IN THE SUPREME COURT OF BELIZE, A.D. 2002

ACTION NO.: 507 OF 2002

	(MIKE WILLIAMS	**PLAINTIFF**
	(	
BETWEEN	**(AND**	
	(	
(1.	**ATANASCIO COB**	
(2.	**UNIVERSAL HEALTH SERVICES**	
	(COMPANY LIMITED and	
(3.	**UNIVERSAL SPECIALIST HOSPITAL**	
	(COMPANY LIMITED	
	(both doing business as UNIVERSAL	
	(HEALTH SERVICES MEDICAL	
	(ARTS AND SURGICENTER	**DEFENDANTS**

Mr. Rodwell Williams, S.C., representing the plaintiff.

Mr. Philip Zuniga, S.C., representing the defendants.

AWICH, J.

00.04.2004 **J U D G M E N T**

1. *Notes:* *Negligence:- a claim based on doctor's professional negligence; duty and standard of care required of a professional or skilled person, the standard is of the ordinary skilled professional exercising and professing to have that special skill; injury such as perforation of oesophagus is not in itself proof of negligence there must be proof of the negligent act.*
Consent of patient :- there is a duty on a doctor to obtain consent of a patient to treatment, lack of consent is sometimes regarded as rendering the treatment an unlawful assault, consent maybe implied.
Contributory negligence:- arose because plaintiff preferred to seek medical treatment abroad thereby delaying necessary urgent treatment with aggravating consequences. Shareholders in a company:- do not become the company and employer

2. Mr. Michael Williams, the plaintiff, came to this Court with a complaint about injury and financial loss to him, which he said were caused by

professional negligence on the part of Dr. Atanascio Cob, the first defendant. Mr. Williams was 69 years old then. He joined in his complaint, Universal Health Services Company Limited and Universal Specialist Hospital Company Limited, who he said were the employers of Dr. Cob. He cited them as the second and third defendants respectively.

The Facts and Issues.

3. The outline of the facts on which Mr. Williams made his complaint is as follows. On the evening of 10.6.2002, when Mr. Williams was having a meal he experienced a sudden discomfort in his throat. He thought, "a piece of steak got stuck in [his] throat". When he drank liquid, he said, "I could not keep it down". The following morning, 11.6.2002, he still had the discomfort. He went to see Dr. Leandro Amin Hegar, witness for the defendants, No. DW3, who advised him, "to consult an ENT specialist". Dr. Hegar explained in Court that he was an ophthalmologist, and that although he had attended a short course in Audiology Medicine, he was not an ENT doctor, that was the reason he advised Mr. Williams to consult an ENT specialist.

4. Mrs. Gretta Martha Williams, witness for the plaintiff, No. PW6, contacted their family doctor, Dr. Bernard Bulwer, witness for the plaintiff, No. PW3. Dr. Bulwer advised them to go to Dr. Cob. They contacted Dr Cob who told Mr. Williams to meet him at Universal Health Services Medical Arts and Surgicenter, a hospital. I shall refer to it simply as Universal Health Hospital.

5. At the Universal Health Hospital, Dr. Cob examined Mr. Williams and found, “pooling of saliva in the throat”. He thought there was, “probable food obstruction in the oesophagus”. He requested and obtained x-ray photos, now exhibits P(MW)1 and P(MW)2. Dr. Cob was of the opinion that the x-ray photos “corroborated that [Mr. Williams] had obstruction ... most likely caused by food which had been there for 14 to 15 hours”. Dr. Cob asked Mr. Williams to attend at another hospital, the Belize Medical Associates Hospital, where Dr. Cob would perform a procedure to remove the obstruction. The procedure was carried out.

6. Mr. and Mrs. Williams said that after the procedure Dr. Cob told them that the problem was not a piece of meat, it was cancer. Dr. Cob on the other hand, said he told them there was a tumour, he did not mention cancer. Dr. Cob then told the Williams that he would arrange to have another doctor, a surgeon, remove the tumour (or cancer) the following day and that he had taken a biopsy. He asked Mr. Williams to attend a CAT scan which was done back at Universal Health Hospital. Mr. Williams said that he did not consent to the CAT scan and that during the scan, barium swallow was literally forced down his throat, the whole procedure caused him great distress and that he felt very ill. Dr. Julio Manuel Diaz, DW5, said Mr. Williams drank the diluted barium by a straw out of a cup by himself. The result of the biopsy never found its way into the evidence because it was properly objected to on the grounds of surprise and that the witness through whom it was sought to have it tendered was not the maker of the report.

7. Upon being told about tumour or cancer, Mr. And Mrs. Williams were

worried, they decided to go to Miami, USA, instead of continuing treatment in Belize. Mrs Williams said she and her daughter made the decision right away when Dr Cob told them about the cancer. On their own they made arrangement to travel the following day. They asked Dr. Bulwer to find and make arrangement with a doctor in Miami. Dr. Bulwer did and accompanied them to Miami. They travelled by plane. Before they left they obtained a report from Dr. Cob to take to the doctor they would see in Miami. The report is exhibit P(MW)3.

