Judgement Book

IN THE SUPREME COURT OF JUDICATURE OF JAMAICA

IN COMMON LAW

SUIT NO. C.L. 1996 G-105

BETWEEN	HOWARD GENAS	CLAIMANT
AND	THE ATTORNEY GENERAL OF JAMAICA	1st DEFENDANT
AND	THE BLACK RIVER HOSPITAL BOARD OF MANAGEMENT	2nd DEFENDANT
AND	DR. K.D. MSHANA	3rd DEFENDANT

Mrs. Janet Taylor and Ms. Kadia Wilson instructed by Taylor, Deacon and James for the Claimant; Mr. Curtis Cochrane and Ms. Rolande Price instructed by the Director of State Proceedings for the Defendants.

Heard February 16 and 17, 2006 and October 6, 2006

Medical Negligence – Allegation of doctor's negligence through inaction; Applicability of the Test in Bolam v Friern Hospital Management Committee; whether test now modified by doctor's duty to provide information to patient.

CORAM: ANDERSON J.

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Howard Genas is a young farmer from Accompong Town, Bethsalem Post Office, a small district in the parish of St. Elizabeth. On or about the 9th day of September 1995 when he was around 29 years of age, he fell from the motor cycle that he was riding and injured his right leg in an incident which was to change his life dramatically. On that Sunday night, as a consequence of the accident, he was taken to the Black River Hospital which was operated by the 2nd named Defendant and was eventually seen by the 3rd named Defendant who was the medical officer in charge of the hospital. How could he have known that, as a result of that fall from his motorcycle, some ten and a half years later, he would be in court seeking redress for the loss of one of his legs? According to the evidence before me, default judgments had been issued in respect of the 2nd and 3rd named Defendants but these have been set aside and the matter is now before me for adjudication.

The Claimant's Statement of Claim sets out the factors which are alleged to give rise to a claim in negligence and it is useful to set out parts of the said claim, including the alleged particulars of negligence, here.

STATEMENT OF CLAIM

1. The first Defendant is sued by virtue of the Crown Proceedings Act, and the action is against the Crown for vicarious liability by virtue of section 3 (1) of the said Act.
2. The Second Defendant operates a Public Hospital situated in Black River in the Parish of Saint Elizabeth.
3. The Third Defendant was at the material time a Medical Doctor attached to the Second Defendant Hospital and was a servant and/or agent of the Defendants.
4. On or about the 9th day of September, 1955 the plaintiff attended the Second Defendant's Hospital as a result of having been involved in a motor cycle accident on the said day.
5. The Plaintiff was admitted to the Hospital as a patient on the said day.
6. The Plaintiff was treated, attended and advised, whilst there by Dr. Mshana, the third Defendant and by other servants and/or agents of the First Defendant.
7. The Plaintiff, on admission to the said Hospital was suffering from injuries to his right leg.
8. That the Third Defendant and other servants and/or agents of the First Defendant were guilty of negligence as they failed to use reasonable care, skill and diligence in and about the treatment, attendance and advice which they gave to the Plaintiff.

PARTICULARS OF NEGLIGENCE

a) Failing to perform promptly, completely, professionally and with due care and diligence the necessary treatment;
b) Failing to observe or to heed or to take any reasonable steps to investigate properly or at all, the serious and obvious deterioration in the condition of the Plaintiff whilst under the care of the Defendants.
c) Failing to detect, diagnose or suspect the seriousness of the Plaintiff's condition and/or failing to give or procure any treatment for the same or any investigation which would have discovered same;
d) Failing to observe or to heed or to take any reasonable steps to investigate the complaints of the plaintiff;
e) Failing to pay any or any sufficient attention to the Plaintiff's complaints of pain and treating the same insufficiently, incompetently, unprofessionally and without due care, dispatch and diligence.

9. Subsequently the Plaintiff on the 18th day of September, 1995 was transferred to the Kingston Public Hospital, in the parish of Kingston, and there his right leg was amputated on or about 20th September, 1995 and as a consequence there the Plaintiff suffered great pain and sustained severe injuries and incurred loss of expense and he has thereby suffered loss of damage.

In the course of the trial which lasted some two (2) days, there were two witnesses as to fact, the Claimant and the 3rd Defendant while there was an expert witness, Dr. Warren Blake, a consultant Orthopaedic Surgeon. Each of the witnesses as to fact

provided a witness statement and was cross-examined thereon. In the case of Dr. Blake, it was sought to introduce a report which he prepared pursuant to a notice to adduce hearsay evidence pursuant to the Evidence Act but the Defendants required that Dr. Blake attend to give his evidence and be cross-examined.

According to the witness statement of the Claimant, on the day of the accident, after he fell from his motorcycle, he was taken by his brother to the Black River Hospital. There, he waited for over half an hour before seeing a doctor, the 3rd Defendant, Dr. Mshana. He claims that he was advised by the doctor that in view of the swelling of the injured leg, he (the doctor) would be unable to do anything until the swelling abated. He further averred that he spent the night at the hospital in considerable pain but got no medication although he complained to the nurse on duty. It was not until the following day that an x-ray of his injured leg was done. He was then given a prescription by the 3rd Defendant and, according to his witness statement, was told that because his leg was "cold" he would need to get a blanket from home to cover the leg, presumably to keep it warm. He was unable to get the blanket from his home and Dr. Mshana got one for him.

The Claimant remained at the Black River Hospital for a total of nine (9) days during which time it was his testimony that the only medication he received was from the prescription he had got on the Monday morning following his admission and which he had asked a friend to purchase. The nurses would ensure that his leg remained covered by the blanket. During his stay at the hospital, the Claimant says that he requested and continued to request that he be transferred to the Kingston Public Hospital for his condition to be treated but was advised that, as there were "more dogs than bones at KPH", he would not be sent there. The Claimant also averred that on about the 3rd day he was advised by the 3rd Defendant to remain in bed. He said, however, that he was provided with a wheel chair by the said Dr. Mshana, which wheel-chair he would use to go to the bathroom. He stated that he stayed in bed apart from his trips in the wheel chair to the bathroom. It was his testimony that on the 5th day of his hospitalization, the 3rd Defendant advised his visitors that they could push him outside for him to "breeze out", although his foot was hurting so badly that he still stayed in bed most of the time. He said he noticed from about the third day of his hospitalization that his leg "started getting black" from the knee first, then it spread

down toward his toes. He said he mentioned this to Dr. Mshana as from about the fifth day his leg had no feeling but was advised to just keep the blanket over the leg.

