In The Supreme Court of Bermuda

CIVIL JURISDICTION

2005: 217

RAYNOL SHANE TODD

Plaintiff

V

DR. ANNAMALIE PANAGAL CHELVAM

Defendant

JUDGMENT

(in Court)[1]

Medical negligence-delayed diagnosis-breach of duty-proof of damage

Date of hearing: November 15, 2016
Date of Judgment: December 2, 2016

Mr. Bruce Swan, Apex Law Limited, for the Plaintiff
Mr David Kessaram and Ms Akilah Beckles, Cox Hallett Wilkinson Limited, for the Defendant

Introductory

1. The present judgment follows a trial for the liability limb of a medical negligence claim in which borderline negligence was effectively admitted at trial but damage was disputed.

2. The Plaintiff was legally aided and did not receive funding for his medical expert to attend to give oral evidence at trial; however the relevant expert report was read into

[1] The present Judgment was handed down without a hearing.

evidence instead. The Defendant's spinal injuries expert Mr Peter Dyson gave oral evidence.

The Plaintiff's pleaded case and the governing legal principles

3. The crucial averment which was relied upon at trial was the following plea:

> "*17.3 The First Defendant was negligent in failing to order and/or request imaging (whether x-ray or MRI or otherwise) of the Plaintiff's cervical spine in or about June or July 2003 or any later date, which imaging would have revealed the herniated disc at the C6/C7 level.*"

4. An additional complaint that unnecessary knee surgery was carried out was not pursued. The main item of physical damage complained of was pleaded under the Plaintiff's Particulars of Damage as follows:

> "*18.1 The Plaintiff has suffered paraplegia and/or near paraplegia from in or about June 2003 through November 2003…*
>
> *18.3 The Plaintiff has suffered pain and continues to suffer pain…*"

5. In his Defence, paragraph 17.3 was denied and paragraph 18 was not admitted.

6. The governing general legal principles on liability were not in dispute. However, it is helpful to remember what they are. The Plaintiff must prove (1) the existence of a duty of care, (2) breach of the duty of care, and (3) resultant loss or damage. In *Hotson-v-East Berkshire Health Authority* [1986] EWCA Civ J1114-3, where the legal and factual matrix was broadly similar to that in the present case, Sir John Donaldson (MR) stated:

> "*The answer I think lies in examining precisely what the plaintiff has to allege and prove. First, he has to prove a duty. This is no problem in this case, since it is admitted. But for that admission, it would have been necessary to establish the duty, the necessary factual basis being proved on the balance of probabilities. I say that because there is no room in either justice or law for holding a defendant liable on the basis that he <u>may</u> have been subject to a duty. Either he was or he was not. Second, the plaintiff has to prove a breach of that duty. Here again there is no problem, since the failure to treat the plaintiff properly on the occasion of his first visit to the hospital admittedly constituted a breach of that duty. But if this breach had had to be established, any necessary facts would have had to have been proved on the balance of probabilities. Again I say this because there is no room in justice or law for*

holding a defendant liable on the basis that there is a significant possibility, not amounting to a probability, that he was in breach of his duty. Third, in the case of tort but not of contract, the plaintiff has to prove some loss or damage and must do so on the balance of probabilities. It is this third requirement which requires further analysis. Hereafter, for simplicity, I will refer to 'loss or damage' simply as 'loss'.

Factual findings-breach of duty

7. There was ultimately no material dispute between the Plaintiff and the Defendant as to what symptoms were apparent to Defendant when he saw the Plaintiff initially in July 2003. He was referred by Dr Burton Butterfield in respect of a knee problem indicated by X-ray reports in June 2003 and was first seen by the Defendant on July 1, 2003 when he was walking with a cane. The Plaintiff reported to the Defendant weakness in the limbs which the Plaintiff attributed to a fractured skull sustained 20 years previously. Because of this the Defendant as a precaution ordered a CT scan of the patient's head which was received on July 3, 2003 and was unremarkable. Arthroscopic surgery was carried out on the right knee on July 7, 2003. The Defendant saw the Plaintiff at the Fracture Clinic on July 17, 2003. He was still walking with a cane and made no complaints about numbness to his legs. The Plaintiff was last seen by the Defendant on July 29, 2003.

