moderation and prudent commonsense." (I may digress her to add that, while in the eyes of the civil law, the reasonable man is a paragon, in the eyes of the criminal law, he is a potential criminal, being prone to grave and sudden provocation - See Justice E.F.N. Gratiean, KC. The reasonable Man, Law College Review 1950 Vol. XI).

Whenever a person engages himself voluntarily in rendering professional services requiring a special skill, knowledge, or capacity for its proper performance, he is required to manifest a reasonable degree of such skill, knowledge, or capacity. When the conduct of a skilled professional is in question, naturally, the standard of an ordinary reasonable man would be ill-equipped and unsuited to judge his competence; thus the notional reasonable man is substituted with the notional reasonable skilled professional. This is not an exception to the general principle in Roman Dutch Law, but is merely an application of it; for the reasonable prudent man will not

voluntarily undertake to perform a task for which he has not the requisite knowledge, skill or capacity. The required standard will be that which, having regard to the general level of skill in the profession or class which offers the service, may reasonably be expected. Culpability or blameworthiness will depend on either the want of skill on the part of the professional or a deficient or ineffective exercise of that skill on his part. This is where the standard and 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*[19]. 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 possess 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 body of medical men skilled in that particular 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. West Midlands Regional Health Authority*[20] (decided in May 1983) the House of Lords having considered the Bolam test, held that it had to be recognised 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*[21] (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 Bolitho - deceased) Vs. City and Hackney Health Authority*[22]. 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 capable 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. Whittaker*[23] the High Court held, at least in relation to cases of non-disclosure of medical risks, the Bolam test should no longer be applied. The 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 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.*

*Trindade {1993} 109 Law Quarterly Review, where a suggestion is made for the abandonment 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 Wyk Vs. Lewis*[24] 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*[25] 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 as 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. Jayathillaka, 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 19.6.1992, 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 5.10.1992 to the inquiring officer of the Ministry of Health, in response to a petition sent by the plaintiff to His Excellency the President, as well as in her answer dated 15.1.1993, 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 ?

(A) *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 that 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 objecively, 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 5.10.1992, 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 observasions 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 Soyza - 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 Skull - 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 abnormility'*. 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 skull 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.

(B) *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 absense of definite focal signs a normal CT scan may occur in the early stages of the lesion and therefore follow - up is important. (Bouchez, Assaker, 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, nonpatterned 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, dysarthia, and an awkward gait may occur. The exact site of disfunction within the extrapyramidal 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 choreiform 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 Lamababusuriya 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*[26] for the benefit of both the Medical and Legal professions. Lord Wilberforce said at 276 "While some degree of consultation between experts and legal advisers 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 Knee jerks (2) Ankle clonus (3) Choreiform movements which includes inability to use arms and (4) slurred speech. As regards brisk knee jerks, both Dr. Pieris 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 Text book of Medicine again shows 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 hereself 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 in 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. Karunaratne 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 18.4.92." 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 Epilin was increased. On the same day Professor Lamabadusuriya wrote to Dr. Newton Jayaratne, consultant radiologist to 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. Gunasekera 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 Lamabadusuriya, 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. Gunasekera. 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 Paediatrics (1999) on Oncology gives the following description at page 601;-

"**Tumor/Site** - Brain stem glioma

**Manifestations** - Onset between 5 and 7 yr of age; triad of multiple cranial nerve deficit (vii, ix, x, v, vi) pyramidal tract,

and cerebellar signs; skip lesions common; Increased Intracranial 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:-

24. (a) Was the said child found to be suffering from a rapidly progressive extremely malignant (cancerous) incurable tumour of the brain stem in an inaccessible site as pleaded in para 2 13(g) of the answer?

(b) Was the death of the child necessarily a part of the nature of the disease which was never preventable at any stage and with an inevitable fatal outcome?

(c) If either (a) or (b) is answered in the defendant's favour can the plaintiff maintain this action against the defendant?

Both Courts below answered the above mentioned issues 24(a) and (b) in the affirmative in favour of the defendant, and

proceeded to answer the consequential issue 24(c) also in the affirmative, but in favour of the plaintiff. Strangely, the Court of Appeal, having answered the issue 24(b) in the affirmative (to the effect that the death of the child was a necessarily a part of the nature of the disease which was never preventable at any stage and with an inevitable fatal outcome) went on to add contradicting that position - "With proper diagnosis and treatment it could have been prevented or postponed".