8. At Miami Airport Mr. Williams was met and taken to the nearest hospital, the Pan American Hospital, as a matter of the rule of the ambulance operators. He was admitted and received urgent treatment. Then he was transferred the same evening to the Baptist Memorial Hospital, Miami, the hospital that Dr. Bulwer had made arrangement at. Mr. Williams received extensive treatment there for about seven weeks before he was discharged. After the discharge he remained in Miami for another two weeks to receive treatment as an out-patient. His wife rented accommodation in Miami during treatment of Mr. Williams. He returned to Belize in September and gradually resumed work.

9. In his statement of claim, the plaintiff particularised the acts of negligence as follows:

> "(a) Performing an oesophagoscopy on the plaintiff when the first defendant is an Ear, Nose and Throat specialist and not a gastroenterologist, and was not equipped with the requisite skill, experience or qualifications to perform the same.

(a) Performing a rigid rather than a flexible oesophaguscopy.

(b) Perforating the plaintiff's oesophagus.

(c) Performing an unnecessary and wrongful biopsy that was in any event without the plaintiff's consent.

(d) Wrongly diagnosing the plaintiff as having a tumour and prescribing wrong and harmful follow-up procedures.

(e) Ordering a thorax CT scan with a barium swallow in circumstances where, especially with a torn oesophagus, the barium liquid was certain to escape into and contaminate the mediastinum (free cavity, periaortic space, etc.), as well as the pleural cavity. The first defendant at the time knew, or ought to have guarded against the possibility of the torn oesophagus."

10. The plaintiff also particularised injuries which he said were caused to him by the negligence, as follows:

"(1) Perforated oesophagus;

(2) Infection of and damage to, mediastinum;

(3) Infection of, and damage to, pleural cavity;

(4) Lung collapse and respiratory failure;

(5) Right peroneal DVT;

(6) Pleural empyema;

(7) Damage to right common femoral artery; and

(8) Left upper extremity deep venous thrombosis."

11. From all that, Mr. Williams' case is that he suffered much pain, incurred huge medical bills and related costs and lost earnings for about three months.

He has claimed: special damages in the sum of $809,259.49, general damages, interest on award of damages and costs. The special damages comprised $769,259.49 for medical bills and related travel expenses and accommodation, and $40,000.00 for loss of employment or business income.

12. The defendants admitted some of the pleadings and evidence for the plaintiff, and expressly denied others. Some of the admitted salient facts are as follows. Mr. Williams attended as a patient on Dr. Cob on 11.6.2002. Dr. Cob had x-ray photos taken and carried out a procedure known as "a rigid oesophaguscopy", at the Belize Medical Associates Hospital, not at the Universal Health Hospital. That Dr. Cob told the plaintiff that there was a tumour in the oesophagus, he did not mention cancer. He requested a CAT scan, but did not direct that barium swallow be administered. He prepared the medical report, exhibit P(MW)3 for the benefit of the doctor or doctors who would attend to the plaintiff in Miami.

13. The defendants denied that Dr Cob was professionally negligent in any way, and that he was employed by the second and third defendants. They denied any vicarious liability. It was their contention that only the third defendants owned the hospital and that the second defendants only had shares in the third defendants. They said that Mr. Williams refused further treatment in Belize so Dr. Cob could not carry out further necessary treatment, and that it was unnecessary for Mr. Williams to go to Miami for treatment that could have been easily provided in Belize at less costs. The defendants counterclaimed that the injuries and losses suffered by Mr Williams were caused or contributed to by him on the advise of Dr. Bulwer.

14. At the close of the evidence it was clear that no evidence had been led for the plaintiff to show that Universal Health Services Company Limited (the second defendants) employed Dr. Cob or that they owned, whether jointly with Universal Specialist Hospital Company Limited (the third defendants), the medical establishment known as Universal Health Services Medical Arts and Surgicenter out of which Dr. Cob practised, and there was no evidence to show that the establishment was run as a joint venture between the two companies. It was, however, testified for the defendants that the establishment was owned and run by Universal Specialist Hospital Company Limited (the third defendants) not together with the second defendants, and that the only connection was that the second defendants owned shares in the third defendants. No statutory company papers or registration of business names papers were produced. According to Company Law, owning shares does not make the second defendants the same legal persons as the third defendants nor does it give the second defendants any ownership right in the businesses and assets of the third defendants or right to employ anyone in the business of the third defendants. Right at the outset I have to dismiss the plaintiff's claim against Universal Health Services Company Limited with costs. The rest of this judgment will concern the first and third defendants only.

