[2024] JMSC Civ 60

IN THE SUPREME COURT OF JUDICATURE OF JAMAICA

IN THE CIVIL DIVISION

CLAIM NO. 2014HCV04393

BETWEEN	**STEVE WRIGHT**	**CLAIMANT**
AND	**VENKATA KRISHNA RAO GUDAPATI**	**DEFENDANT**

IN OPEN COURT

Mr. Raymond Samuels instructed by Samuels Samuels for the Claimant.
Mr. John Graham KC and Ms. Lorna-Gaye Gooden instructed by John G. Graham and Company for the Defendant.

Heard: January 15 and 16, March 1, 2024, April 17, 2024 and May 14, 2024.

Procedural defect – Whether originating pleadings signed by claimant – Whether the failure to sign certificate of truth in originating pleadings is fatal – Discretion of court pursuant to Rule 3.13 of the Civil Procedure Rules 2002, as amended – Whether claimant's statement of case should be struck out.

Negligence – Medical negligence – Nature of the duty of care of general practitioner – Duty of general practitioner to refer patient to specialist – Contributory negligence – Whether a patient owes a duty of care to himself to seek alternative medical attention if unsatisfied with his treatment and recovery – Credibility – Whether the general practitioner delayed in referring the patient to a specialist or whether the patient delayed in returning to see the general practitioner – Duty of doctor to inform patient of all relevant risks in treatment

– Expert opinion – Whether specialist can give opinion on the standard of care expected of a general practitioner – Measure of damages.

N. HART-HINES, J

BACKGROUND

[1] Sometime in late February 2012, the claimant contracted an eye infection after what he perceived to be dust particles entered his left eye. Having regard to the fact that the claimant had known the defendant since he was an adolescent, he visited the defendant's medical practice on March 2, 2012. The basis for the visit, whether it was for treatment or for a referral to an eye specialist is in dispute. The defendant prescribed medication which the claimant used. However, his condition did not improve. The claimant alleges that he consulted the defendant on three (3) occasions between March 2, 2012 and March 30, 2012 and that the delay by the defendant in referring him to a specialist resulted in him losing the vision in his left eye and losing the left cornea and contents of the eyeball on April 27, 2012, following a surgery performed at the Kingston Public Hospital. The claimant has been assessed by an ophthalmologist as having 24% impairment of the whole person. The claimant now sues the defendant for negligence in the treatment of his eye infection.

[2] The defendant denies that he was negligent in the treatment of the claimant, and instead attributes the claimant's misfortune to his alleged failure to promptly return to his office for a review of the progress of recovery. He denies that he saw the claimant on three (3) occasions in March 2012. Instead, he avers that the claimant was only seen by him on two (2) occasions, on March 2, 2012 and twenty-eight (28) days later on March 30, 2012. It was on the latter date that he referred the claimant to eye specialists at the Cuban Eye Clinic at the National Chest Hospital, at the request of the claimant, due to financial constraints.

The Notice of application to strike out the claim

[3] During the trial, King's Counsel cross-examined the claimant on January 15, 2024 and January 16, 2024 and the claimant was shown signatures on the claim form filed on September 18, 2014 (at page 1 of the Judge's bundle), particulars of claim (at page 5), amended particulars of claim (at page 16) and a letter dated March 6, 2014, addressed to the Medical Council of Jamaica. He was asked if he had signed these documents. After the conclusion of the evidence, the defendant filed a Notice of Application on February 8, 2024 to strike out the claimant's statement of case and to have it declared a nullity on the basis that the claimant could not confirm that he signed the claim form. I will first address the application before addressing the issues in the claim.

[4] For the purposes of the hearing of the application, the relevant provisions of the Civil Procedure Rules 2002 as amended ("the Rules") for the court's consideration are Rules 3.6(3)(d), 3.12, 3.13 and 8.1(3). Rule 8.1(3) states that "*a claim form must be in Form 1 except in the circumstances set out in paragraph (4)*".

[5] Rule 3.6(3)(d) states that every document to be filed at the court must be signed by the person filing it. The relevant portions of Rule 3.12 state:

> *(1) Every statement of case must be verified by a certificate of truth.*
>
> *(2) The general rule is that the certificate of truth must be signed by the lay party personally.*
>
> *(3) Where it is impracticable for the lay party personally to sign the certificate required by paragraph (1) it may be given by that person's attorney-at-law. In the case of the Attorney General, the certificate of truth may be given by his or her attorney-at-law.*
>
> *(4) A certificate of truth given by the attorney-at-law must also certify-*
>
>> *(a) the reason why it is impractical for the lay person or the Attorney General as the case may be, to give the certificate; and*
>>
>> *(b) that the certificate is given on the lay party's or the Attorney General's instructions the case may be.*
>
> *(7) A certificate of truth by a lay party personally must be in the following form - "I [name] certify that I believe that the facts stated in this [name document] are true."*
>
> *(8) A certificate given by the attorney-at-law for a party must be in the following form - "I [name of the individual attorney-at-law giving the certificate] certify that –*

> *(a) the [claimant or as the case may be] states that he believes that the facts stated in this [name document] are true; and*
>
> *(b) this certificate is given on the [claimant's or as the case may be] instructions. The [claimant or as the case may be] cannot give the certificate because [state reason]."*

[6] Rule 3.13(1) provides that "*the court may strike out any statement of case which has not been verified by a certificate of truth*". An application may be made for an order under paragraph (1) (Rule 3.13(2)).

[7] Based on the answers given, submissions were made on behalf of the defendant that the signature on the claim form was not the claimant's and he did not recall whether anyone else, including his Attorney-at-Law, signed the claim form with his permission. It was further submitted that the claimant made it clear that he did not sign it and that he gave no one authority to sign on his behalf. Further, it was submitted that if an Attorney-at-Law had signed on his behalf, said Attorney-at-Law would have affixed his own signature and not written as if he was the claimant, signing in the claimant's name.

[8] The aim of Rule 3.12 is to ensure that a party certifies his/her honest belief in pleadings. The claimant's case seems to have been conducted in line with the pleadings. I have noted the claimant's evidence that he does not recall signing the various documents shown to him. The claimant subsequently said that Mr. Cameron wrote and signed the letter to the Medical Council of Jamaica, and that Mr. Cameron was his first lawyer and "probably" signed the claim form. The claimant has been consistent in saying that he does not recall signing the various documents, including the claim form. I find that throughout cross-examination, he never denied that he signed the originating pleadings. There is no expressed admission or concession that the claimant did not sign the claim form. He simply said that he does not recall if he did so. I must bear in mind that more than 10 years have elapsed since those documents were prepared, and that memories fade. However, it is a concern that when asked whether or not he signed the letter to the Medical Council of Jamaica, he said "*I don't sign in join up*" and that all the other documents shown to him appear to have a signature written in cursive.