8. According to the Defendant's Witness Statement which was supported by his notes:

> "*13. On or about the 29th July 2003, Mr Todd attended my office complaining of a recent onset of numbness in both feet…With respect to his complaint of numbness, I noticed that his gait appeared a bit spastic…*
>
> *14. In order to assist in the diagnosis I ordered an MRI of his lumbar spine. I did not order a full spinal MRI at this time because there were no clinical findings to suggest that there was compression in the upper spine. Mr Todd did not state that he was suffering from pins and needles in his arms and he was still walking, albeit with the assistance of a cane. His motor power of Grade 4 T was normal for Mr Todd.*"

9. I find that the Plaintiff first complained of any symptoms capable of indicating an upper spine problem on July 29, 2003. I accept that the Defendant did not recognise the spastic gait as indicative of such problems because in the vast majority of cases such an injury would manifest itself in the upper limbs as well. Mr Dyson (the Defendant's own expert) testified, and I accept, that Dr Chelvam might never come across more than one patient in his career who had an upper spine problem without

complaining of upper body pain or discomfort. Mr Dyson himself has only come across possibly three similar cases. He has been a consultant orthopaedic surgeon for over 30 years. For the last 20 years he has been a Consultant Spinal Orthopaedic Surgeon with the West Hertfordshire NHS Trust. Mr Dyson's crucial conclusion was as follows:

> "*2.1 From the evidence available, I consider that Dr Chelvam should have either organised an MRI scan of the whole spine, or sought a neurological opinion, following his assessment on 29th July 2003. At that time he noted that the patient had a spastic gait and it was therefore not logical to do an MRI scan of the lumbar spine in isolation.*"

10. Dr Winer, the Plaintiff's Arizona-based expert (an Orthopedic Surgeon for 40 years), agreed with this view through his Report. His additional findings that earlier negligence occurred are not sustainable because they are clearly based on an assumption that the Plaintiff reported symptoms before July 29, 2003 which I find were not in fact reported to the Defendant.

11. Accordingly I am bound to find that the Plaintiff has proven on a balance of probabilities that the Defendant breached his admitted duty of care on July 29, 2003 by failing to order a cervical MRI for the Plaintiff.

Factual findings-damage

<u>Primary findings</u>

12. It is far easier to determine what actually happened than it is to determine what might have happened had the breach of duty not occurred. However, the key events in the narrative were as follows:

- the lumbar spine MRI was requisitioned on July 29, 2003 and an appointment was scheduled for August 21, 2003 at 10.00am according to a manuscript note on the typed requisition form;

- the MRI Report was obtained on or about August 21, 2003 and showed "*no disc herniation*" ("the 1st MRI");

- on or about September 19, 2003 the Defendant, having spoken to the Plaintiff by telephone and learnt of worsening symptoms, faxed an urgent referral letter to Dr Cros, the Boston-based Consultant Neurologist who periodically visited Bermuda, stating that the Plaintiff "*seems to be getting progressive*

spastic paresis of both lower limbs with numbness of his feet…his progressive spastic paresis of his legs are very recent an MRI of lumbar spine is also not significant". He also completed a Department of Financial Assistance form on the Plaintiff's behalf;

- the Defendant was examined by Dr Cros on September 29, 2003. As a result the Defendant prepared that evening an overseas referral form to enable the Plaintiff to travel to Boston;

- a second MRI Report was obtained on September 30, 2003 ("the 2nd MRI"). There is no available requisition and despite the Defendant's conviction that he requisitioned the 2nd MRI on or about September 19, 2003, it seems possible that this was only ordered by Dr Cros on September 29, 2003;

- the 2nd MRI revealed "*LARGE DISC EXTRUSION AT C6-7 CAUSING SEVERE CORD COMPRESSION*";

- on October 16, 2003, the Plaintiff was admitted to the King Edward VII Memorial Hospital ("KEMH") with worsened weakening of his legs. He remained at KEMH pending overseas transfer until on or about November 7, 2003. This was because he was on the United States Stop List and no alternative available Canadian Hospital could be found. He accordingly was flown to the UK;