The Law:

15. How does a claim in negligence arise? I would say a claim in negligence arises when one person, the plaintiff, is placed in relation to another, the defendant, such that the defendant is deemed by law to owe the plaintiff a

duty of care, which the defendant has failed or omitted to exercise. The duty arises because the plaintiff is exposed to reasonably foreseeable risk of injury or loss which may occur if the defendant fails or omits to exercise reasonable care. Lord Atkin's dictum *in* ***Donoghue (or M'Alister) v Stevenson [1923] AC 562,*** is still the standard statement of the genereal rule about liability in the law of negligence. At page 580, Lord Atkin stated:

> *"The rule that you are to love your neighbour becomes in law, you must not injure your neighbour; and the lawyer's question who is my neighbour, receives a restricted reply. You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in law is my neighbour? The answer seems to be persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called into questions."*

16. It is not an issue in this case that a doctor and a patient relation imposes on the doctor a professional duty of care. When a patient presents himself to a doctor who accepts to treat the patient, the law imposes a duty of care on the doctor when he makes diagnosis, gives advice and provides treatment. It is also accepted that there are circumstances in which a doctor owes a duty of care to receive for treatment a person in need and that his refusal would be a breach of the duty. Further, it is the duty of every doctor to obtain the consent of the patient to the treatment intended by the doctor. Sometimes the facts are such that consent is implied.

17. On 11.6.2002, Mr. Williams presented himself to Dr. Cob for treatment. He was accepted. A duty of care arose. Dr. Cob owed Mr. Williams a professional duty of care in the diagnosis he would make, the advice as to the treatment he would undertake including advice as to attendant risk, and in the actual treatment. The standard of care expected of Dr. Cob who was an Ear, Nose and Throat specialist was that of the ordinary skilled ENT specialist *exercising and professing to have that special skill*. Dr. Cob said he also professed a specialist skill in the area of throat and oesophagus. So in addition, he was to exercise the ordinary skill of a specialist in those areas. I took that case law about the standard of care from the words of a trial judge, McNair J in ***Bolam v. Friern Hospital Committee [1957] 2 All ER 118.*** McNair's words have been approved as the correct restatement of the law, by the House of Lords in several subsequent cases, notably; ***Whitehouse v. Jordan and Another [1981] 1 All ER 267*** and ***Maynard v. West Midlands Regional Health Authority [1983] 1 All 635, both*** from the UK, and in ***Chin Keow v The Government of Mayaysia and Another [1967] 1 WLR 812,*** a Privy Council case from Malaysia. In 1985 the Jamaica Court of Appeal applied the ***Bolam*** standard in, ***Millen v University Hospital of the West Indies Board of Management 4 WIR 274***.

18. ***Bolam's Case*** was one in which a consultant was not found to have failed in his duty of care; and so in ***Whitehouse's Case*** and ***Maynard's Case.***

19. Briefly, in ***Bolam's Case,*** a consultant treated the plaintiff, a mental patient, with his consent, by the use of eletro-convulsive therapy which was a

treatment accepted by all the doctors who testified as the correct treatment. There was inherent in that treatment, a risk of one in ten thousand, of fracture of bones, about which the patient was not warned. Some doctors would administer a relaxant drug before the therapy; it was admitted that use of relaxant excluded the risk of fracture completely. Other doctors preferred not to use relaxant because of the risk of mortality associated with the use of it. The consultant preferred not to administer a relaxant. He applied minimal manual control, and only at the shoulder and chin and had a pillow under the patient's back. He had two nurses stand on each side of the bed to prevent the patient from falling if it were to occur. Some doctors would use much manual control when a relaxant had not been used, others took the view that the risk of fracture increased when much manual control of the body was done. On the second occasion of treatment, the plaintiff sustained severe fracture of the hip bone. He sued in negligence on the grounds that: (1) he was never given any warning of the risk of fracture so that he could decide whether to accept the treatment; (2) the consultant did not use any relaxant drug; and (3) that the consultant failed to use adequate manual control to avoid movement of bones and fracture. McNair, J. gave directions which included this:

> *"[W]here you get a situation which involves the use of some 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 have 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."

20. Later in his directions McNair, J. elaborated in these words:

"I myself would prefer to put it this way: 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. I do not think there is much difference in sense. It is just a different way of expressing the same thought. Putting it the other 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."

21. Applying those directions together with others to the evidence, the jury found that the consultant was not negligent.

22. In ***Whitehouse's Case***, a specialist doctor caused tragic severe brain damage to the plaintiff at birth. It resulted in paralysis. He sued by his next friend, the mother, alleging that the injury had been caused by the negligence of the doctor because in "a trial of forceps delivery" which ended in a caesarean delivery anyway, the doctor had pulled the baby too hard and too long and caused asphixia and brain damage. The trial court found so and held that there had been professional negligence. On first appeal, the Court of

Appeal allowed the appeal. On further appeal to the House of Lords, the decision of the Court of Appeal was upheld. The House of Lords said that in such cases there was no liability without fault and that if the injury was the result of an error that a doctor acting with ordinary care might have made then there was no negligence. The House held that there had not been negligence.