The witness said that on the 9th day when he showed his brother his leg, "he got vex and say if they did not transfer me that day to Kingston Public Hospital he was going to take me himself". He said that as a result of his brother's behaviour it was decided to transfer him to the KPH on that day. However, before he was released, his father was required to pay a bill at the Black River Hospital of some $1,500.00. It is common ground that on or about Monday the 18th day of September 1995, the Claimant was transferred to the KPH where, two (2) days following, he had an above-the-knee amputation, it having been confirmed that the leg had become gangrenous. He said he remained at the KPH for about six (6) days and further stayed in Kingston for about two months after the amputation his leg and during that time, he visited the surgery ward at the KPH about five (5) times for check ups and dressing. He stayed with a relative in Franklin Town and visited the local clinic in that area about three times. He subsequently was a patient of the Sir John Golding Rehabilitation Centre (Mona Rehab) to which he was referred by the doctor at KPH and from where he received a prosthesis. The cost was $15,000.00 but he still owed $5,000.00. He was given physical therapy, was taught to swim and to walk with his prosthesis. There were numerous visits to this facility, over fifty (50) according to the Claimant, and each time he incurred registration fees of $50.00. In addition, he had to charter a taxi to take home from his home in Accompong to the Mona rehab Clinic on each trip as he was unable to cope with the public transport system.

After spending approximately two (2) months in Kingston, the Claimant returned to the district where he normally resided. Subsequently, he had a fall and the stump of the amputation again started to swell so that he had to seek further medical attention from a Dr. Johanna. He had to visit this doctor on two (2) subsequent occasions, incurring expenses on each such occasion. The loss of his leg had severely impacted negatively upon his ability to earn a livelihood as a farmer and as a result, he had lost considerable income.

In cross-examination, the Claimant denied suggestions that he was placed on a drip when he was admitted to the Black River Hospital.

The 1st Defendant denies liability in respect of any negligence or breach of a duty of care towards the Claimant. As indicated above, there are already default judgments against the 2nd and 3rd Defendants. The defence of the 1st Defendant is essentially a denial of liability or at worst a claim that the claimant contributed to his own loss by failing to follow the regime for "absolute bed rest" of which he was advised by the 3rd Defendant. The defence, in relevant part, is set out hereunder:

PARTICULARS

a) The Third Defendant exercised all reasonable degree of skill and ordinary care in administering treatment to the Plaintiff.
b) The Third Defendant exercised a reasonable degree of care in his treatment of the Plaintiff.
c) The Third Defendant's diagnosis of the Plaintiff's condition was one which a reasonably competent doctor would have made in the circumstances.
d) The Third Defendant made his diagnosis of the Plaintiff's condition after a thorough examination of the Plaintiff and the symptoms observed.
e) The Third defendant followed the Plaintiff's progress by conducting regular medical examinations.
f) The Third Defendant monitored regularly the treatment of the Plaintiff.
g) The Third Defendant immediately referred and arranged for the transfer of the Plaintiff to another hospital upon detecting that the Plaintiff's condition had changed for he worst.

9. This Defendant will say that the acts complained of were caused or contributed by the negligence of the Plaintiff.

PARTICULARS OF NEGLIGENCE

(a) Failing to co-operate with the administering of his treatment by failing to keep still.

(b) Failing to heed the warning of the Third Defendant to remain in absolute bed rest or risk the deterioration of his injury due to the precariousness of the circulation in his limb.

The evidence in support of the case for the 1st Defendant is contained in the witness statement of Dr. Kichawele Daudi Mshana, the 3rd Defendant. Dr. Mshana, the Senior Medical Officer at the hospital at the time of the Claimant's hospitalization, said that he was trained as a doctor in Cuba having got a first degree in medicine in 1982 and completed his general surgery training in 1986. He says that he recalls that he attended a patient named Howard Genas who was admitted to the Black River Hospital where he worked, on or about the 10th day of September 1995. I pause here

to note that there is some difference of opinion as to whether the claimant was in fact admitted to the hospital on the 9th or the 10th September 1995. In my view, nothing turns on this. However, there was a suggestion in the evidence of the Claimant that the accident occurred on a Sunday night and in 1995, the 19th day of September was the Sunday, not the 9th. Dr. Mshana indicated that the observations made in relation to this individual was that he was in "obvious pain and distress"; fully conscious and pointing to his right lower limb as the source of his distress; "his right lower limb was grossly swollen from the mid thigh region to the foot with an obvious deformity of the knee joint. There were multiple superficial skin abrasions; the sensitivity of the limb remained normal but the tibial and dorsalis pedis pulses were weak. It was strongly suspected that there was a compromise of blood circulation of the limb; the x-rays of the right lower limb revealed a depressed fracture of the medial plateau of the right tibia bone with a posterior-inferior displacement".

Dr. Mshana avers that the patient was admitted with the following orders made:

- The limb was cleaned and the abrasions dressed accordingly; and at his bed it was elevated using a Brown's Splint, and padded to keep it warm.
- Absolute bed rest.
- Antibiotics.
- Anti-inflammatory (Voltaren 75 mg SR PO q8h.
- Vasco active drugs (Trental 400 mg and Daflon 500 mg PO q8h.
- Lasix 40 mg PO qd.
- Pethidine 50 mg 1M q4h PRN

The 3rd Defendant in his witness statement avers that the Claimant was visited everyday "where we focussed our attention and examination on the local temperature, swelling, tibial and dorsalis pedis pulses of the limb. A gradual decrease of the swelling and healing of the abrasions was noticed". Dr. Mshana stated that on the weekend of the 16th-17th September 1995, the relatives of the patient "took him off his bed and placed him on the wheel chair and rolled him out of the ward. On Monday the 18th September 1995, we observed that the limb was very swollen again and it was cold, we did not feel the dorsalis and tibial pulses. We suspected a complete shutdown of circulation of the limb due to damage of the blood vessels by tear, puncture,

thrombosis and or compression due to swelling. In view of these findings he was immediately transferred to the Kingston Public Hospital for a possible alternative to save his limb". Regrettably, this move was too late and some two (2) days later, the Claimant had his right leg amputated above the knee.

The 3rd Defendant's witness statement ends with assertions that seem to suggest findings which, in my view, are the court's duty to make. Thus, it concludes:

> "All the necessary investigations were done and we arrived at a correct diagnosis in time. No delays were made in instituting a prompt attention, advice and treatment. Evaluation and interaction was done on a daily basis. Medically, it was not advisable to transfer the patient as this could have created more risks such as thrombo-embolic accident and an increase in the swelling of a limb with an established blood circulation compromise already. Furthermore, the condition at which the limb was, if transferred, the line of management would have remained more or less the same". He also refers to the finding made during the operation to amputate at the KPH as being "thrombosis of the right popliteal artery and suggests that the Claimant lost his leg as a "product of a complication of the trauma he sustained rather than a management failure".