[9] In any event, any defect in the original pleadings in terms of a failure to give a certificate of truth is not necessarily fatal. The Court of Appeal has pronounced on the issue in the decisions in **Shakira Dixon (By her next friend Norrine Bennett) v Donald Jackson** (unreported), Court of Appeal, Jamaica, Supreme Court Civil Appeal No 120/2005, judgment delivered on 19 January 2006, **James Wyllie & Ors v. David West & Ors** (unreported) Court of Appeal, Jamaica, Supreme Court Civil Appeal No. 120/2007; App No. 8 of 2009, judgment delivered 30 July, 2009, **Peter Kavanaugh v The Attorney General and another** [2015] JMCA Civ 9 and more recently in the case of **Kenrick Layton v The Island Traffic Authority and others** [2021] JMCA Civ 46.

[10] In **Shakira Dixon**, Harrison P. stated that the failure to verify a defence was not fatal and reiterated that the court must always give effect to the overriding objective in interpreting the rules. In the **James Wyllie** case, Smith JA observed that the misplacing of signature of the attorney-at-law should not render the signature ineffective, as "*it is better for a thing to have effect than to be made void*" (paragraph 36). In **Peter Kavanaugh**, the Court of Appeal considered that the learned judge had not misunderstood the law and had properly exercised his discretion under Rule 3.13. In the **Kenrick Layton** case, at paragraph 77 Justice Dunbar-Green JA (Ag) (as she then was) said that the cases of **Shakira Dixon** and **Peter Kavanaugh** establish that "*the absence of a certificate of truth does not automatically render a party's statement of case liable to be struck out. It depends on the circumstances of the case*". At paragraph 79 the learned judge said that "*where the statement of case is not verified by a statement of truth, it is not a nullity and the irregularity may be cured, for example, by an unless order requiring that within a specified time, verification is served on the other party, failing which the case is struck out (see the UK's Practice Direction 16 (Statements of Case) para. 4.2, referenced by the learned authors of the White Book in Part 22.3.2)*". Alternatives to striking out ought to be considered.

[11] Even if I were to find that the claimant did not sign the claim form and find that the certificate of truth does not comply with Rule 3.12, I would nonetheless find that there is no prejudice to the applicant/defendant and find that to strike out

the case at this stage would not be in keeping with the overriding objective. In exercising my discretion under Rule 3.13, I must refuse the application, having regard to its timing, the absence of prejudice to the applicant/defendant, and the fact that I am able to assess the claimant's credibility in determining the issues in this case, and in determining whether he has resiled from anything in the pleadings.

[12] A statement of case without a validly signed statement of truth would remain effective until it is struck out by the court. The evidence having already been led at trial before the application was made, it would seem inappropriate to strike out the claim. In any event, I note that an Amended Claim Form and 3rd Further Amended Particulars of Claim were filed on April 13, 2022, with the leave of the court to correct the record of the defendant's name. These documents purport to be signed by the claimant and his current attorney-at-law and no challenge is raised to these documents. The trial has proceeded on the amended pleadings filed on April 13, 2022 and not the original pleadings. I accept the submission of Mr Samuels that any defects in the original pleadings have now been cured by the amendment. In the circumstances, I dismiss the application to strike out the claim.

THE CLAIM

[13] Based on the claimant's pleadings, it seems the alleged failure of the defendant to swiftly refer the claimant to a specialist was the primary basis for alleging that the defendant breached his duty of care to him. The secondary basis alleged is that the medication prescribed was incorrect or ineffective and therefore the defendant failed to exercise the proper skill in the treatment of the claimant. It is further alleged that both failings caused the claimant to lose vision in his left eye.

[14] The particulars of negligence are stated as follows:

> *"A) The Defendant prescribed the wrong medication to the Claimant.*

B) The Defendant prescribed medication for a skin rash instead of a medication to treat the Claimant's eye
C) The Defendant having observed the continued deterioration of the claimant's eye failed to refer him to an eye specialist in a timely manner.
D) The Defendant failed to use all due care and skill throughout the period that he was treating the Claimant.
E) The treatment rendered to the claimant fell below the standard of care required of a competent doctor in the circumstances.
F) The Defendant failed to adequately respond to the change in condition of the eye of the Claimant.
G) He continued to treat the Claimant when he knew or ought to have known such treatment was beyond his expertise.
H) Not properly examining the Claimant's eye before proscribing treatment
I) Being negligent and not showing the proper duty of care that is required by law
J) Not sending the Claimant for an x-ray and/or a more intense examination by an eye specialist considering that the complaint concerned the vision of the Claimant.
K) That the Defendant was negligent in prescribing the wrong medication, not doing a proper examination, not noticing the deterioration of the Claimant's condition and failed to exercise the proper skill and interest.

17. *The Claimant further stated that at all material times the Claimant was under the care of the Defendant. The Claimant therefore plead and rely upon the doctrine of law know as res ispo loquitor.*

18. *That due to the loss of his eye the Claimant's career as an Entertainer was destroyed and that he has suffered a collapse of his career.*

19. *That the Claimant has suffered serious economic and psychological setbacks and is suffering post-traumatic stress."*

THE DEFENCE

[15] The defendant denies being negligent in the treatment of the claimant and asserts that at all material times he exercised due skill, care and diligence in examining diagnosing, treating and advising the claimant, as would be expected of and exercised by a reasonably competent physician.

[16] The defendant alleges that the claimant was diagnosed on March 2, 2012 with an inflammation of the left cornea known as Keratitis, as well as a fungal skin condition known as Tinea Versicolor or Pityriasis Versicolor, commonly referred to as "liver spots". At the time the claimant was first examined, the defendant observed the "*left eye was swollen and the left cornea had a tiny white patchy area in the left lower quadrant*", but "*the patient had normal vision*". The defendant says that he prescribed TobraDex eye drops to be used three times a day for one (1) week. He alleges that the claimant was advised to wear sunglasses to help alleviate any stress on his eyes and to return to his office if

there was no improvement. The defendant also says that the claimant was prescribed Terbisil once a day for two (2) weeks and Terbicare Cream to treat the Tinea Versicolor skin condition. The defendant further alleges that when he next saw the claimant on March 30, 2012, he was diagnosed with corneal leukoma, which he explained (in his viva voce evidence) was a "*healed patch or scar of the cornea consequent to keratitis*". The defendant alleges that on March 30, 2012, he examined the claimant and found swelling of the eyelids and white patches in the same position as previously observed. He referred the claimant to the Cuban Eye Clinic due to the claimant's financial constraints.