23. ***Chin Keow's Case*** was one in which the Privy Council held that there was negligence. The deceased died within an hour of having been given an injection of procaine penicillin. The doctor had failed to carry out test to determine whether the deceased had been allergic to penicillin. Had he investigated he would have discovered that the deceased had earlier suffered adverse reaction to penicillin injection and that had been endorsed on her hospital card. The omission was regarded as one that an ordinary skilled doctor exercising and professing his skill might have not made.

24. In ***Millen's Case,*** the plaintiff who had a bad obstetric history was pregnant. She was diagnosed to have "incompetent cervix". She was unable to carry a baby for the full term up to delivery because her cervix would dilate and discharge the baby prematurely. The exit of her uterus was secured with a "Shiodka Suture" which had to be removed two weeks before the due date for delivery. The doctors could not accurately estimate the date of delivery because the plaintiff was unsure of the date of her menses. She went into labour "unexpectedly" before the due date. She was taken to the hospital and delivered with difficulty. She was duly discharged. Subsequently she suffered pain, bleeding, severe vaginal discharge, foul ordour, tenderness

and was unable to have sex. She attended several times at the hospital and finally went to a private doctor who discovered that the suture had not been removed. It could be seen with the naked eye. He removed it. The plaintiff's conditions abated. She sued, claiming that the doctors who were employees of the defendants were negligent because: 1) they left the suture in place until birth and 2) failed to remove it after birth. The trial judge decided that there had been negligence and that the Board of Management of the hospital was liable, but that because the period limited for bringing action under the Public Authority Act of Jamaica had expired, the action was time-barred and the claim could not be enforced. On appeal and cross appeal, the Court of Appeal of Jamaica held that: 1)there had been no negligence up to delivery because the doctors could not determine accurately when delivery was due so as to remove the suture timely, the plaintiff had been unsure of her menses, 2) there had been negligence in failing to see and remove the suture after the delivery, but 3) that the hospital was a public corporation, the action had been time-barred and could not be enforced.

25. So the decision as to whether Dr. Cob did not exercise the ordinary skill of an ENT specialist, also knowledgeable in throat and food canal, must be based on what is acceptable by the standard of such a skilled specialist exercising a specialist's ordinary skill, in the view of responsible and competent doctors. Even among the best there will be the best of the best. It is not the standard of the single best of the best that is demanded.

26. Both learned Senior Counsel, Mr. Rodwell Williams for the plaintiff, and Mr. Philip Zuniga for the defendants, carried out their duty to prove their

clients' cases to satisfaction. Mr. Williams called four doctors, namely; Dr. Niberto Moreno, a cardiovascular thoracic surgeon of 16 years experience, at the Baptist Hospital, Miami, Dr. Bernard Bulwer, a fellow in cardiovascular diseases at Havard University Medical School, Dr. Virginia Smith, and Dr. Julio Manuel Diaz, both radiologists at the Universal Health Hospital. Mr. Zuniga also called four doctors, namely; Dr. Cob himself, Dr. Victor Lizarraga, Dr. Leandro Hegar and Dr. Gregorio Pott, a consultant surgeon of 27 years and 31 years in all of experience as a doctor in Belize. Of course it was not a contest of numbers or of equations of numbers as obtains in Algebra, Chemistry or Physics. Medically skilled persons were necessary witnesses. It is from their medical expertise that the question of negligence must be decided. However, the value of the testimony of each professional must depend on the quality of the content. His views must be well grounded on Medical Science to be regarded as responsible opinion.

Determination: *Was Dr. Cob Lacking in Expertise and Experience?*

27. The evidence to support the plaintiffs' statement that Dr. Cob was an ENT specialist and so was not qualified, not skilled and not experienced to carry out oesophaguscopy was expected to come from Dr. Niberto Moreno and Dr. Bulwer. Questions were put in examination in chief and answered by Dr Moreno as follows:

Question: "... in circumstances where there arises a diagnosis of a complete obstruction of the distal third oesphagus, by an ENT, ... is that an area ... of competence of an ENT?"

Answer: " The answer to that can be complex, it can be very simple. In our practice usually problems of the distal third of the oesophagus are treated either by a gastro-enterologist or a thoracic surgeon or a general surgeon. Ear, nose and throat in our practice usually stays in the ear, nose and throat, and the esophagus is part of the throat so that part of the oesophagus, I believe, is appropriate for an ENT to address. I cannot speak to the capacity of physicians in Belize ... because I don't know how many endoscopies the person has done or if he is an expert in this kind of field ..."

28. Then later Dr. Moreno gave the following answer about referral of a condition of obstruction in the distal third oesophagus:

" In our practice, usually not to an ENT, it would either be to a thoracic surgeon or a gastro-entorologist".