It should be noted that the Claimant's original docket at the hospital has not been found despite several attempts to secure same. Dr. Mshana felt that it should be at the hospital whose employ he had left subsequent to this incident. Thus, the closest records that were available to the court were a report of the 3rd defendant dated May 16, 1996, some eight (8) months after the accident, and one from the Kingston Public Hospital. It was in this letter that Dr. Mshana stated the following:

> The patient was advised to remain on absolute bed rest as the circulation of the limb was precarious. In the following days we noted that the swelling was subsiding gradually and the pain was diminishing significantly. On the weekend following his admission he was visited by relatives who took him and put him on a wheelchair and rolled him out of the ward. The following morning we noticed that the limb was more swollen than before, cyanotic and cold. The dorsalis podis and tibial pulses were not felt. It was then suspected that the blood circulation of the limb was severely compromised. The same morning, Monday September 18, 1995, he was transferred to the Kingston Public Hospital for further management.

The other report which may be considered proximate was that of Dr. Aston S. Young of the Department of Surgery Kingston Public Hospital, dated July 1, 1996.

According to that report, the Claimant was admitted to the surgical ward of the KPH on September 18, 1995. Dr. Young said the following was noted.

> On admission examination revealed that the right lower limb was swollen with superficial abrasion to the popleteal fossa (behind the knee). The right foot was cold with bluish discolouration. There was *no evidence of circulation to the right leg. There was a loss of sensation and movement of the right foot.* (My emphasis)
>
> He received treatment with anticoagulation medication. However, by the following day he was diagnosed as having gangrene of the right foot which needed amputation.

Dr. Young's report was admitted into evidence as an exhibit.

The other evidence which was before the court was that of Dr. Warren Blake, a consultant Orthopaedic Surgeon. Dr. Blake, an expert witness, provided a report dated November 6, 2001. The attempt to have his report put in as hearsay under the Evidence (Amendment) Act was opposed by the Defendants who required him to attend to give oral evidence and be cross examined.

Dr. Blake's credentials indicated that he was a graduate of the University of the West Indies with a Bachelor of Medicine and Bachelor of Surgery degrees. (MB.BS.) He was a Fellow of the Royal College of Surgeons, specializing in orthopaedics, and eminently qualified to be an expert in the area of dispute in this claim. In fact, in answer to a question posed in cross examination, he stated that as a person who dealt with fractures and orthopaedic problems, he would also be an expert in circulatory problems which routinely appear in dealing with fractures.

Dr. Blake conceded that since he did not see the Claimant until more than six (6) years after the accident, it would be difficult to make a definitive assessment of the circumstances surrounding the Claimant's loss of his leg in the absence the Claimant's docket. He was referred to his report dated November 6, 2001 where he stated: "It would seem prudent that transfer should has (sic) been effected much earlier than was actually done". When asked what was meant by the use of the term "earlier than was actually done", he expressed the view that based upon the nature of the injury described by Dr. Mshana, the fracture of the tibia and the suspicion of circulatory compromise, there should have been immediate reference to the

orthopaedic specialist who could have advised on the treatment for the fracture and the vascular damage. This was not done and in his view, "The act of non-transferring the patient cannot be medically justified because of precarious circulation; in fact, this would be the justification for early transfer". He expressed the view that a patient with the diagnosis of the Claimant should have been transferred to a specialist facility within twenty-four (24) hours. He also testified that at the time of the incident in 1995, he was a member of the government's medical service and only two (2) hospitals, the Kingston Public Hospital and the Cornwall regional Hospital had the kind of specialist services which would have been required by the Claimant. Certainly, the Black River Hospital did not have those facilities or specialist staff. As an orthopaedic specialist, he was not of the view that it was necessary for the swelling to have ameliorated before transfer and operation on the fracture, a position espoused by Dr. Mshana.

Dr. Blake was vigourously cross examined by Mr. Cochrane for the defendants. He agreed that he had not seen the Claimant until some six (6) years after the incident, but denied that there would be any difficulty in making an assessment of the quality of thee treatment accorded the patient by the 3rd Defendant, as he could base his assessment upon Dr. Mshana's own report. He agreed that there were other injuries apart from the fracture. However, the report spoke of a depressed fracture of the tibia and circulatory compromise and, based upon his twenty years experience as an orthopaedic surgeon, he was of the firm view that both these conditions would have required early treatment.

The part of his testimony which I found most compelling was in relation to the swelling noted in Dr. Mshana's report. He said that it would be possible to operate on the fracture while the leg was swollen. In fact, the swelling was most likely the cause of the circulatory compromise because of the blood vessels right behind the tibia. It was his professional opinion that the only acceptable way to treat what was exemplified by the report of Dr. Mshana was to fix the fracture as soon as possible and examine the circulatory problem after fixation. If the circulation was restored there would be no further need to do anything. If there were still a problem, then there would be a need to examine the blood vessels, but one would need to have arteriography or ultrasound. "None of this was done in this case and that is why I can

state without being there that the standard of care fell far short of what was required in this case". Indeed, the facilities for doing the foregoing were not available at the Black River Hospital.

In answer to the Court, Dr. Blake expressed the view that the 3rd Defendant should have ensured that the Claimant was removed to a specialist facility as soon as possible and by any means, including transporting him by ambulance.

It is clear from the totality of the evidence and in particular that of Dr. Mshana, that there were two (2) medical issues which needed to be considered. The first was the displaced fracture of the plateau of the tibia which was revealed by the x-rays done of the Claimant's leg, and how it was to be treated. The second was the issue of circulatory compromise caused, in all likelihood according to Dr. Blake, by the displaced fracture of the tibia.

Insofar as the evidence of the witnesses was concerned, having observed their demeanour, I am prepared to accept that the Claimant although a simple person, was in fact, a witness of truth and his evidence was to be preferred to that of the 3rd Defendant wherever there was a conflict. If that position is correct as I hold it is, I am now able to make the following findings of fact. In particular, I am sceptical about the assertion in Dr. Mshana's report of May 1996, that the Claimant had been advised to have "absolute bed rest". In any event, there is no evidence that the complete and unqualified bed rest purportedly intended by Dr. Mshana was ever conveyed to the Claimant. I am strengthened in this view because nowhere in his statement or in his oral evidence did the 3rd Defendant say he explained the importance of "absolute bed rest", or its peculiar importance in the context of the possible consequences of circulatory compromise that might lead to amputation. Indeed, I accept the Claimant's version of the facts with respect to provision of the wheel chair and in other material particulars.

Dr. Mshana would have the Court believe that, there was improvement up to the Sunday September 17, 1995, in the Claimant's condition, but that the act of the Claimant's relatives in pushing him in the wheel chair on that one occasion

precipitated a total collapse of the circulation in the Claimant's leg. In the circumstances, having reviewed the evidence I find the following facts:

1) The Claimant was admitted to the Black River Hospital on September 10, 1995 following a motor cycle accident in which he injured his leg.
2) The Claimant received no treatment from hospital staff until the morning after he was admitted to the Black River Hospital.
3) The Claimant did request that he be transferred to KPH at various times during his stay at the Black River Hospital.
4) That the 3rd Defendant kept the Claimant at the Black River Hospital "waiting and watching" to see whether the swelling of the leg would subside for a period of about eight (8) days before transferring him to the KPH.
5) The defendants knew, or ought to have known that the specialist care which was required for the problems of the Claimant, whether confirmed or suspected, was only available at the KPH or the Cornwall Regional Hospital.
6) The Claimant complained of his leg being cold and discoloured during the time spent in the BRH.
7) That he was provided with a blanket to keep his leg warm.
8) That the 3rd Defendant despite saying that he would consult and seek specialist if he felt that it was necessary, made no attempt to do so.