[17] The defendant alleges that he gave the appropriate treatment to the claimant. The defendant denies that he did not properly examine the claimant's eye before prescribing treatment and he denies that he prescribed the wrong medication. He also denies the allegation that that he failed to notice the deterioration of the claimant's condition, or, that having observed the continued deterioration of the claimant's eye, he failed to refer him to a specialist in a timely manner. He denies that the treatment which the claimant required was beyond his expertise. Finally, the defendant denies that he caused the injury and loss which the claimant alleges he has suffered.

THE ISSUES

[18] Counsel for the parties have identified the following issues for the court's determination:

1. Did the defendant owe the claimant a duty of care?

2. Did the defendant's diagnosis and/or treatment of the claimant fall below the standard of a competent general practitioner?

    a. Whether the defendant breached the duty of care owed to the claimant in prescribing medication. This issue will require a consideration of the following question:

   i. Did the claimant complain of a white patch on his skin on March 2, 2012, for which Terbicare cream was prescribed?

b. Whether the defendant failed to refer the claimant to an eye specialist in a timely manner. This issue will require a consideration of the following questions:

   i. Did the claimant request a referral to see an eye specialist on March 2, 2012?
   ii. Would it have been reasonable for the defendant to make the referral on March 2, 2012 even without a request from the claimant?

c. Whether the defendant failed to exercise reasonable skill and care in his treatment and review of the claimant. This issue will require a consideration of the following questions:

   i. Did the claimant visit the defendant's office on March 14, 2012 and see the defendant?
   ii. Did the defendant prescribe a second box of TobraDex eye drops for the claimant?

3. Whether the defendant's acts or omissions caused and/or contributed to the claimant's injury.

4. What is the nature and extent of the injuries sustained and losses incurred by the claimant.

5. Did the claimant contribute to his injuries? This issue will require a consideration of the following questions:

   a. Did the claimant’s use of the Terbicare cream on or around the eye contribute to his loss of vision?
   b. Was the claimant told to return to see the defendant in one (1) week, and was there delay on the part of the claimant in returning to see the defendant for a follow up on the progress in his condition?

c. Did his delay cause or contribute to his injuries?

[19] In addition to the issues indicated above, upon my appraisal of the evidence, I believe that the following issues are also to be determined by the court:

1. What are the potential risks involved in prescribing TobraDex eye drops and was it an effective medication to treat the claimant's condition?
2. Was the claimant told of the potential risks associated with using TobraDex eye drops?
3. Did the claimant owe a duty of care to himself to seek further medical treatment if the medication was not working?

[20] I will address the issues globally throughout my analysis of this matter.

SUBMISSIONS

[21] I thank counsel for their closing submissions filed which I have found helpful. Counsel should feel assured that I have considered the submissions. I will not summarise the submissions here, but instead refer to the most salient points made at appropriate points in my analysis of the case.

THE EVIDENCE

[22] It is useful to set out the evidence of the claimant by way of a chronology of the events as alleged on the claimant's case.

- On March 2, 2012, the claimant visited the medical practice of the defendant
- On March 14, 2012, the claimant allegedly visited the medical practice of the defendant
- On March 30, 2012, the claimant visited the medical practice of the defendant
- On April 2, 2012, the claimant visited the medical practice of Dr Brooks. The claimant was then referred to the Kingston Public Hospital ("KPH")
- On April 5, 2012, the claimant was admitted to the Eye Ward at KPH. He was diagnosed with a left central corneal abscess with central perforation.

Antibiotics therapy was ordered immediately. Hourly Vancomycin and Fortum eye drops plus oral Ciprofloxacin 750 mg twice daily for two weeks were commenced. A bandage contact lens was inserted to promote healing and to decrease the chance of prolapse of the contents of the eye. A third antibiotic eye drop (Gentamycin) was added a week after admission but there was no improvement.

- On April 21, 2012, a temporary tarsoraphy was performed where the eyelids were stitched together.
- On April 23, 2012, the claimant was discharged from KPH and given an appointment to return on May 1, 2012.
- On April 26, 2012, he returned to KPH complaining of severe pain in the eye after he sneezed. An examination revealed a breakdown of the temporary tarsoraphy and prolapsed of the contents of the eye through the perforation. He was again admitted and booked for evisceration of the eye.
- On April 27, 2012, the surgery was performed and the eye removed. He was noted to be depressed and was referred for psychiatric counselling.
- On May 2, 2012, he was seen by a psychiatrist and given a two (2) week clinic appointment.

The claimant's evidence

[23] The claimant was cross-examined about his purchase of the medication, his understanding of how to use it and his actual use of the Terbicare cream. It is noted that he fumbled a few times when asked to read the names of the medications or the directions. However, I find that the claimant is literate. He said that it was his first experience filling a prescription. He said that he had a conversation with the pharmacist at the time of filling the prescription and she told him how to use the medication. He also said that his empress assisted him in using the eye drop after she read the box. He further said that as a result of what the pharmacist said to him, he applied the cream "*to the affected area*", as he thought it was for the pain and swelling of his eye. He demonstrated that he applied it around the left eye. He was asked if the cream seeped into his eyes when he perspired. He denied that this happened.

[24] He was cross-examined about his alleged request for a referral to a specialist. He was shown the letter addressed to the Medical Council of Jamaica, which

he said was prepared by his Attorney-at-Law at the time, with his instructions. He eventually conceded that, as stated in the letter, he went to the defendant for treatment on March 2, 2012. He then said "*it was both*" for treatment and a referral, and added "*to get look[ed] after*". He was also asked why it was that he did not see another doctor if he was dissatisfied that he did not get a referral letter. He replied that the reason was that the defendant sent him to the pharmacy on March 2, 2012. As regards his reason for not seeing another doctor after his visit on March 14, 2012, he replied that the reason was that he didn't know any other doctor, and that he was using the medication and that the defendant said that he must have patience. I note that this assertion is not contained in his witness statement as regards the visit on March 14, 2012. His witness statement indicates that it is only when he returned on March 30, 2012 that the defendant is alleged to have told him that he was "impatient". The claimant was also asked by the court if there was any reason he did not go to the public hospital. He replied "*No. I just went to the home doctor for him to refer me if anything… Yes. I just go to the doctor I know. I did not go to KPH*".

[25] The claimant was cross-examined about whether he was told by the defendant to return for a review in one (1) week. He denied this, saying that he was told to use the medication for three (3) weeks. He was asked about any contracts he had for performances overseas and he said that he had one but was unable to produce same for the court's consideration.