- on admission to The London Clinic on or about November 13, 2003, the Plaintiff was almost completely paralysed. He "*had just a flicker of movement in the toes of both feet….MRI scans…indicated severe compression at the C6/7 level with a massive disc disruption and with marked signal change within the very compressed spinal cord*" (Mr John O'Brien, November 24, 2003 letter report). Surgery was carried out the next day and the damaged disc and bone were removed and replaced by a bone graft;

- Mr Afshar by letter dated April 11, 2005 described the Plaintiff's recorded post-operative history as follows. Within days of surgery the Plaintiff was able to walk with a walker and when he returned to London in May 2004 he could walk for 400 metres using two sticks: "*He had grade four power in the lower extremities but remained spastic*…";

- the Plaintiff had a second operation in 2006 "*for C3 through C7 decompression*" (Dr Winer). There is no credible evidence that this was caused by the first operation;

- it is unclear precisely why it took from September 30, 2003 until November 13, 2003 (six weeks) to get the Plaintiff to London. However, he was uninsured and unable to travel to the US or Canada and flying him to the UK was an unusual procedure. It is in any event clear that his condition declined most dramatically between October 16, 2003 and November 13, 2003.

Conclusory findings

13. Various scenarios were explored in cross-examination and in argument with a view to elucidating what would likely have happened but for the breach of duty which occurred. The two most straightforward elements of an alternative hypothetical scenario are the following:

    - the Defendant requisitioned a full MRI on July 29, 2003 and scheduled it for August 21, 2003;

    - on or about August 21, 2003, the Defendant learned that the Plaintiff had an upper spinal compression problem and needed to be referred to Dr Cros. Mr Dyson himself positively opined that an "*MRI scan of the cervical spine…at this time* [i.e. July 29, 2003] *would have revealed a hernia at the C6/7 disc*."

14. What is more difficult to assess is how events would have unfolded after that point. Important considerations are firstly that the Plaintiff in actuality did not complain of worsening symptoms to the Defendant till on or about September 19, 2003. That prompted him in fact to line up the Plaintiff for a consultation when Dr Cros next visited Bermuda in late September. Mr Dyson did not consider it was obvious that if 2nd MRI had been obtained in late August, plans for overseas surgery would immediately have been put in train. He felt some consultation would have first occurred. I accept that judgment from an expert who has opined, contrary to the Defendant's pleaded case, that a breach of duty did in fact occur On the other hand, it is clear that even before the 2nd MRI had been obtained on September 30, 2003, Dr Cros had already counselled overseas testing and formed the provisional view that spinal compression was possible. The Defendant testified as much: on the evening of September 29, 2003 after speaking to Dr Cros, he took the first steps towards arranging an overseas referral. The Plaintiff had, after all, deteriorated from using a cane on July 29, 2003 to using crutches on September 29, 2003. And it is clear that the Defendant himself was aware of the need for overseas consultation as early as September 19, 2003 without the 2nd MRI.

15. So has the Plaintiff proved that it is more likely than not that if the Defendant had received the 2nd MRI report before the Plaintiff's symptoms worsened in mid-September that the overseas surgery train would have left the station earlier than it actually did? In my judgment it is important to avoid crossing the line between drawing inferences from the proven facts and engaging in pure speculation. I am bound to find nevertheless that but for the breach of duty the Defendant would have obtained a clear diagnosis of spinal compression by August 21, 2003 at the earliest. In my judgment there is no sufficiently clear basis for the further conclusion that a decision to send the Plaintiff overseas for surgery would have been made in the absence of any medical signs that the Plaintiff's position was worsening. On balance, I find that it is improbable that a positive decision for overseas treatment would in any event have been made before on or about September 19, 2003 at the earliest. The operative delay of which the Plaintiff can complain is no more than 10 days. If one assumes that the time lag between deciding on overseas treatment and the surgery taking place (six weeks) were pushed back by 10 days, the surgery would have taken place on November 4, 2003 rather than on November 14 when it actually occurred. What loss can the Plaintiff prove flows from this delay?