Has the Claimant established liability in the Defendants for the loss of his leg?

In seeking to answer this question, the court has to satisfy itself as to the following issues:

1. That a Duty of Care is owed to the Patient/Claimant;
2. Breach of Duty because of failure to exercise the necessary level of Care;
3. Injury caused by the breach;
4. The damage suffered is not too remote.

Duty of Care

What is the nature of the duty if any owed by the Defendants to the Claimant? It has been suggested that the duty is a "single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment" 2) **SIDAWAY V. GOVERNORS OF BETHLEM ROYAL HOSPITAL (1985) AC 871, PER LORD DIPLOCK AT P 893**). There is no question but that the Claimant was owed a

duty of care by the Defendants and in particular, the 3rd Defendant. I accept the evidence of Dr. Blake as quite credible and further accept that as an expert. But since this is a trial in a court of law and not one in which the expert evidence determines whether liability is established, I need to make the additional observation that what I understood Dr. Blake's evidence to be saying is that a physician in the position of the 3rd Defendant, exercising the ordinary standard of skill which he would be expected to have and exercise, should have realized the necessity to have transferred the Claimant to a specialist. The question to be considered in determining whether that duty was breached is to ask the question: What level of skill or care does a doctor owe his patient?

Counsel for the Claimant submitted that it has been held in several cases that the test for whether a doctor's actions constitute the tort of negligence is to apply the test of the ordinary skilled man exercising and professing to have the relevant skill. The *locus classicus* of the test for the standard of care required of a doctor or any other person professing some skill or competence is the direction to the jury given by McNair J. in **BOLAM v. FRIERN HOSPITAL MANAGEMENT COMMITTEE [1957] 1 W.L.R. 583, 587**, and recently cited in a Belizean case referred to below.

> "[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 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."
>
> "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."

It was this test which Lord Scarman articulated in different words, in **Maynard v. West Midlands Regional Health Authority [1984] 1 W.L.R. 634, 639**: in the following passage.

". . . I have to say that a judge's 'preference' for one body of distinguished professional opinion to another also professionally distinguished is not sufficient to establish negligence in a practitioner whose actions have received the seal of approval of those whose opinions, truthfully expressed, honestly held, were not preferred. If this was the real reason for the judge's finding, he erred in law even though elsewhere in his judgment he stated the law correctly. For in the realm of diagnosis and treatment negligence is not established by preferring one *respectable* body of professional opinion to another. *Failure to exercise the ordinary skill of a doctor (in the appropriate speciality, if he be a specialist) is necessary."* (My emphasis)

The continuing validity of this test was re-affirmed in this region, as recently 2005 in the Belizean Court of Appeal decision, **CIVIL APPEAL NO. 9 OF 2004, MIKE WILLIAMS v ATANASCIO COB, UNIVERSAL HEALTH SERVICES CO. LTD, UNIVERSAL SPECIALIST HOSPITAL CO. LTD. (doing business as UNIVERSAL HEALTH SERVICES MEDICAL ARTS & SURGICENTRE**). In his judgment, the learned judge, Morrison J.A. in upholding a decision of the Court at first instance that negligence had not been established, said the following:

The learned trial judge expressly based himself on the law relating to professional negligence of medical practitioners as laid down in the well known decision of **Bolam v Friern Hospital Committee [1957] 2 All ER 118**, and subsequently approved in **Whitehouse v Jordan and another [1981] 1 All ER 267, Maynard v West Midlands Regional Health Authority [1985] 1 All ER 635, Chin Keow v The Government of Malaysia and another [1967] 1 WLR 812** and **MILLEN v UNIVERSITY HOSPITAL OF THE WEST INDIES BOARD OF MAMAGEMENT (1986) 44 WIR 274.** He placed particular reliance on the following well known passages from the directions to the jury of McNair J in the **Bolam case** (described by Lord Edmund-Davies in **Whitehouse v Jordan** (at page 276) as "the true doctrine ..."):

Morrison J.A. then quoted the words of Justice McNair's direction to the jury cited above and continued:

After a careful review of the authorities, the learned judge accordingly concluded that the question whether the first respondent was negligent in his treatment of the appellant "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" (paragraph 25). That, if I may say so, is a conclusion which was fully justified by the authorities.

The Claimant's counsel further submitted that a claimant must have suffered damage as a result of *the act of the tortfeasor*. However, as the following analysis and cases demonstrate, an omission or failure to act in appropriate cases, could lead to a finding of negligence. (See ***BOLITHO v CITY AND HACKNEY HEALTH [1998] A.C.232***.) In that case in the House of Lords, Lord Browne-Wilkinson stated:

> Where, as in the present case, a breach of a duty of care is proved or admitted, the burden still lies on the plaintiff to prove that such breach caused the injury suffered: *Bonnington Castings Ltd. v. Wardlaw* [1956] A.C. 613; *Wilsher v. Essex Area Health Authority* [1988] A.C. 1074. In all cases the primary question is one of fact: did the wrongful act cause the injury? But in cases where the breach of duty consists of an omission to do an act which ought to be done (e.g. the failure by a doctor to attend) that factual inquiry is, by definition, in the realms of hypothesis. The question is what would have happened if an event which by definition did not occur had occurred. In a case of non-attendance by a doctor, there may be cases in which there is a doubt as to which doctor would have attended if the duty had been fulfilled.

In light of the foregoing, I am satisfied that there has been a breach of duty of care owed by the 3rd Defendant to the Claimant. The liability also attaches to the 2nd Defendant as the employer of the 3rd Defendant but also to the 1st Defendant by virtue of the Crown Proceedings Act. In **CASSIDY v MINISTRY OF HEALTH [1951] 1 ALL ER 574)** Lord Denning said that whenever hospital authorities accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment. The hospital authorities, cannot, of course, do it by themselves. They have no ears to listen through the stethoscope, and no hands to hold the knife. They must do it by the staff they employ, and, if the staff are negligent in giving treatment, they are just as liable for their negligence as is anyone else who employs others to do his duties for him.

The breach in the instant case is the failure to recognize that the reasonable and responsible approach by a person in the 3rd Defendant's position and who purported to have the ordinary skill for that position, would be to transfer the Claimant to a facility at which specialized treatment could have been afforded to him.

Has there been injury or damage caused by the breach of the defendants? That there has been damage is self-evident. There was no evidence that the nature of the injuries received in the original motor cycle accident were threatening to the limb of the Claimant. In fact, I believe it is open to the court in these circumstances to acknowledge that a depressed fracture of the tibia is not one which routinely leads to the loss of a leg.