29. Dr. Bulwer who knew Dr. Cob well, obviously initially took the view that an ENT specialist such as Dr. Cob, was the proper specialist to attend to food obstruction in the oesophagus. Dr. Bulwer described Dr. Cob as, "a collegue who was better qualified to attend to that type of problem." He added, "I referred him [Mr. Williams] to Dr. Felix Cob, an ear, nose and throat surgeon ..." Dr Bulwer later said the following in answer to question:

Question: "Dr Bulwer, in your professional opinion in the context of the diagnosis of complete obstruction of the distal

third of the oesophagus ... would you consider it within the competence of an ENT, given the location of the obstruction ...?"

Answer: "Some ENT surgeons, depending on where and what the custom and the practice is in their institution or University Hospital, can and have done and do look into the oesophagus, remove foreign bodies, but in the age of increasing specialization and medical turf in the institution where I worked in England as a clinical fellow in Diabetics, Endocrinology and General Medicine, our practice was to refer such patient, all such patients with gastro-oesophagus problems to the gastro-enterologist. But there is an overlap in medical specialities and it just doesn't apply to ear, nose and throat. Gastro-entherology, it applies to general surgery, but it depends on the institution and the individual's experience."

30. Allowing for different turfs (to borrow the figurative), I wish to note that one of the two professionals has been clearer in his testimony. From the above evidence for the plaintiff alone, there has been instead, proof to the contrary. The evidence for the plaintiff alone proved that an ENT may be qualified as a specialist to deal with cases of obstruction in the oesophagus.

31. Side by side with the evidence for the plaintiff, Dr. Cob himself testified as to the suitability of his Laryngology specialist training which he said made

him qualified to deal with conditions in the oesophagus and as to his experience of 10 years as a specialist and 16 years in all as a doctor. There has been no evidence to the contrary. Dr. Hegar also said that an ENT was the suitable specialist. Dr. Gregorio Pott, the most senior in experience confirmed that an ENT would be a competent specialist if his training included the oesophagus and he was experienced. I have not made use of the testimony of Mr. Williams that he went to Dr Hegar because he was an ENT doctor. Even if Mr. Williams' view at the time must have been that an ENT was the suitable specialist, that was a layman's view not to be relied on even if it was unfavourable to his own case.

32. The sum of the evidence proved that an ENT doctor, and in particular Dr Cob, was qualified to accept referral of oesophagus condition and treat it. The particulars that there has been negligence because as an ENT specialist Dr. Cob was not qualified, not skilled and not experienced and should not have carried out the oesophaguscopy fail.

The Rigid other than Flexible Oesophaguscopy.

33. The particulars of negligence averred at (b) were that Dr. Cob performed "a rigid oesophaguscopy" other than "a flexible oesophaguscopy", that is, that he used a rigid other than a flexible instrument, the scope, and that was negligence. The assertion in that was that a rigid oesophaguscopy was an unsuitable procedure and below the standard of care required. About that Dr. Moreno for the plaintiff said:

"Rigid oesophaguscopy has been performed for many years because we did not have fibre optics. In the late sixties/seventies fibre optics became available and then flexible endoscopy came into play. Rigid oesophaguscopy is still done and actually it is one of the "indications" to be done with foreign body. ..... I believe if you do not do a flexible then you do a rigid. However, it depends on your expertise in what you do ... so it depends on the expertise of the physician."

Q: "Are there any risk attendant to the rigid oesophaguscopy?"

A: "The incidence of perforation is higher with rigid and again it depends on the person using. Because if the person is extremely experienced .... I wouldn't let somebody who does three flexible oesophaguscopies do one on me, I would want somebody who does 50 or 60 a year at least".

34. Dr. Bulwer testified to the same effect as follows:

B: "In my professional opinion, based on what I have subsequently read and researched, which reflect sometimes differing views; that in the hands of an inexperienced specialist whether it is rigid oesophaguscopy or whether using the flexible, meaning it can bend, flexible oesophaguscope or gastroscope, these can be equally unsafe in the hands of an inexperienced operator, whether an ENT whether a gastroentrologist and the converse is also true. Even the most adviseable instrument is dangerous in

the hands of an unskilled and inexperienced operator."

When asked about the use of the type of scope in the distal third of the oesophagus, Dr. Bulwer said he would prefer to use the flexible scope "because the anatomy, the oesophagus, is not straight".

35. Those items of evidence in the testimonies of Dr. Moreno and Dr. Bulwer do not suggest to me that rigid oesophaguscopy was no longer a procedure in use or no longer adviseable at the time. There certainly has not been evidence to show that rigid oesophaguscopy was then and now a procedure that an ordinary skilled specialist would not perform. There has been merely evidence of preference, not of acting outside a practice accepted as proper in the opinion of responsible medical experts.

36. For the defendants, apart from Dr. Cob himself, Dr. Pott said that the widely used scope in Belize was the rigid scope. He laid emphasis on training and whether the specialist had been certified by the trainer. Dr. Moreno from Miami went as far as mentioning that it was "one of the 'indications' to be done with foreign body." That supported to some extent, the testimony of Dr. Cob that rigid oesophaguscopy was the preferred treatment when a foreign body is involved.