[26] The claimant was not asked about the progression of pain and other symptoms between March 2 and March 30, 2012 or about the worsening of his eye condition after he applied the cream.

Richard Bell's evidence

[27] Mr Bell is a former record producer and owner of the Star Trail record label. He has worked with several of Jamaica's most renowned reggae artistes in producing songs or records. He was called as the claimant's witness to bolster

his evidence that he was a budding musician with contracts and tours arranged prior to losing his eye and that he suffered financial losses as a consequence.

[28] In essence, Mr Bell recanted from the evidence in his witness statement that the claimant would earn $50,000.00 per song released. He said the claimant did not always earn that sum and some of his songs were not released. He did not tell the court how many songs were released. In any event, the evidence suggests that the claimant was just entering the entertainment business and was not yet established. Mr Bell admitted that one reason the claimant was not signed to his label was because he (Mr Bell) left the business. He further said that the loss of vision in his left eye did not stop the claimant from recording his music, but the pain he endured affected his ability to work.

The defendant's evidence

[29] During cross-examination, the defendant was asked about his observations of the claimant's eye when he first attended the defendant's office. He noted that the left eyelids were swollen on March 2, 2012. He admitted that an ophthalmologist would have better equipment for examining the eye than the flashlight which he used. He was asked the following as regards the risk associated with the condition and with the drug TobraDex:

> *Q: Did you explain to him what Keratitis is and the risk?*
> *A: Yes. I explained that it was an inflammation of the lower part of the cornea.*
>
> *Q: But you did not explain that in your witness statement?*
> *A: No but I always explain to my patients …*
>
> *Q: Did you explain any dangers of using the drug [TobraDex]?*
> *A: I explained to him to use the medicine for a short period and to check back in one week's time for review*

[30] Although his witness statement indicates that he did not see the claimant on March 14, 2012, during cross-examination, the defendant seemed less sure of this. When it was suggested that the claimant came back to his office on that date, advising that the medications were not working, he replied "*I don't recall*

that". He was asked if he re-examined the claimant that day, and he replied "I don't recall". He later said "*whether he came and I did not see him*". He was asked if he prepared a prescription for the claimant on that date, and again he said "*I don't recall that*". He offered an explanation as to how the claimant obtained a prescription for a second bottle of eye drops. He said "*sometimes when the patient knows the pharmacy well, example if they are good friends, they can get the medication without a prescription. They might have the box from the previous prescription and the pharmacists helps*".

[31] When asked if the claimant's eye was in a worse condition than before on March 30, 2012, the defendant said "*[n]o. Actually his vision was normal. I didn't see any much more swelling.... Vision was normal. Only thing complaining was some pain*". He went on to add "*[w]hen he came, there was no protrusion of the eyeball. It was just the same except for the pain he was experiencing*". This evidence must be compared to the findings of Dr Brooks three (3) days later. I will address this later.

[32] The defendant was asked if he could not have made the referral on March 2, 2012 and he said "*No, as a GP you treat and hope for improvement*". When asked if he could not refer the claimant to KPH, he replied "*he asked me specifically to refer him to the Cuban eye clinic*".

Expert evidence

[33] Both parties relied on the medical reports provided by ophthalmologists. The claimant relied on a medical report from the Kingston Public Hospital ("KPH"), signed by Dr. Albert Lue, and a report from Dr. Kevin Waite, while the defendant relied on the medical report of Dr. Donald Cameron-Swaby. The claimant also relied on a medical report from Dr. Lloyd Brooks, a general practitioner attached to the Ivy Green Medical Centre. The defendant relied on the report of pharmacist Dr Dahlia McDaniel Dickson. The ophthalmologists, general practitioner and the pharmacist were certified as the court's experts pursuant to orders made on 18 September 2018, 17 April 2023 and 20 July 2023 and

their reports dated July 16, 2014, September 6, 2018, December 10, 2017, July 11, 2016, and August 28, 2023 were tendered into evidence (as Exhibits 6, 7, 8, 13 and 14) without the need for their attendance at trial. The claimant also relied on two other medical reports from the KPH.

[34] Dr. Albert Lue's medical report dated July 16, 2014 set out the treatment which the claimant received at KPH, his pain and suffering and that a whole person impairment of 14% was assigned based on the American Medical Association Guide (the "Guide"). The nature and extent of the treatment is indicated above in the chronology.

[35] Dr. Lloyd Brooks's report dated July 11, 2016 sets out the history given to him by the claimant and the fact that when he conducted a physical examination of the claimant's eye on April 2, 2012, he found that the "*left eye was in a pretty bad condition and that he needs urgent ophthalmological specialized attention*". He was given a prescription for Voltarene eye drops for the pain and a referral to KPH.

[36] Dr. Kevin Waite's report is dated September 6, 2018. A whole person impairment of 24% was assigned based on the American Medical Association Guide. Dr. Waite offered his opinion on the standard of care required of a General Practitioner. He said:

> *"I am of the opinion based on the facts that the standard of care given to Mr. Wright in March 2012 is not the standard required or expected of General Practitioners. It is also my considered opinion that had he been referred to an Eye Specialist at the first or indeed second visit the left eye could have been saved and the condition treated successfully".*
>
> "*The delay in receiving specialist care certainly contributed to the loss of the left eye*".

[37] Dr Donald Cameron-Swaby's report is dated December 10, 2017. While Dr Cameron-Swaby said "*Dr Rao's management of the patient was in keeping with the protocol used by Family Practitioners in the management of peripheral corneal ulcers and I do not believe he was negligent in the initial management*

of Mr. Wright", I have noted that Dr Cameron-Swaby's report is not entirely favourable to the defendant in that he said the following:

- *"… The patient should have been referred to a specialist if the symptoms failed to improve after one week or earlier if the condition is worsening".*
- *"**The application of topical TobraDex eye drops could have caused the symptoms to worsen under certain conditions** for example if a fungus or the herpes virus caused the ulcer".*
- *"… [Terbicare cream] has not been associated with the worsening of a pre-existing corneal ulcer and symptoms should reverse following the cessation of the drug".*
- *….*
- *"It is normal practice to warn patients that topical and systemic steroids can cause certain corneal ulcers to become worse and emphasize the importance of keeping their follow up appointments. **A specialist may have arranged corneal scrapes and tried to isolate the infective organism before starting any topical treatment, however this is not performed in every case and it often depends on the severity of the symptoms and signs**". (My emphasis)*

[38] Dr. Dahlia McDaniel Dickson's report is dated August 28, 2023. In her opinion. Terbicare Cream may be used on the external skin of eyelid, but not in the eye.