Defendants' Submissions

I pause here to note the essential submissions of the Defendants. Firstly, it was submitted that the Claimant was "treated in accordance with a practice accepted as proper in the medical profession". I do not agree. As noted above, the evidence of Dr. Blake was to the effect that the normal approach to this type of injury which was, according to the 3rd Defendant's notes not observed to be a crush injury, would be to get the patient to a facility where he would have had access to specialist care in the fixation of the fracture and the treatment of circulatory compromise, neither of which was available at the Black River Hospital. Dr. Blake was not saying that "as a consultant this is what I would have done", but that ordinary standards of skill of a medical practitioner at the level of the Senior Medical Officer, should have dictated that course of action. Dr. Mshana himself conceded in his evidence that these services were not available at the Black River Hospital and further that he did not consult with any specialist, although he would have done so at some point had the swelling continued to be an issue in the care of this patient, in whose case he had recognized circulatory compromise very early on. It would not be unreasonable to observe that doctors, like any other professionals, should know their limitations and could be negligent in failing to enlist the advice and assistance of a specialist.

The second main limb of the submissions for the defendants was to the effect that "the extent of the injury and the failure of the patient to comply with the instructions for his care" were the main if not the only cause of the loss of the Claimant's leg. In other words, the Claimant was either entirely the author of his own misfortune or he has contributed to it. I do not agree that this is what the evidence reveals. Indeed, I have already indicated my view of the Dr. Mshana's statement about the meaning of "absolute bed rest" and whether this was ever explained to the claimant. There is no evidence that what Dr. Mshana said was intended was ever explained to the Claimant.

In this regard, it is instructive to consider what the authorities say about the duty of disclosure.

In the United States, several of the state courts have developed the doctrine of informed consent which seeks to ensure that a patient gives consent to the medical treatment proposed by a medical practitioner. Usually, this is in relation to surgical procedures where it has been held that risks associated with the particular procedure must be disclosed to the patient.

In an article by a California attorney, John Blumberg, it is stated as follows:

> Informed consent is the principle that a patient has the right to know about the risks and benefits of a medical procedure before making a decision whether to undergo the treatment. The corollary of this right is the duty of the physician to disclose certain information to the patient.

He referred to the development of the law of informed consent from its beginnings in a case of **Cobbs v. Grant (1972) 8 Cal.3d 229, 104 Cal. Rptr. 505**, in which the California Supreme Court laid out certain propositions:

> (1) That patients are generally unlearned in medical sciences;
> (2) an adult has the right, in the exercise of control over his own body, to determine whether or not to submit to medical treatment;
> (3) that a patient's consent must be informed, and
> (4) that the patient has an abject dependence upon and trust in his physician.

He continued:

> "The Court established that the duty of care required that a physician must explain to a patient, in lay terms, the inherent and potential dangers of a proposed medical treatment".

It seems that the courts in the United States have been far more aggressive in pursuing this doctrine of "informed consent" to assist in founding liability in cases where there are risks in medical treatment, than courts in other common law jurisdictions such as Australia and England, and the doctrine is not without its critics. However, even in these latter jurisdictions in the last fifteen (15) to twenty (20) years or so, there has been an increasing acceptance of the importance of patient consent to treatment and the duty of the medical personnel to provide information on which such consent is to be given. Thus in the state of Western Australia in 2000, the state issued for the

benefit of public hospitals and health facilities "Guidelines for Patient Consent to treatment and Disclosure of Material Risks to Patients". The guidelines provide in the first place as follows:

> Whether or not medical treatment is to take place is *a decision for the patient, and treatment may not take place without a patient's consent*. Failure to obtain consent may render the practitioner liable to an action in battery, or even in extreme cases, to criminal sanctions.
> As well as the need to obtain the patient's consent to treatment (and equally importantly), *a medical practitioner has a legal obligation to provide appropriate information about any proposed treatment to a patient, including any material risks inherent in the treatment.* Failure to disclose such material risks to a patient prior to the patient deciding whether to undergo medical treatment may result in a finding that the practitioner has acted negligently towards the patient and that there has been a breach of the duty of care owed to the patient. Failure to disclose material risks to a patient may render the practitioner or health service liable to pay damages to the patient.

While these guidelines speak to a person undergoing medical treatment, it seems clear that in the instant case, although there was no surgical procedure which was done at the Black River Hospital, there was "treatment". This is because Dr. Mshana's evidence is that he decided to "watch and wait" rather than pursue other therapies. "Watching and waiting" is, in my view, a treatment modality. It was the responsibility of Dr. Mshana to have explained the implications of that modality as well as the risks of moving the Claimant so as to provide him with a proper basis for making a decision. But as noted above, I accept the Claimant's evidence that he did request a transfer to Kingston Public Hospital. There is no evidence that Dr. Mshana explained to either the Claimant or his relatives what his concerns were, if indeed he had any. As I have also stated above, I accept Dr. Blake's evidence that ordinary standard of care of a person in Dr. Mshana's shoes, would have required that the patient be transferred to a facility at which he could have received specialist treatment.

In an article in the British Medical Journal, Volume 324 No: 7328 in 2002, Professor Loane Skene of the Faculty of Law University of Melbourne and Richard Smallwood, Chief Medical Officer of the Commonwealth of Australia, suggested that the Bolam Test for liability in medical negligence cases, was being modified in an important way, and particularly in the area of the information to be provided to a patient facing medical choices in treatment of a medical condition. The learned authors suggest:

> Recent English case law suggests that the Bolam test is being modified so that a court can reject medical opinion if it is not "reasonable or responsible."[1] For example, in **Smith v Tunbridge Wells Health Authority** it was "neither reasonable nor responsible" for a surgeon not to mention the risk of impotence from rectal surgery, even if some doctors do not mention that risk[2]. And in Pearce v United Bristol Healthcare NHS Trust the court of appeal applied a "reasonable patient" standard:[3] "If there is a significant risk which would affect the judgment of the reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or she should adopt."[4]

The learned authors continue:

> The similarity of this test to the test stated by the high court of Australia in 1992 in the well publicised case of **Rogers v Whitaker**[5] makes recent Australian experience relevant to the English scene, together with the efforts of professional bodies in each country to explain the law to doctors. In Rogers v Whitaker an ophthalmologist failed to mention the possibility of sympathetic ophthalmia, a rare but serious complication of eye surgery, despite the patient asking about possible harm to the non-operated "good" eye. This complication occurred and the patient became, in effect, blind. The high court, in finding 6-0 against the ophthalmologist, said it is part of the doctor's duty of care to disclose "material" risks. A risk is material, if: "in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is, or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it."