16. Mr Dyson accepted that in general terms the best outcomes are achieved by operating sooner rather than later. Dr Winer only positively opined that "*surgery at least two months earlier would have had the prognosis of 80%-90% improvement in his condition at the time of his surgery vs. the limited improvement he had as a result of surgery done in November.*" Putting aside Mr Dyson's criticism of that opinion and its percentage comparisons on the grounds that they are unintelligible without further elaboration, it seems self-evident that if the surgery had been carried out on September 14 rather than November 14, the Plaintiff's starting point would have been significantly higher than it was when surgery was actually performed. However, I am unable to find that but for the breach of duty the operation would have occurred two months earlier. Dr Winer's opinion was based on a timeline which was itself based on reports made by the Plaintiff to his UK doctors about his medical history which were quite different to what he admitted at trial he told the Defendant.

17. In the event, there is no direct and credible expert evidence before the Court supportive of the conclusion that the delay had a material impact on the outcome from the surgery which actually took place. This flows from two evidential considerations. Firstly, I am unable to find, the burden of proof resting on the Plaintiff, that the surgery probably would have taken place before the most dramatic decline in the Plaintiff's condition which took place after his admission to KEMH in mid-October 2003 and before his arrival at the London Clinic on November 13, 2003. There is no clear evidence of precisely when this decline actually occurred. Did it occur before or after November 4, 2003? This is the notional date I have selected as to when the surgery would likely have been performed had the cervical MRI been requisitioned on July 29, 2003 with the results obtained on August 21, 2003 when the 1st MRI was actually obtained.

18. Mr Dyson in any event positively opined that the medical records suggested to him that the Plaintiff actually recovered more or less to his baseline position prior to the breach of duty (July 29, 2003) by May 2004. He also disagreed with Dr Winer's opinion that the delay in diagnosis exposed the Plaintiff to "*a significantly greater neurologic impairment with greater risk of chronic edema and deep vein thrombosis*". No credible expert evidence was adduced on the Plaintiff's behalf explicitly addressing how the Plaintiff's post-operative state differed from either:

    (a) the Plaintiff's condition before the Defendant's breach of duty, whenever that was; and/or

    (b) what level of recovery might have been achieved had the operation taken place earlier.

19. This evidential gap is understandable because it is very difficult to measure, bearing in mind that a second apparently unrelated back operation was performed and the Plaintiff's condition after 2004 appeared worse to Mr Dyson than in the year immediately following the first operation. Mr Dyson was not qualified to opine on whether the Plaintiff was placed at an increased risk of vascular problems by the delayed first operation as that was a medical topic beyond the scope of his expertise. I am unable to accept Dr Winer's written opinion, untested by cross-examination, that the Plaintiff would have had a 80-90% prospect of recovery had the surgery been performed earlier, both because it is difficult to understand and was also based on the hypothesis of a far longer delay than I find occurred. Mr Dyson opined:

    "*I confirm that I believe that if it was possible to measure the difference in function between the date of Breach and the date of full recovery, that this difference would probably not have been measurably changed by a 7 week delay in diagnosis consequent to the Breach.*"

20. This opinion cannot be accepted uncritically, however. At the liability stage, the Court is not concerned with measurement of loss but with the broader question of whether any loss occurred as a result of the delay. It being common ground that in general terms delay adversely impacts on recovery prospects, the crucial questions which arise for determination are the following:

    (a) did the delay probably cause the Plaintiff any loss or damage, such as pain and suffering, demonstrable loss of recovery prospects apart?

(b) did the delay cause the Plaintiff some harm in terms of loss of the chance of better recovery prospects, even though it is impossible or difficult to measure any actual loss?