37. It should not be understood that I am justifying the use of antiquated instrument in Belize. I am pointing out that the evidence merely proved that the use of the rigid scope was not and still is not considered by responsible specialists to be a practice below the standard expected of a specialist doctor.

38. On the evidence, I have to reject the particulars at (b), that carrying out rigid other than flexible oesophaguscopy was in itself a negligent act. The particulars at (b) fail. The question remains, however, whether Dr. Cob carried out the rigid oesophaguscopy in a negligent manner. The next particulars are relevant to that question.

39. One aspect of this question gave me much thought. It was my view that Dr. Cob owed a duty to inform Mr. Williams about the comparative risks in the use of rigid as opposed to flexible oesophaguscopy, he did not inform Mr. Williams and that would be negligence. However, that view is attended with two difficulties. First, failure to inform was not pleaded so that the defendants could have opportunity to respond to. Second, responsible opinion of the expert witnesses called were not solicited as to whether in the circumstances, failing to inform Mr. Williams about the comparative risks in rigid oesophaguscopy and flexible oesophaguscopy would have been contrary to the practice accepted at the time as proper by a responsible body of medical opinion. I found that those difficulties were sufficient to defeat my initial view-see ***Sidaway v Bethlem Royal Hospital Governors and Others [1985] 1All ER 643.***

Perforating the Oesophagus.

40. The particulars of negligence at paragraph (c) was stated simply as "perforating the plaintiffs' oescophagus". I expanded that to mean that it was pleaded that Dr. Cob negligently perforated Mr. Williams' oesophagus. That was still too general a statement. I suppose it was based on the clear

evidence of a fistulla that demonstrated that there was perforation in the oesophagus and on the circumstantial evidence to the effect that the perforation occurred during the oesophaguscopy carried out by Dr. Cob. He properly admitted that since there had been no escape of barium swallow, a contrast medium, into the mediastanum before the oesophaguscopy, but after, and since in the end there was no tumour as he had diagnosed, it was reasonable inference that the perforation may have occurred during the rigid oesophaguscopy he had carried out. It is to be noted that the admission was that he caused the perforation; it cannot be taken to mean that Dr. Cob admitted that he caused the perforation because of negligence on his part.

41. There are again two difficulties in answering the question as to whether the perforation was caused by negligence. First, the probable inferences from the evidence were that the perforation was caused: (1)when Dr Cob may have pushed the rigid oesophaguscope too hard when he reached “the point when it could go no further”, or “reached the obstruction”, or (2) by pinching which was part of taking biopsy of the tumour. Whichever inference is accepted, it must be demonstrated by evidence that negligence accompanied it if liability for compensation is to attach. Second, is that there was no evidence as to the nature of the perforation from which one may deduce whether there had been negligence.

42. Dr. Moreno was the only other witness who had a look at the inside of Mr. Williams’ oesophagus. He said he did not identify the perforation, and that was not unusual, “because of the inflammatory process ... especially in almost 48 hours of the inflammatory process”. He suggested that it would

have been in the form of a pimple. They had to wait for the perforation to heal by itself. His opinion was that the oesophagus was, "pretty good". I suppose because of that explanation, he was not asked as to whether from his observation of the oesophagus he could say that the perforation had been negligently caused. His evidence suggested to me that the perforation was a tiny one though significant in the fistulization that occured.

43. This is not a case of *res ipsa loquitur*, where the event and injury speak for themselves - see the judgment of Lord Wilberforce in ***Whitehouse's Case*** in the House of Lords, and of Lord Denning in the Court of Appeal. It is my decision that there has been no evidence to prove that the perforation by Dr. Cob was caused by negligence, that is, by an act which was below the standard of care demanded of a specialist. The particulars of negligence averred at (c) fail.

The Diagnosis of Tumour or Cancer, the Biopsy and CT Scan.

44. It is convenient to consider particulars of negligence at (d), (e) and (f) together because both the averrments at (d), that unnecessary and wrongful biopsy was performed and at (f), that thorax CT scan with barium swallow was negligently and wrongfully ordered, arise from the averrment at (e), that a wrong diagnosis of tumour (changed to cancer in testimonies) had been made by Dr. Cob.

The Diagnosis.

45. I start with the particulars at (e), that a wrong diagnosis was made and that

was negligence. It has been proved by the admission by Dr. Cob that he made a wrong presumptive diagnosis of "a tumour that bled easily". The next fact to prove was that the mistake was such that an ordinary specialist exercising and professing that expertise might have not made that wrong presumptive diagnosis. The evidence must prove that if liability for negligence is to attach. In deciding the question, I think it is useful to trace the actions taken by Dr. Cob up to the moment he saw what he described as a tumour and to assess whether the expert witnesses called might have described what Dr. Cob saw as a tumour.