The approach of the Courts to the duty to warn of risks or the duty of disclosure has unfolded over the years in decisions in the United Kingdom, the United States and Australia. As early as 1985, in the House of Lords case of **SIDAWAY v GOVERNORS OF BETHLEM ROYAL HOSPITAL [1985] A.C. 871**, in a dissenting judgment, Lord Scarman heralded the retreat of the Courts from a wholesale application of the Bolam principle as it related particularly to a doctor's

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[1] Bolitho v City and Hackney Health Authority [1998] AC 232 at 243
[2] [1994] MLR 334 (HL)
[3] [1998] E and WCA 2243 (May 29, 1998)
[4] See case cited at note 3 above
[5] [1992] 175 CLR 479

duty of disclosure of potential risks. That dissenting judgment was cited with approval by the Australian High Court in the Rogers case in the joint judgment of Mason C.J., Brennan, Dawson, Toohey and McHugh JJ. There it is stated:

> In dissent, Lord Scarman refused to apply the Bolam principle to cases involving the provision of advice or information. His Lordship stated 1985) AC, at p 876.):
>
> > "In my view the question whether or not the omission to warn constitutes a breach of the doctor's duty of care towards his patient is to be determined not exclusively by reference to the current state of responsible and competent professional opinion and practice at the time, though both are, of course, relevant considerations, but by the court's view as to whether the doctor in advising his patient, gave the consideration which the law requires him to give to the right of the patient to make up her own mind in the light of the relevant information whether or not she will accept the treatment which he proposes."
>
> His Lordship referred to American authorities, such as the decision of the United States Court of Appeals, District of Columbia Circuit, in Canterbury v. Spence 1972) 464 F 2d 772), and to the decision of the Supreme Court of Canada in Reibl v. Hughes (1980) 114 DLR (3d), 1) which held that the "duty to warn" arises from the patient's right to know of material risks, a right which in turn arises from the patient's right to decide for himself or herself whether or not to submit to the medical treatment proposed.

The decision and reasoning of the High Court of Australia in **Rogers** on the issue of disclosure of information was followed in a later case in the same court, **ROSENBERG v PERCIVAL, [2001] HCA 18 (April 5, 2001)**. On the other hand, in **PEARCE AND ANOR v UNITED BRISTOL HEALTHCARE NHS TRUST** (judgment delivered May 20, 1998), the English Court of Appeal denied a claim for negligence against a consultant. There the pregnant Claimant had visited the doctor on a day when she was already fourteen days beyond term on November 27, 1991, and sought advice about whether induction or a Caesarean section would be advisable. The doctor advised that it would be best to wait and have a normal delivery. In the result, the Claimant went into hospital on December 4, 1991 when it was found that the baby was not viable. She was induced and gave birth to a still-born baby girl on December 4, the baby having died, *in utero*, between the 2nd and 3rd of December. She claimed that she had not been advised of the risks of waiting to effect a normal delivery, and that the doctor was in breach of his duty to give information of the risk

of still birth in that case. The questions which the court had to consider were as follows:

1. Should the doctor have advised Mrs Pearce of any increased risk of the baby being stillborn as a result of the passage of time subsequent to 27 November?
2. If the doctor should have so advised, would the advice which he had given have altered the decision of Mrs Pearce to allow time to pass so that the child could be born naturally, or certainly on 4 December?

It was held that the decision of the doctor not to advise the Claimant of this statistically insignificant risk was not a breach of duty. Further, the evidence showed that the Claimant would not have acted differently even if the risk had been specifically pointed out, and she would have if even reluctantly, accepted the doctor's advice to wait further and have a normal delivery. There was no evidence that the treatment otherwise, in any way, fell short of satisfying the Bolam test.

Although most of these cases concern situations where there was the option of some surgical procedure, I am of the view that the principles articulated apply whenever a doctor directs his mind to the type of treatment which is to be given in any particular case. If there is some risk in a procedure or course of treatment, however small, it would seem that it is the responsibility of the doctor to bring it to the attention of the patient. In the instant case, the risk of waiting and watching should have been explained to the Claimant and also the risk of moving him to the Kingston Public Hospital. It seems clear from the evidence before that the Claimant would have taken the risk of being transported rather than the risk of remaining in the Black River Hospital.

Causation

Notwithstanding the existence of a duty of care, a breach of that duty and damages, it is clear that unless there is a causal link between the breach and the damages, judgment must be given for the defendants. From the findings of fact at which I have arrived and which are set out above, I am satisfied that the Claimant's loss of his leg was due to the care, or lack of it, provided by the defendants at the Black River Hospital and I so hold.

Inherent in the foregoing analysis is my finding that the 3rd Defendant had been negligent not only in not transferring the patient to the Kingston Public Hospital or the

Cornwall Regional Hospital at which specialist treatment would have been available, but also in not informing the Claimant of the options available to him and the risks if any, associated with each choice. In fact, Dr. Blake's evidence was to the effect that those two institutions were the only ones in Jamaica at that time which had consultants in the specialities concerned.

Damages

In the Claimant's amended statement of claim, a number of items were claimed in relation to medical expenses including prescriptions, ($66,100.00) cost of transportation, ($83,200.00) and loss of earnings, ($1,092,000.00) for total special damages of $1,241,300.00. The Claimant gave some evidence as to his special damages to include the cost of some of these specific heads of damage. Regrettably, he provided little in the way of documentary evidence as to those special damages. While it is a well-settled rule that litigants should prove their damages "strictly" and should not just "write down the particulars and, so to speak, throw them at the head of the court, saying, 'this is what I have lost; I ask you to give me these damages'"[6] the court must take into account the circumstances of the particular case and the evidence which is available to support any claim, in determining what amounts to "strict proof". Thus in the unreported Jamaican Court of Appeal case of **BOWEN v HOSHUE, SCCA No 23 of 2002**, Cooke J.A. (Ag) (as he then was) referred to the case of **DESMOND WALTERS v CARLENE MITCHELL 29 J.L.R. 173**. There, in considering what was to be accepted as strict proof, Wolfe J.A. (as he then was) adopted a common sense approach to that determination when he said that:

> "...to expect a side walk or a push cart vendor to prove her loss of earnings with the mathematical precision of a well organized corporation may well be what Bowen, L.J., referred to as ' the vainest pedantry."

As his Lordship Cooke J.A. said in the Bowen case:

> However, what is sufficient to amount to strict proof will be determined within the context of the particular case. For example, a casual worker could not be expected to produce documentary evidence of his earnings. The position would be the same in respect of income earned from a sidewalk vending trade.

In so far as the Court accepts that special damages have been established, the following would appear to be recoverable under the said head. In assessing this head of damages, I adopt the approach and the principles articulated in the cases cited

[6] Per Lord Goddard C.J. in Bonham-Carter v Hyde Park Hotel Ltd (1948) 64 T.L.R. at page 178

above. I have also considered and adopted the common sense approach of the local courts. In **CENTRAL SOYA JAMAICA LTD. v. JUNIOR FREEMAN (unreported) S.C.C.A. 18 of 1984** the learned President of the Court of Appeal, Rowe, P., stated:

> 'In casual work cases it is always difficult for the legal advisors to obtain and present an exact figure for loss of earnings and although the loss falls to be dealt with under special damages, the Court has to use its own experience in these matters to arrive at what is proved on the evidence.'
>
> 'This principle is no less applicable to a plaintiff involved in the sidewalk vending trade. This is a small scale of trading. Persons so involved do not engage themselves in the keeping of books of accounts. They buy, and replenish their stock from each day's transaction. They pay their domestic bills from the day's sale. They provide their children with lunch money and bus fare from the day's sales without regard to accounting.'