In respect of causation, I shall set out in full at this stage, all what the Court of Appeal was pleased to express before answering the three issues in the manner mentioned above. " The damages claimed in an action would be in relation to the effect brought about by the act or omission of the defendant and will have a direct relationship to the cause. In this instance the negligence of the defendant which was caused by the non-diagnosis of a brain stem glioma in the child Suhani around 18. 04. 1992 and most probably the wrong diagnosis of rheumatic chorea, both resulted in the child not being treated in time for the brain stem glioma. If treated in the time the medical evidence confirmed that there was a possibility of the child living for some more time. The early death of the child on 19. 06. 92 therefore was a direct result of the non-diagnosis of the defendant. The death of the child therefore could be attributed to the negligence of the defendant. Thus negligence of the defendant was the cause and the death of the child was the result".

I shall now refer to a few decided cases that illustrate the principle of causation. In the case of *Fish Vs. Kapur*[27], it was held that there was no loss which flowed from the defendant dentist's failure to diagnose a broken jaw, because even if he diagnosed it, there was no treatment which could have been given. There was no proof of any damage following on the failure to diagnose. In *Barnett Vs. Chelsea & Kensington Hospital Management Committee*[28], 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 cause of death. In the more recent case of *Kay Vs. Ayrshire and Arran Health Board* [29] a child who suffered from 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 sequela 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 tortious cause was responsible for the damage, if it was not first proved that it was an accepted fact that the tortious cause was capable of causing or aggravating such damage.

In *Hotson Vs. East Berkshire Area Health Authority* [30], it was held that the crucial question of fact which the judge had to determine, was whether the cause of 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 authority was irrelevant in regard to the plaintiff's disability. That question was to be decided on the balance of probablities. 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 tortious 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*[31] and *Mc Ghee Vs. National Coal Board*[32]. He submitted that although in *Wilsher Vs. Essex Health Authority*[33], 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*,(supra) the plaintiff workman sued his employer for damages caused by negligence. He worked for eight years for the employer in the dressing shop of a foundry, producing steel castings and contacted the disease called pneumoconisis 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 pneumoconisis. 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.

It appears to me that neither the original Court nor the Court of Appeal gave adequate consideration to the question of causation. In any event, the Court of Appeal was clearly in error when it concluded that the defendant was negligent in non-diagnosis of the BSG around 18th April. I have already given my reasons for holding that the defendant was not negligent in her initial non-diagnosis of the BSG. The negligence of the defendant in not ordering the CT scan which would have led to the diagnosis of BSG, in all probability occurred just prior to the 20th of May, when the choreiform movements, brisk knee jerks and ankle clonus simultaneously manifested themselves. Neither Court could have fallen to this error, if as observed by me earlier, a proper evaluation of the evidence was made, as to what symptoms of the malady manifested and when they did manifest.

On the question of causation, the plaintiff relied on the testimony of Dr. Sri Lal Dias, neurosurgeon, the important parts

of whose evidence on this crucial issue, I shall quote verbatim. It must be borne in mind that he examined Suhani after the diagnosis of the BSG was made and therefore at the time he gave evidence he had sufficient hindsight. Before I deal with the evidence of Dr. Dias, I must refer to what the plaintiff chose to set out in his Annex A sent along with his letter dated 17. 08. 1992 to His Excellency, purpoting to be the view of Dr. Dias. "any form of interventional therapy either surgery or radio therapy (conventional or stereotactic) has limited scope in any definitive treatment of the lesion, as the possible benefits would be marginal and unlikely to provide any improvement of quality of life".

In examination-in-chief Dr. Dias testified as follows:-

"Q. Why was surgery not done at that time?

A. At the time the child was presented to me disability mostly in terms of physical disability would certainly not have improved. Even if surgery had been successful at that stage, she was extremely depressed and any attempt at surgery would not have been an improvement at that time to the patient and in view of that it was decided after discussion that any attempt of surgery would not be carried out.

Q. You decided that surgery should not be carried out at that time, because even if surgery was successful there would not have been much improvement in the 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 this child was presented to you at an earlier time when her condition was better and the lesion less could surgery have been performed with a lesser risk of 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 followed 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 judgements 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.

**BANDARANAYAKA, J.** - I agree.

**ISMAIL, J.** - I agree.

*Appeal allowed.*