Variance in impairment ratings assigned

[39] I have noted a variance between the whole person impairment rating assigned by Dr Albert Lue, and that assigned by Dr Kevin Waite. Dr Lue assessed the degree of impairment caused by the injury to be 14%[1], while Dr Waite assessed the degree of impairment as 24% of the whole person. Both ophthalmologists relied on the American Medical Association Guides to the Evaluation of Permanent Impairment ("the Guide"), but neither ophthalmologist indicated which edition of the Guide he was relying on. As far as I am aware, the Sixth Edition of the Guide is the most current and accepted edition. When I perused chapter 12 of the Guide which deals with the Visual System, I observed that Table 12-2 indicates a range of impairment of between 10% and 25%, depending on the visual acuity score. I also observed that Table 12-5 of the

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[1] See Exhibit 6 - Medical Report dated July 16, 2014 at page 2.

Guide indicates that the range of impairment for the loss of one eye is between 10% and 25%, depending on the average radius if loss concentric and the visual field score.

[40] Dr Lue did not indicate how he arrived at the impairment rating of 14% of the whole person. No visual acuity score or visual field score is indicated in his report. In contrast, Dr Waite indicated a visual acuity score of the right eye as 20/50. I would therefore prefer Dr Waite's assessment since he offers an explanation.

[41] However, I have also noted that Table 12-2 of the Guide indicates that where the visual acuity score is 20/50, the impairment rating is 20% and not 25% as indicated in Dr Waite's report. Notwithstanding, I am prepared to accept Dr Waite's assessment of 25% of the visual system or 24% of the whole person, as I mindful of the fact that it is in the purview of the specialist to opt to adjust the impairment rating based on other considerations. Table 12-1 of the Guide indicates the calculation steps for the visual system and indicates that the ophthalmologist is to consider the visual acuity score (VAS) and the visual field score (VFS) and may make an adjustment "*for other vision problems*" and may "*combine with impairment of other organ systems if applicable*". It may well be that Dr Waite had regard to the fact that the "*cornea and contents of the left eyeball [were] surgically removed*" and the fact that the claimant will require a prosthetic eye "*to aid in the cosmetic appearance of his face and also his self-confidence*". I therefore accept Dr Waite's assignment of 24% whole person impairment.

[42] I will indicate my findings as regards the evidential value of the reports of Dr Waite and Dr Cameron-Swaby later.

THE LAW

The duty of a doctor and standard of care

[43] A doctor owes several duties to his patient and the breach of any of those duties may give rise to a claim in negligence if harm results from the breach. The relationship between patient and doctor is usually a contractual one, but the remedy for the failure of the doctor to discharge his/her duty to exercise reasonable care in treating the patient is based in tort. The claimant must therefore establish that the defendant breached the duty of care owed to him and that there is a causal connection between that breach and the damage which resulted, and that the particular damage was foreseeable.

[44] The overarching expectation is that a doctor will act with a reasonable degree of care and skill, that is to say, he/she is expected to use a fair, reasonable and competent degree of skill in diagnosing, advising and treating a patient. Before commencing treatment the doctor is expected to garner as much information about the patient's medical history as possible and where appropriate, to carry out any necessary investigatory tests in order to reach a possible diagnosis and determine the most appropriate treatment at that time based on the information available to the doctor. A doctor must provide medical treatment with reasonable care, utilising an appropriate level of knowledge and skill to address the patient's condition. Where the doctor does not have the requisite skill or competence, he should refer the patient to a specialist.

Assessing the conduct and standard of care

[45] The courts have acknowledged that there may be more than one viable way of treating a patient. Consequently, the courts require that the doctor acts in a way which is supported by "a body of respectable medical opinion". This concept was enunciated in **Bolam v Friern Hospital Management Committee** [1957] 2 All ER 118. However, following the House of Lords decision in **Bolitho v City and Hackney Health Authority** [1998] AC 232, the law has evolved to allow

the courts to find that a medical practice is unreasonable, although it conforms to the **Bolam** test.

[46] In **Bolam**, McNair J said this:

> *"The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that **it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising <u>that particular art</u>**. In the case of a medical man, **negligence means failure to act in accordance with the standards of reasonably competent medical men <u>at the time</u>**. There may be one or more perfectly proper standards, and if he confirms with one of these proper standards then he is not negligent." (My emphasis)*

[47] The conduct of the doctor should be compared with that of a reasonable doctor of the same specialism and status. Phillips JA reiterated this in **Dr Veon Wilson v Victor Thomas** [2020] JMCA Civ 28 when she said that "*a general practitioner was not expected to attain the standard of a consultant specialist*"[2]. Regard must also be had to the special circumstances of the case, for example, if the circumstances necessitated emergency treatment and the impact of the prevailing conditions on urgent diagnosis, decision making and treatment.

[48] The court must be mindful of using the benefit of hindsight to judge the conduct of the doctor. In **Ter Neuzen v. Korn** [1995] 3 SCR 674, (1995) 127 D.L.R. (4th) 577, the Supreme Court of Canada stated as follows at paragraph 34:

> *"It is also particularly important to emphasize, in the context of this case, that the conduct of physicians must be judged in the light of the knowledge that ought to have been reasonably possessed at the time of the alleged act of negligence. As Denning L.J. eloquently stated in Roe v. Ministry of Health, [1954] 2 All E.R. 131 (C.A.), at p. 137, "[w]e must not look at the 1947 accident with 1954 spectacles". That is, courts must not, with the benefit of hindsight, judge too harshly doctors who act in accordance with prevailing standards of professional knowledge."*

[49] In assessing whether the doctor's conduct fell below the required standard and were unreasonable in the circumstances, regard is had to expert medical evidence on what the standard practice entails or should entail. However, the court may find the doctor liable for negligence if, based on the evidence, he exposed the patient to a foreseeable and unreasonable risk of harm, that such

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[2] At paragraph 45.

conduct amounts to a breach of the duty of care, and that the said breach of duty caused or substantially contributed to the harm or injury suffered. In the instant case, I believe that it is appropriate to have regard to the duty of a general practitioner to refer patient to specialist and the duty of a doctor to notify a patient of all material risks involved in the treatment options.