I would venture to say that a small farmer such as the Claimant, would be in exactly the same position as the persons adverted to by the learned President. Additionally, as was suggested by Carberry J.A. in another case,[7] "courts have experience in measuring the immeasurable".

In **ASHCROFT v CURTIN [1971] 1 WLR 1731; [1971] 3 All ER 1208, CA,** there was considerable difficulty in establishing the precise quantum of special damages under a particular head, loss of profits. It was held that the difficulty of assessment (in that case, unreliable accounts data) did not mean no recovery/nominal damages, and that impossibility of (certain/accurate) assessment not a bar to recovery: the best estimate rule applied That case is authority for the proposition that where (quantum) evidence is rejected on the ground of unreliability and where no better evidence is obtainable, *the court must make its own assessment on the basis of the evidence of harmful consequences or primary facts alone*. The principle applied in that case was therefore the best estimate rule. As Edmund Davies L.J. said: "[A nil award] is a conclusion to which I have been frankly loth to arrive, for it does not seem to me to meet the justice of the case. It means that, in the words of Holroyd Pearce LJ in **DANIELS v JONES ([1961] 3 ALL ER 24 AT 28, [1961] 1 WLR 1103 AT 1109)**, 'arithmetic has failed to provide the answer which commonsense demands'". The approach with respect to specific items of special damages was approved in a subsequent case in the English Court of Appeal.[8] It was also reflected in the judgment of Barrington-Jones J. in the Supreme Court of Belize in the case of **OSWALD**

[7] United Dairy Farmers Ltd. et al v Goulbourne, SCCA 65/81, decided Jan 27, 1994

[8] Alger, Brownless and Court Copy Services Ltd. v Jitesh Thakrar (Trading as Thakrar & Co) A Firm

SUTHERLAND v EWART METZGEN AND MABEL FRAZER (NO 23 OF 1977) decided April 28, 1980. There, he looked at the specific items of claim and considered what, if any, evidence had been led in that particular.

In the instant case, the Claimant does have a prosthesis and his evidence is that he paid $15,000.00 and still owes $5,000.00. It is also very likely that he would have had to use crutches for some period and the court may accept as true, his evidence that he paid around $2,000.00 for that item. His claim that he paid fees of $1,500.00 to the Black River Hospital but that the receipts are not now available is not unreasonable. He also gave evidence, which I accept, that he made three visits to a private doctor in relation to an injury to the stump of the amputated leg and that each visit cost $1,200.00. He also claimed that he paid registration fees of $50.00 on each of fifty visits to the Mona Rehab Centre for a total of $2,500.00 and not $25,000.00 as set out in the amended statement of claim. On the other hand, he throws in, without any real basis for calculation, a figure of $10,000.00 for prescriptions. The court is hard put to accept this figure without more. But even Dr. Mshana conceded that there were medications that were prescribed for the Claimant that were no available at the Black River Hospital. I would accordingly allow a sum of $2,500.00.

With respect to transport costs claimed, in his witness statement the Claimant specifically refers to three trips to the doctor in Lacovia for which he allegedly paid a total of $1,100.00. There is a claim for transport to the Kingston Public Hospital from FranklinTown while the Claimant was recuperating from the surgery. This is for the modest sum of $2,100.00 and common sense dictates that there would be some such costs and the figure is not unreasonable. There is also a claim for transport from Black River to Mona Rehab in Kingston for $80,000.00 but there is no evidence whatsoever of the number or the cost of those trips and so I would disallow that claim.

The most uncertain item of claim put forward by the Claimant is that in relation to loss of earnings. The evidence of the Claimant here is quite unsatisfactory as regards to quantum. The Court however, accepts that he is a witness of truth and his evidence that he was a small farmer growing catch crops, such as bananas, dasheens and peppers. The Claimant says he earned about $4,200.00 from his farming activities before the loss of his leg. He also says that at present he was earning $2,000.00 to

$2,500.00 per week subsequent to that loss. However, it is perhaps instructive to note that the particulars of claim, reflecting what the Claimant says in his witness statement, uses the figures which he said were paid to the his brother and a friend respectively. These figures were $4,200.00 per week for two (2) years at and $1,800.00 per week for 364 weeks. It is not clear what the Claimant did, in fact, earn from his farming activities. However, once the evidence that he was a farmer is accepted, and there was a period of incapacity during which he could not have carried out this activity, it is open to the court to use its best estimate. The Claimant also said that things had "slowed down" as he could not manage as well as he used to. He did, however, make the point that even up to the week before the trial, he had secured help in his field as it was time for reaping dasheens and he could not do this on his own. I believe that in the circumstances in which there is evidence that the Claimant was farming, that it is open to the court to make some award, albeit based upon "guess-work" and an appreciation of the context in which such small farmers operate. This exercise does probably amount to "plucking figures from the air".[9] Accordingly, I am prepared to proceed on the basis that the Claimant lost income of $1,000.00 per week for the period of four hundred and sixty-eight weeks as averred in the claim, up to the time of filing of the amended particulars on July 30, 2004, and for another seventy-five weeks up to the date of trial, or a total of 543 weeks. There is however, no claim for loss of future earnings. Given what I have said, the figures which I would allow for special damages are as follows:

Cost of the prosthesis	20,000.00
Fees for Dr. Blake (Consultation and Report)	7,500.00
Cost of crutches	2,000.00
Registration Fees at Mona Rehab Centre	2,500.00
Prescriptions/Medication	2,500.00
Transport costs	3,200.00
Loss of Earnings	543,000.00
TOTAL	**577,700.00**

[9] Per Edmund Davis L.J. in Ashcroft v Curtin

I move on now to a consideration of the general damages for pain and suffering and loss of amenities. Dr. Blake assessed the Claimant's Total Permanent Partial Disability as being 90% of the lower extremity and 36% of the whole person, using the American Medical Association Guidelines for this evaluation.