21. In my judgment it is self-evident that the Plaintiff suffered some additional pain and suffering which was materially contributed to by the delayed diagnosis even on the assumption that this delay was only 10 days. This was not explicitly addressed by the Plaintiff in evidence as he did not prepare a witness statement. However, judicial notice can be taken of the fact that the protraction of a worsening condition of paralysis in the legs while awaiting surgical intervention causes a claimant pain and suffering to a legally cognizable extent. Delays measured by hours causing more complicated injuries are legally actionable. As the Judicial Committee of the Privy Council held in *Williams-v-Bermuda Hospitals Board* [2016] UKPC 4 (per Lord Toulson), by way of illustration:

> "*41. In the present case the judge found that injury to the heart and lungs was caused by a single known agent, sepsis from the ruptured appendix. The sepsis developed incrementally over a period of approximately six hours, progressively causing myocardial ischaemia. (The greater the accumulation of sepsis, the greater the oxygen requirement.) The sepsis was not divided into separate components causing separate damage to the heart and lungs. Its development and effect on the heart and lungs was a single continuous process, during which the sufficiency of the supply of oxygen to the heart steadily reduced.*
>
> *42. On the trial judge's findings, that process continued for a minimum period of two hours 20 minutes longer than it should have done. In the judgment of the Board, it is right to infer on the balance of probabilities that the hospital board's negligence materially contributed to the process, and therefore materially contributed to the injury to the heart and lungs.*"

22. In the present case it was common ground that the Plaintiff's condition gradually worsened after July 29, 2003, prompting him to report (via telephone) changing symptoms to the Defendant in mid-September and to admit himself to KEMH in mid-October. Having found that surgery was delayed by 10 days by reason of the Defendant's negligence, and the present phase dealing only with the question of whether any damage has been sustained as a result, not how much, I find that the Plaintiff has proved actionable damage through his broad plea of pain and suffering. The clearly modest claim need not be particularised until the quantum stage. Judicial examples of such findings exist. For example, in *Medway Primary Care Trust-v-Marcus* [2011] EWCA Civ 750 (at paragraph 8):

> "*as an afterthought, the claimant's counsel claimed modest damage for the additional time during which the respondent had suffered pain by reason of the ischaemia and before the amputation. There was a pleaded general unspecific claim for pain and suffering. The deputy judge ruled that this covered this small claim, and there is no appeal against that ruling.*"

23. I afforded Mr Kessaram an opportunity to respond to this issue and the supporting authority which were not referred to at trial. On December 1, 2016 he filed 'The Defendant's Supplementary Submissions' which did not oppose my proposed finding that a pain and suffering award was appropriate and concluded with the following assertions which broadly support rather than undermine my cautious approach to the evidence on this issue:

> "*11…The Defendant accepts that damages for reasonably foreseeable pain and suffering caused by the breach of the Defendant's duty of care are claimable; but asserts that in the assessment of such damages the application of the legal test of causation does not lead to the conclusion that this covers the whole period between the breach and the successful treatment.*"

24. The legal principles governing loss of an opportunity for an enhanced recovery are complex and have been controversial and were not addressed in argument. Both parties were content to deal with factual considerations alone. While ultimately this aspect of the Plaintiff's claim turns on the facts, I find it helpful to identify the legal lens through which the evidence must be viewed. Lord Nicholls in *Gregg-v- Scott* [2005]UKHL 2 opined as follows:

> "*44. The way ahead must surely be to recognise that where a patient is suffering from illness or injury and his prospects of recovery are attended with a significant degree of medical uncertainty, and he suffers a significant diminution of his prospects of recovery by reason of medical negligence whether of diagnosis or treatment, that diminution constitutes actionable damage. This is so whether the patient's prospects immediately before the negligence exceeded or fell short of 50%. 'Medical uncertainty' is uncertainty inherent in the patient's condition, uncertainty which medical opinion cannot resolve. This is to be contrasted with uncertainties arising solely from differences of view expressed by witnesses. Evidential uncertainties of this character should be resolved in the usual way.*"

25. This view, which would have suggested a liberal approach to the evidence in favour of the Plaintiff, was rejected by the majority of the House of Lords. However, Lord Hoffman, with whom the majority agreed, opined as follows:

"*89. In Fairchild's case [2003] 1 AC 32, 68, Lord Nicholls of Birkenhead said of new departures in the law:*

> *'To be acceptable the law must be coherent. It must be principled. The basis on which one case, or one type of case, is distinguished from another should be transparent and capable of identification. When a decision departs from principles normally applied, the basis for doing so must be rational and justifiable if the decision is to avoid the reproach that hard cases make bad law."*

90.I respectfully agree. And in my opinion, the various control mechanisms proposed to confine liability for loss of a chance within artificial limits do not pass this test. But a wholesale adoption of possible rather than probable causation as the criterion of liability would be so radical a change in our law as to amount to a legislative act. It would have enormous consequences for insurance companies and the National Health Service. In company with my noble and learned friends Lord Phillips of Worth Matravers and Baroness Hale of Richmond, I think that any such change should be left to Parliament.