Duty of general practitioner to refer patient to specialist

[50] The authors of Medical Negligence, Fourth Edition (2008) state at page 357:

> *"Where a doctor is unable to diagnose or treat the patient he will normally be under a duty to either seek advice from an appropriate specialist or refer the patient on to a specialist. If he attempts to diagnose or treat the patient himself, he is in effect, undertaking work beyond his competence, for which he will be held liable if harm results.*

[51] A delay in the referral to an appropriate specialist might result in irreparable physical and psychological harm. It is the claimant's case that timely diagnosis and treatment by an ophthalmologist would have saved the sight his left eye and the omission to refer him to a specialist therefore caused him to lose his vision.

[52] Counsel Mr Samuels relies on the Court of Appeal decision in **Dr Veon Wilson v Victor Thomas**[3]. There, Dr. Veon Wilson appealed the decision of Justice Cole-Smith, who found him negligent in the diagnosis and treatment of the respondent and in failing to refer him to a specialist. Victor Thomas suffered injury to his right eye from a piece of metal while repairing a bus. He sought treatment from Dr. Wilson, who examined his eye with a light, rubbed it with a piece of cloth and gave him eye drops from her office with instructions to return in two for a follow-up visit if his vision did not return. Later that night his eye became swollen with pus and blood and his pain worsened. Consequently, he visited the Spanish Town Hospital which referred him to the KPH, at which he was admitted for twenty-seven (27) days. There, he underwent surgery to

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[3] Supra at paragraph 47.

remove a metal particle from his eye. Unfortunately, notwithstanding the surgery and visiting several eye specialists in Jamaica and in the United States of America his sight was not restored. The respondent claimed that the appellant failed to diagnose the foreign object in his eye, failed to refer him to promptly a specialist, caused the metal particle to be lodged further in his right eye by rubbing same with a piece of cloth and failed to take any adequate precautions to avoid doing further damage to his eye. These factors he said lead to his blindness. He also relied upon the doctrine of Res Ipsa Loquitur.

[53] The appellant said she examined the respondent's right eye using a light and observed conjunctival haemorrhage and gave him "TobraDex" eye drops to reduce inflammatory reaction and infection. She said she used a sterile gauze from a sterile commercial packet to "sweep" the eye in a feather-like movement without applying pressure. She said that told the respondent that if he felt any discomfort in the eye in the next 24 to 48 hours he was to return immediately and mentioned the possibility of a referral to a specialist. This was denied by the respondent.

[54] Cole-Smith J found that the delay in referring the respondent to a specialist and initial inadequate medical response contributed to the progression of the respondent's injuries. The trial judge found the appellant negligent, attributing the probable cause of blindness to her actions, and awarded damages to Thomas. The Court of Appeal upheld the trial judge's decision and the award of $4,500,000.00 in June 2012.

The duty to disclose material risks in treatment options

[55] By virtue of the United Kingdom's Supreme Court landmark decision in **Montgomery v Lanarkshire Health Board** [2015] UKSC 11, doctors are now required to reasonably ensure that patients are aware of any "material risk" associated with recommended treatments, and of any reasonable alternative treatment. The court recognized that patients should be allowed to exercise greater autonomy in the decision-making process surrounding their treatment

and propounded a "reasonable patient" standard whereby there is an inquiry as regards what sort of information a reasonable patient would have wanted to know before commencing treatment. Patients have a right to communication and the duty of care to a patient therefore now includes the duty to disclose the material risks associated with treatments or procedures and to disclose alternative treatments, if the "reasonable patient" would consider it relevant to their weighing up of material risks. Lord Kerr and Lord Reed, who delivered the judgment, discussed several cases including **Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital** [1985] AC 871 and said at paragraphs 53 and 65 "… *the question for the judge is whether disclosure of a risk was so obviously necessary to an informed choice on the part of the patient that no doctor who recognised and respected his patient's right of decision and was exercising reasonable care would fail to make it*". At paragraph 87 of the judgment, the learned judges said the following:

> "*… An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments.* ***The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it***". (My emphasis).

[56] On the facts of the **Montgomery** case, the court observed that the risk of shoulder dystocia to the unborn child as a result of natural birth (as distinct from the alternative of delivery by caesarean section) was around 9-10%. This risk was said, on the evidence, to be "substantial" and consequently, the court held that "*the exercise of reasonable care undoubtedly required that it should be disclosed*"[4].

[57] The decision of Singapore's Court of Appeal in **Hii Chii Kok v Ooi Peng Jin London Lucien** [2017] SGCA 38[5], is said to have gone further than

[4] Paragraph 94 of the judgment.
[5] See https://www.elitigation.sg/gdviewer/s/2017_SGCA_38.

Montgomery "*holding that material information is not 'limited to risk-related information' and includes 'other types of information that may be needed to enable patients to make an informed decision about their health*" [6].

[58] Both courts in ***Montgomery*** and ***Hii Chii Kok*** noted that the patient is often a "passive" participant or recipient of treatment and opined that this should no longer be so. At paragraph 93 of the ***Hii Chii Kok*** judgment, the court noted the "*material difference in the dynamics of the doctor-patient relationship*" as regards the diagnosis and the treatment stages, but said that the patient must assume an active role "*after a working diagnosis has been formed and before the recommended treatment is administered*" since this is "*the moment where it is generally for the patient to make his decision"*.

[59] However, the England and Wales Court of Appeal later went on to indicate that no claim for damages may arise purely from a failure to disclose without a causal link to the injury sustained (see **Lucy Diamond v Royal Devon & Exeter NHS Foundation Trust** [2019] EWCA Civ 585).

[60] The principle to be applied in the instant case is that once the defendant was aware of the dangers associated with the TobraDex drug, he was required to indicate same to the claimant. Further, once the defendant was aware that a delayed referral to a specialist carried with it the risk that irreparable damage could be done to the claimant's eye, he ought to have swiftly referred him to a specialist.

ANALYSIS

[61] It is accepted that the defendant owed the claimant a duty of care by virtue of the doctor-patient relationship. What is in issue is whether he breached that

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[6] See paragraph 138 of the judgment. See **Differentiating Negligent Standards of Care in Diagnosis**, Medical Law Review 2022 Winter; 30(1): 33–59 by Kathleen Liddell, Jeffrey M Skopek, Isabelle Le Gallez and Zoe Fritz, Published online at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8865747/.

duty. The credibility of the parties must be determined before I address the issue of whether there was a breach of duty.

Credibility

[62] In addressing the issue of the credibility of the claimant, King's Counsel urged the court to be guided by dictum in the Privy Council decision in **Charles Villeneuve v Joel Gaillard** [2011] UKPC 1, at paragraph 67:

> *"I have found it essential … always to test their veracity by reference to the objective facts proved independently of their testimony, in particular by reference to the documents in the case, and also to pay particular regard to their motives and to the overall probabilities. It is frequently very difficult to tell whether a witness is telling the truth or not; and where there is a conflict of evidence such as there was in the present case, reference to the objective facts and documents, to the witnesses' motives, and to the overall probabilities, can be of very great assistance to a Judge in ascertaining the truth."*

[63] It is accepted that the court should assess the credibility of the claimant in conjunction with "*other evidence in the case which is capable of throwing light on its reliability*"[7]. I have identified four (4) areas in which other evidence has assisted me in determining the parties' credibility.