46. After he had observed that there was pooling of saliva in Mr. Williams' throat, Dr. Cob decided as a first step, to investigate the complaint by having xray photos taken of the thorax. That has not been faulted by any expert witness. He said he saw that the barium swallow, "well dilated the oesophagus up to the distal third", where from only a trickle went into the stomach. That was also what Dr. Smith said. Dr. Cob concluded that there was an obstruction at that point. That assessment was also not faulted. Then Dr. Cob decided to do an oesophaguscopy by "special forceps". He explained that to the Williams, although he did not mention "the possibility of a tear". Mr. Williams consented to the treatment. All expert views agreed that oesophaguscopy was the correct treatment. So the decision to carry out oesophaguscopy was not wrong nor negligent. The witnesses were not asked whether failing to inform the patient of the possibility of a tear, in the circumstances was failure to do what would be accepted as the proper thing. They were also not asked about omission by Dr. Dob to inform Mr. Williams about the comparative risks in using the rigid scope. Dr. Cob selected the rigid as opposed to the flexible oesophaguscopy. That has been

challenged by the plaintiff as negligent. I have already decided that the choice was available at the time and used by experts, and that choosing rigid oesophaguscopy was not in itself negligence. Dr. Cob carried out rigid oesophaguscopy, his assessment was that "[he] did not see the food that was said to have been swallowed, instead he saw a swelling, an inflamation". That was not directly challenged, but it was of course challenged that whatever he saw was not a tumour or cancer, he was negligent in that.

47. Let me mention here that in my view, it was not improbable that the piece of meat or food had gone down into the stomach by the time Dr. Cob did the oesophaguscopy so that he could not see it. I base that on the testimony of Mr. Williams that when he drank barium swallow during the x-ray, he was surprised that he, "did not have any problem taking it", and on the fact that about twenty four hours had passed since the onset of the complaint.

48. There has been evidence, however, that where the meat had been lodged would be inflamed. The question then is: Could a specialist exercising due care describe what Dr. Cob saw as "a swelling, inflammation" as a tumour?

49. Again let me start with what Dr. Cob himself said about the tumour: He testified as follows:

> "We advanced the scope further down up to the third distal oesophagus where there was an obstruction and the scope could not be advanced any further. In that area there was swelling, inflammation. I didn't see the food that was allegedly swallowed. The swelling and the inflammation appeared to me like a tumour". And I decided to do

a biopsy".

Then he was asked: "How does a tumour look? He answered:

> "A tumour may have several ways how it can look. In benign tumour it can have smooth surface depending on how much blood supply it has, it can have varying degrees of colouration, from very low pink to red and purple. Its surface can be irregular, it can appear just a bump, especially if it is under some tissues or under the skin or within the muscle. In a cavity it can appear to be stemming from a pedicel or we can find that it doesn't have a specific area where it is attached. It can undergo inflammatory changes which can make its surface swollen, it can undergo infection, then we will have exculates on the face, like the yellow or green mucous or puss, and it can undergo erosion. I saw a very endematous mucosa, meaning swollen with thickening of the walls of the oesophagus, with inflammation, and that is the reason why it bled easily when you touched it..... It was on the wall, the whole wall of the oesophagus was thickening."

50. The plaintiffs' witnesses were not asked whether what Dr. Cob saw could be described as a tumour or even as a swelling or inflammation. Their testimonies did not advance contrary views as to what Dr. Cob described as a tumour. Dr. Moreno only had opportunity to say that "cancer is a tumour, but a tumour is not a cancer". He said that he did not see a tumour in Mr. Williams' oesophagus, nor did he see oesophagitis. "There was a little

erosion, but not anything significant," he said, and further that the oesophagus looked, "pretty good." Dr. Pott (for defence) described a tumour as, "actually a very loose term that just indicates a space occupying legion". He said that an inflammation respondent to whatever irritation could be described as a tumour. He accepted that it was possible that inflammation with the history of Mr. Williams' complaint could disappear in 24 hours, but added that it depended on what type of tumour, a malignant one would not.

51. Given the evidence I have pointed out, I accept that Dr. Cob saw a swelling, an inflammation, and that the inflammation could be described as a tumour albeit in the loose sense. I have to conclude that the presumptive diagnosis that Dr. Cob made may have been mistaken, but not negligent. Moreover, he took step to confirm or negative it by taking a biopsy. He did not have the opportunity to come to conclusion because Mr. Williams left.

52. Much argument was made about whether Dr. Cob told Mr. And Mr. Williams that the condition was that of cancer other than a tumour. The preponderance of evidence pointed to the word tumour having been used. That, however, is not significant, in my view. Even if the word tumour was used, the effect was the same, it was understood by Mr. And Mrs. Williams as most likely cancerous. Mrs. Williams seemed to have more than just a general knowledge of medical matters, she often used medical expressions in her testimony. Even Dr. Bulwer and Dr. Moreno who read the report that mentioned tumour and not cancer took it to mean cancer. Of more significance is that Mr. And Mrs Williams knew that the diagnosis of tumour

or cancer was only presumptive, Dr. Cob had taken biopsy and ordered CT scan to confirm or exclude cancer. They decided not to wait for the conclusive diagnosis.