26. The Privy Council in *Williams* cited with approval a related part of Lord Hoffman's speech. And Lord Toulson's judgment concluded with the following cautionary words about assessing risks in the context of causation in the medical negligence field:

"*48. Finally, reference was made during the argument to the "doubling of risk" test which has sometimes been used or advocated as a tool used in deciding questions of causation. The Board would counsel caution in its use. As Baroness Hale of Richmond said in Sienkiewicz at para 170, evaluation of risk can be important in making choices about future action. This is particularly so in the medical field, where a practitioner will owe a duty to the patient to see that the patient is properly informed about the potential risks of different forms of treatment (or non-treatment). Use of such evidence, for example epidemiological evidence, to determine questions of past fact is rather different. That is not to deny that it may sometimes be very helpful. If it is a known fact that a particular type of act (or omission) is likely to have a particular effect, proof that the defendant was responsible for such an act (or omission) and that the claimant had what is the usual effect will be powerful evidence from which to infer causation, without necessarily requiring a detailed scientific explanation for the link. But inferring causation from proof of heightened risk is never an exercise to apply mechanistically. A doubled tiny risk will still be very small.*"

27. The above cases merely confirm that the Plaintiff bears the burden of proving any damage complained of, including the increased risk of an unfavourable outcome, a legal position which was not in dispute at trial. I saw no need to invite supplementary submissions on these cases. The key primary fact which I have found is that the breach of duty occurred on July 29, 2003 and the key conclusory findings which I have reached thus far are that but for this breach, (a) the correct diagnosis would have been made on August 21, 2003 and (b) the corrective surgery would have taken place on November 4, 2003, 10 days earlier than actually occurred. I am unable to find that it is more likely than not the Plaintiff was caused an increased risk of a worse surgical outcome. Based on the facts as I have found them, the outcome falls to be measured not by the Plaintiff's condition as at July 29, 2003, as the Defendant was willing to concede, but rather by reference to any increased risk proven to have been suffered by the operative delay: between November 4 and 14, 2003.

28. Using this comparative frame, the Plaintiff has failed to prove any worse outcome as a matter fact (the evidence clearly supports the finding that he was post-operatively in better condition than when he admitted himself to KEMH on October 16, 2003). More importantly still, the only credible expert evidence before the Court is that of Mr Dyson, who plausibly opined that it is impossible to measure the extent to which, if any, the Plaintiff's recovery chances were diminished by the delayed diagnosis, even using the earlier July 31, 2003 date as the Plaintiff's baseline condition. Accordingly the primary limb of the Plaintiff's case on damage fails.

Conclusion

29. The Defendant breached his duty of care to the Plaintiff by failing to diagnose what his expert Mr Dyson described as a diagnosis which was "*only obvious in hindsight*". This occurred in relation initial presenting symptoms so unusual that Dr Chelvam would likely encounter them only "*once in a career*". This delayed the successful operation which the Plaintiff eventually had in London by no more than 10 days. The Plaintiff primarily complained of damage in the form of a substantially reduced recovery outcome. No such damage was proved. However, it was self-evident that the Plaintiff sustained additional pain and suffering through the duration of the additional time spent awaiting surgery.

30. The Plaintiff is accordingly entitled to enter Judgment on liability. Unless either party applies to be heard as to costs, I would reserve costs until the determination of the quantum phase of the present trial. The parties have liberty to apply in respect of any matters arising from the present Judgment.

Dated this 2nd day of December 2016 _____

IAN RC KAWALEY CJ