<u>(1) The letter dated March 6, 2014 addressed to the Medical Council of Jamaica</u>

[64] King's Counsel urged the court to have regard to the contents of documents which purported to have been signed by the claimant, or which were prepared by his Attorneys-at-Law on his instruction. Having reviewed the letter dated March 6, 2014, I have noted that it states that the claimant went to the defendant for "treatment" and I note that after being shown the letter during cross-examination, the claimant conceded that he visited the defendant for treatment on March 2, 2012.

[65] I accept that his Attorneys-at-Law wrote the letter on his behalf and that the said letter accurately reflected the fact that the claimant went to the defendant

[7] Per Lord Bridge of Harwich in **Attorney General of Hong Kong v Wong Muk Ping** [1987] AC 501, at 510.

for treatment of his eye condition. In the circumstances, I do not accept that the claimant asked to be referred to a specialist on March 2, 2012, the date of his first visit to the defendant. I find the claimant to have been discredited on this issue. However, irrespective of whether the claimant asked to be referred to a specialist, the onus was on the defendant to use reasonable skill and knowledge in assessing the claimant's condition and to determine whether he should be referred to a specialist. I will address below whether there were circumstances which necessitated a referral on March 2 or March 14, 2012.

(2) The Terbicare cream and Terbisil antibiotics

[66] King's Counsel submits that the fact that the claimant was prescribed the cream and antibiotics, proves on a balance of probabilities that the claimant had liver spots on his skin on the date of the visit on March 2, 2012. The report of Dr McDaniel Dickson supports the defendant's account. I find the claimant to have been discredited on this issue. I accept the defendant's account that he prescribed the cream and oral antibiotics for liver spots seen on the claimant, and therefore reject the claimant's account there was no discussion about liver spots on March 2, 2012. However, I do not believe that this is an issue that goes to the heart of the case since the report of Dr Cameron-Swaby suggests that the Terbicare cream was not likely to contribute to the loss of the claimant's sight in his left eye.

(3) The TobraDex eye drop box and the alleged visit on March 14, 2012

[67] The claimant relies on the TobraDex box with a pharmacist's label dated March 14, 2012 to support his contention that he visited the defendant's office on that date.

[68] I have given consideration to the accounts of both the claimant and the defendant as regards whether or not the claimant saw and spoke with the defendant on that date. I note the defendant's inability to recall seeing he claimant (see paragraph 30 above). His answers do not evoke confidence that he did not see the claimant and did not write a second prescription.

[69] I have also considered his answer in response to a question from the court that on occasions he might assist patients with a prescription without seeing them.

> *JQ: Is it ever possible for a patient to request a prescription from your nurse without you seeing the patient and for you to give the prescription, for example if the patient is hurrying?*
> *A: if it is a regular patient or there is a serious problem like they lose the prescription, they will ask for it.*
>
> *JQ: And you will give it?*
> *A: (coughs/clears throat) Yes. They don't want check-up but want prescription.*

[70] I have also considered the explanation proffered by the defendant that a pharmacist might have assisted the claimant with the medication without a prescription. While I accept that it is possible for a pharmacist to assist a patient with a repeat prescription without the actual script from the doctor, I believe that this would only be in a case where the patient has a chronic condition such as hypertension or asthma which is known to the pharmacist. However, I have serious doubts that a pharmacist would assist with a "one-off" prescription for eye drops to treat an eye infection, as in this case. Further, having regard to the fact that March 14, 2012 was a Wednesday and the fact that the pharmacist at which the second box of TobraDex was purchased[8] was based in May Pen, Clarendon and both parties were based there, there would be no good reason for the pharmacist to assist the claimant without a prescription when the claimant could simply have returned to the doctor that week to get the prescription.

[71] I have noted that, in response to a question from the court, the defendant denied that he and the claimant ever discussed the incorrect use of the skin cream (as alleged in paragraph 7 of the claimant's witness statement). Finally, no medical records kept in relation to the claimant's office visits were produced for the court's consideration, although he told the court that he "usually" had a patient file on which he would write the notes and the treatment. Such records would have been the best evidence available as regards the office visits, if

[8] Cornerstone Pharmacy at 2A Bryants Crescent, May Pen. The earlier prescription was filled at Prescriptions Ltd at 8 West Queen Street, Kingston.

contemporaneously recorded. They might have been particularly useful, having regard to the fact that more than ten (10) years have passed since the claimant visited the defendant's office and the memories of the parties appear to have faded somewhat.

[72] I prefer the claimant's account to the defendant's and find him credible as regards the visit to the defendant's office on March 14, 2012. I have considered the evidence that it was during that visit that he told the defendant that he had used the Terbicare cream around his eye. I accept the claimant's account that there was a discussion between the parties about the use of the cream on March 14, 2012. I have noted that the claimant freely admitted that he erroneously used the cream around his eye, even though that admission must have been embarrassing for him. This must go to his credit. I can see no advantage to be gained by the claimant's admission of this error.

[73] I find that the TobraDex box (Exhibit 4) corroborates the claimant's account that he visited the defendant's office on March 14, 2012, saw and spoke with the defendant and that the defendant prescribed the eye drops. I accept the claimant's account regarding the office visit on March 14, 2012.

(4) Dr Brooks' findings on the condition of the claimant's eye on April 2, 2012

[74] The medical report of Dr Brooks indicates that the claimant's eye was in a "*bad condition*" as at April 2, 2012, just three (3) days after the visit. The report corroborated the claimant's account that his condition had worsened. I do not accept the defendant's account that on March 30, 2012 he did not observe any "more" swelling to the claimant's eye and that the eye "*was just the same"* as it had been when he initially saw him.

Did the defendant's conduct fall below the required standard?

[75] In determining this issue, I have considered and attached significant weight to some of the matters contained in the reports Dr Waite and Dr Cameron-Swaby. Dr Waite expressed the opinion that the standard of care given to the claimant

in March 2012 "*is not the standard required or expected of general practitioners*". His explanation for this opinion seems to be contained in the next sentence when he said that the delay in referring the claimant to a specialist contributed to the loss of the left eye.