53. About particulars at (d), that unnecessary and wrongful biopsy was taken by Dr. Cob, he explained, in answer to question, his reason for taking a biopsy as follows:

> Question: "Would you explain why you decided to do a biopsy?"
>
> Answer: "A biopsy should be done any time there is a suspicious legion which we do not know its nature and in Mr. Williams' case I did not see any meat, there was a swelling and inflammation, and in my opinion it was necessary to biopsy it".

That explanation was the same as the view of Dr. Moreno given earlier when he was asked the question: "If an examiner through an endoscope sees what he believes to be a tumour what in your expert opinion should he do? Dr. Moreno's answer was:

> "More than likely it is an elective procedure, he should biopsy the tumour. Even if it is not an elective procedure, if the patient is stable then he should go ahead and do a biopsy."

54. I have to conclude that the plaintiff's own witness disposed of the particulars

that taking biopsy was wrong and negligent. Particulars at (d) must fail.

55. That specific consent to take a biopsy was required is unrealistic. Consent for it was implicit in the consent for the oesophaguscopy. The above quoted view of Dr Moreno also seemed to suggest so. Moreover, it would involve terminating the oesophaguscopy and waiting for the patient to recover from general anaethesia then asking for his consent, and if obtained, administering general anaesthesia again and then proceeding to do the oesophaguscopy all over again in order to reach the "tumour" and do biopsy. My conclusion is that the biopsy was not without consent nor wrongful and negligent.

Guarding Against the Perforation.

56. The final particulars of negligence at (f), were that Dr. Cob was negligent when he ordered CT scan with barium swallow when he knew that the oesophagus had been perforated or he ought to have guarded against perforation.

57. First, the evidence shows that Dr. Cob did not know about the perforation until after the result of the thorax scan he had requested. Secondly, he did not specifically order that barium be used. Thirdly, I think expert opinion should have been solicited in evidence about whether due care in the circumstances would require that Dr. Cob specified that barium swallow was not to be used, and whether given what Dr. Cob had seen, it was reasonable to guard against perforation. Moreover, the radiologists, were experts in their field, could they not be trusted with making the right choice of the

appropriate contrast medium? My decision is that negligence was not proved in the particulars at paragraph (f).

58. Based on the testimonies of both Dr Moreno and Dr Pott, that perforation of the oesophagus is a serious condition that requires the institution of immediate treatment with large dosage of antibiotics by injection or intravenously, and that delay by 24 hours increased the risk of mortality to 60% and delay by 48 hours raised the risk up to 80%, it was argued that Dr Cob was negligent in that he failed to undertake the necessary urgent treatment, with the result that Mr. Williams had suffered severe infection by the time he was admitted to hospital in Miami. My view of the evidence is that Mr. Williams, at the instance of his wife and daughter though well intentioned, did not accept any further treatment beyond the CT scan, under the supervision of Dr Cob. They might have accepted advice from Dr Bulwer, but he only learnt of the perforation while on the way to the airport with the patient. He might have been placed in a difficult situation. I note that Dr Pott, a much more experienced doctor, said that even if he were faced with a patient about to leave on a flight, he would have advised commencing immediate urgent treatment.

59. I acknowledge that the perforation of Mr Williams' oesophagus was a grave incident and that it led to several serious complications that put Mr Williams within only 20% chance of survival and that extensive surgery had to be done. I also note that Mr. Williams lost income as the forseeable result of his illness. It is an occurance that invokes the sympathy of anyone, including mine. However, my duty is to decide the question of

compensation against the defendants, based on the law of negligence. The law required me to determine on evidence available whether there was a duty of care called for on the defendants towards Mr Williams. I have determined that the law imposed such a duty on Dr Cob and possibly on Universal Specialist Hospital Company Limited. Issues such as whether Mr. Williams was in the care of the hospital or the plaintiff selected his own doctor who took him to Universal Health Hospital remain outstanding. Further, the law required a determination as to whether the defendants did not act with the due care required of them. The standard of care that the law called for was that of an ENT specialist whose training and experience included the oesophagus, or of a gastroentrologist, exercising the ordinary care of such a specialist, professing the skill of a specialist. The evidence in my view did not disclose that Dr Cob acted below the standard required. The evidence from the plaintiff's own witnesses tended to prove that Dr Cob acted in accordance with what other responsible professional experts expected and would accept as proper although a mishap took place. I think learned Counsel Mr. Williams SC, did an excellent job in presenting the plaintiff's case, but of course the evidence was something beyond his power.

60. It is my decision that the plaintiffs' claim in negligence fails. It is dismissed with costs. Had I decided that the defendants were liable, I would have found contributory negligence based on the decision of the plaintiff not to accept further treatment on the suggestion of Dr Cob thereby delaying the necessary immediate treatment required, which delay aggravated his condition.

61. Delivered this Wednesday the 12th day of May 2004.

At the Supreme Court,

Belize City

Sam Lungole Awich

Judge, Supreme Court