Both sides cited a number of authorities which it was suggested should guide the Court in its determination of the general damages. The Claimant's attorney-at-law cited **LEALAN SHAW v COOLIT LIMITED AND GLENFORD COLEMAN KHAN'S VOL 4**, at page 41. There the Plaintiff suffered a head injury, a 15cm L-shaped laceration over the right parietal region; a 7cm laceration to posterior of the proximal third; a 5cm laceration to lateral aspect at juncture of middle and distal third; a 6cm x 5cm laceration on right thigh with muscles protruding over anterior-lateral aspect at junction of middle and distal third and three lacerations over anterior aspect of right knee measuring 2.5 cm, 2cm and 2cm, respectively and one 2cm over anterior-lateral proximal third and 7cm deep laceration to posterior aspect of popleteal fossa. Upon being transferred to the Kingston Public Hospital, X-rays showed other damage. Four days after his initial admission to hospital, he had an above knee amputation. His permanent functional impairment was assessed at 70% of his right lower limb. He was awarded general damages for pain and suffering of $1.5 Million on July 26, 1995 when the CPI stood at 753.5. Based upon a CPI of 2401.9 in August 2006, that figure would now be $4,781,486.40. **IN TREVOR CLARKE v NATIONAL WATER COMMISSION, KENNETH HEWITT AND VERNON SMITH, KHAN'S VOL 5 AT PAGE 21**, the Plaintiff, as a result of an accident in November 1992, suffered an above-knee amputation and as the gas gangrene infection spread, had a second amputation. He spent two months in hospital and was sent home with the wound still unhealed. Healing was not achieved until June 1993. Even thereafter, the plaintiff continued to have problems and was unable to wear a prosthesis which he had acquired, because of a bony prominence to centre of thigh. Dr. Warren Blake, the witness in our instant case, also was the expert witness in that case and in 1999 he diagnosed the plaintiff as having femoral nerve neuroma. The impairment was assessed at 90% of the lower extremity, equivalent to 36% of the whole person. Smith, J., on October 25, 2001 awarded general damages of $3.0 million, a figure that would now be worth $4,953,392.45.

In **OSWALD ESPEUT v K. SONS TRANSPORT LTD., WOOLWORTH MILLER, MATLAW CONSTRUCTION, DENNIS LAWSON LTD., DENNIS LAWSON AND AMOS MARSHALL, KHAN'S VOL 4 at page 39,** the plaintiff was a janitor in 1988 when he was injured in a motor vehicle accident. On admission to the Kingston Public Hospital, the Plaintiff was in pain and his left leg had several superficial abrasions running along the anterior aspect of the leg from knee to distal third, leg and foot were grossly swollen, painful on touch and deformed. X-Ray showed a compound comminuted fracture of the tibia and fibula. There were no peripheral pulses, sensation was nil cold and clammy. He had an above knee amputation of the right leg but suffered from phantom leg syndrome and had a permanent partial disability of the right leg of 80%. In June 1997, Marsh J (Ag) (as he then was) awarded the plaintiff general damages for pain and suffering and loss of amenities $1,501,360.20. That figure would now be worth $3,456,121. Another case cited by the Claimant's counsel was **JOSEPH FRAZIER v TYRELL MORGAN & TREVOR CORROLL KHAN'S VOL 5** page 19. There the plaintiff suffered a severe crush injury to left lower extremity from middle third of leg to dorsum of foot on August 23, 1986. He was treated at the Kingston Public Hospital where his wound was found to be grossly contaminated. Dorsalis pedis and post tibial pulses were absent on the left and x-rays showed grossly comminuted displaced fracture of left tibia and fibula in midshaft. He had a high below knee amputation and remained in the hospital for three days. His stump healed without complications. His disability was assessed at 80% of the affected extremity and 32% of the whole person. On June 2, 2000, Mrs. Justice Beswick awarded him general damages for pain and suffering and loss of amenities of $2,000,000.00. That figure would now be worth $3,663,108.00.

Defendants' counsel submitted that the court should consider the case of **RUDOLPH GREEN v GOSHEN BLOCKMAKING KHAN'S VOL 3 page 18.** In that case, the plaintiff was injured when left foot went through a protective metal grate mixer into the path of mixer blades. He suffered a crush injury to the left foot with completely lacerated forefoot. He had a below knee amputation of the left lower limb. Damages were settled by consent at $160,000.00 in April 1990 including special damages of $60,000.00. I do not believe that this case provides a great deal of assistance.

Finally, in the case, **ABRAHAM SINCLAIR v MILFORD BAKER & DERRICK MINOTT (Suit No: C.L. 1991/S122)** (Harrison's Law Notes) the plaintiff had injuries of a fractured left femur, right fibula and tibia also fractured and suffered amputation of the right lower limb. Walker J., as he then was, awarded general damages for pain and suffering of $545,000.00 in March 1992 when the CPI was 355.7. That figure would now be worth $3,680,168.00.

Although the extent of the awards given above is roughly comparable for similarly assessed impairment, one should not conclude that the percentage disability is determinative of the amount of the general damages awarded. (In this case, Dr. Blake had assessed impairment as being 90% of the lower limb and 36% of the whole person). It is clearly a factor which has to be taken into account. But courts would do well to remember that the general damages are for pain and suffering and loss of amenities and not merely a function of the percentage permanent disability. In the **Shaw**, **Clarke** and **Espeut** cases cited above, there were severe lacerations and even a second amputation. In **Frazier** there was a severe crush injury. In the instant case the Claimant's loss of his leg only occurs after failure to treat the initial injury appropriately. The pain and suffering attributable to the initial accident can only be taken into account if there was evidence that earlier treatment would have avoided that pain. The Claimant speaks of his girlfriend having left him because of his handicap, and some disability with respect to his farming operations, but does not aver any other specific loss of amenity, (cannot play games etc). However, in the case of **CURTIS SCARLETT (bnf. Joyce Grant) v HENRY WILSON & ANOTHER (Suit No: C.L. 1989/S157)**, Ellis J. stated: "A below knee amputation of necessity results in loss of amenities". It must be concluded that there was here, a loss of amenities. The Claimant was transferred to KPH on September 18, 1995, and his leg was amputated on September 20, according to the Claimant's evidence. It should be noted that the report from Dr. Young of the Department of Surgery (KPH) dated July 1, 1996 said that the operation was done on September 27, 1995 but I believe that this is incorrect. The Claimant's own evidence was that it was done two days after he was sent to the KPH. The evidence of Dr. Mshana himself puts that date at September 18, 1995. He remained at that hospital for a period up to October 1, and was discharged for home on October 1, 1995. In the words of Dr. Young, he "did well post-operatively".

The Claimant does give evidence of being in pain after the amputation of his leg and he did have to make periodic follow-up visits to the Kingston Public Hospital after his discharge in early October. He was in hospital for just under two (2) weeks and had to remain in Kingston for a further two (2) months for treatment after the amputation. Taking all the evidence into account, In all, the circumstances, I believe that the Claimant be awarded general damages for pain and suffering and loss of amenities, the sum of $4,500,000.00. I award this sum with interest at the rate of 3% from July 3, 1996 until July 14, 1999, and 6% from July 15, 1999 until June 22, 2006 with 3% thereafter till the date hereof. In relation to the special damages, interest is awarded from September 20, 1995 until July 14, 1999 at 3% per annum and from July 15, 1999 to June 22, 2006 at 6% per annum and at 3% thereafter until today's date.

The Claimant is to have his costs to be taxed, if not agreed.