[76] King's Counsel submitted that Dr. Waite is not a specialist in the field of general practice and consequently, the court ought not to allow him to give opinion evidence on matters related to the field of general practice. It is my opinion that both Dr Waite and Dr Cameron-Swaby can express an opinion on the standard of care expected of a general practitioner ("GP"), as they would have worked for a few years as a GP prior to studying and qualifying as an ophthalmologist. It is common knowledge that many doctors work in general medicine for years before specializing. I am mindful of the fact that Dr Waite has not indicated how many years he worked as a GP before specializing in ophthalmology. Notwithstanding, I believe that I can rely on his opinion on the standard of care expected of a GP, as he must have worked in such a capacity for a few years before specializing.

[77] At first blush there appear to be two conflicting opinions on management or treatment of the claimant's condition. However, both ophthalmologists agree that there was a need to urgently refer the claimant to a specialist and, as aforesaid, Dr Cameron-Swaby seems to have implied (perhaps unwittingly) that the defendant's conduct fell below the reasonable level of skill required in treating the claimant when he said *inter alia*:

- *The application of topical TobraDex eye drops could have caused the symptoms to worsen under certain conditions for example if a fungus or the herpes virus caused the ulcer"; and*
- *It is normal practice to warn patients that topical and systemic steroids can cause certain corneal ulcers to become worse….*
- *A specialist may have arranged corneal scrapes and tried to isolate the infective organism before starting any topical treatment*

[78] Dr Brooks' report was not particularly helpful. While I prefer the report of Dr Waite, I also rely on the quoted sections of Dr Cameron-Swaby's report. Where

either expert expressed an opinion as regards who caused the delay in the referral, I disregard same as that is not a matter for either expert, but rather is a question of fact for the court to decide.

[79] I will now set out my findings as regards how the defendant's conduct fell below the reasonable level of skill required in treating the claimant.

Delayed referral and the risk of harm

[80] The contention in this case is that the defendant ought to have appreciated the risk of harm caused by the delay in referring the claimant to a specialist, and that in failing to make the referral, he breached his duty of care owed to the claimant. Reliance is particularly placed on the medical report of Dr Waite, to the effect that a referral to an eye specialist by March 14, 2012 might have obviated the need to remove his cornea.

[81] I do not accept the defendant's account in cross-examination that a GP should treat a patient before making a referral as correct since the decision to treat ought properly to depend on the extent of the injury and whether the GP has the knowledge and skill to treat same.

[82] Based on the reports of Dr Cameron-Swaby and Dr Waite, it is apparent that keratitis requires swift ophthalmic care to prevent the infection from spreading throughout the cornea and leading to blindness. The consensus of the expert witnesses relied on by each party is that delay in consulting an ophthalmologist or delay in getting specialist treatment was the primary cause of the loss of the claimant's vision in his left eye.

[83] The primary cause of the loss of the claimant's eye is the delay in the referral. In my assessment of the evidence, there were circumstances present as at March 2, 2012 to justify a referral of the claimant to a specialist. These included the fact that the eyelids were swollen and that the claimant indicated that he felt pain. These facts were admitted by the defendant in his evidence. The fact that there was an "inflammation of the left cornea" and that the

defendant said that the claimant reported to him that this was the state of his eye for almost one week suggests that further investigation ought to have been done by a specialist.

[84] When the claimant returned to see him on March 14, 2012, it should have been apparent to the defendant that the TobraDex eye drops were ineffective at treating the condition diagnosed. A reasonably prudent doctor ought to have questioned the efficacy of the drug and not ordered a repeat of the drug since it had not worked in 12 days. I find that the defendant ought to have referred the claimant immediately to a specialist on March 14, 2012. The defendant breached the duty of care owed to the claimant by delaying or omitting to refer him to an ophthalmologist on that date at the latest.

The medication prescribed (TobraDex eye drops) and the risk of harm

[85] In addition to the issue of the delay in getting specialized care, is the issue surrounding the efficacy and appropriateness of the TobraDex eye drops, and whether there was a medical error when prescribing the medication for the claimant. There is no medical report relied on by the parties which expressly faults the defendant in prescribing TobraDex eye drops. Dr. Cameron-Swaby said "*Dr. Rao's management of the corneal ulcer with topical TobraDex (steroid and antibiotic combination eye drop) is a recognized and frequently used management option for treating marginal keratitis*". However, he later indicated the dangers of the drug and the fact that it is important to know the cause of the ulcer since a virus such as herpes would be a contraindication to the application of the medication. It therefore would have been imperative for the defendant to get the claimant's medical history before prescribing TobraDex. However, it is not part of the claimant's pleadings that the defendant failed to get the claimant's medical history or that there was a misdiagnosis or resultant mistreatment due to a failure to get the claimant's medical history.

[86] It is however pleaded that the wrong medication was prescribed, albeit that the TobraDex eye drops were not specifically pleaded as an inappropriate medication. Based on the evidence, it seems appropriate for me to consider its effectiveness as a treatment. However, it is acknowledged that the main issue for the court's consideration in this case is the issue of delay, which is referred to in the reports of both Dr. Waite and Dr. Cameron-Swaby.

[87] Based on the observation made by Dr. Cameron-Swaby that "*TobraDex eye drops could have caused the symptoms to worsen under certain conditions for example if a fungus or the herpes virus caused the ulcer*", it seems that the TobraDex eye drop might have been intended to only treat bacterial eye infections and not fungal or viral infections, particularly since antibiotics are generally ineffective at treating fungal and viral infections. Dr. Cameron-Swaby said that topical TobraDex is a "steroid and antibiotic combination eye drop" which might cause symptoms to worsen if the ulcer was due to a virus or fungus. No expert evidence was ever presented by the claimant to show that his eye condition was caused by a fungal or viral infection. Notwithstanding, it is abundantly clear from the fact that the claimant's condition worsened, that the TobraDex eye drops were ineffective in treating his condition. I also make this finding based on that portion of Dr Cameron Swaby's report which referred to the danger of the drug in certain instances. I note that it was never suggested to the claimant that he did not take the eye drops as prescribed.

[88] The defendant was asked in cross-examination whether he knew of the potential for the eye drop to cause conditions to worsen. He denied it could do so over a short period. If he was not fully aware of the risks of using the drug, he ought reasonably to have referred the claimant to an ophthalmologist. If he was aware of said danger, then he ought not to have prescribed the drug on March 14, 2012 and ought to have warned the claimant of the risk of injury. He was also asked whether he advised the claimant of the possible dangers of the medication TobraDex. He really did not answer the question[9]. I find that

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[9] He said "*I explained to him to use the medicine for a short period and to check back in one week's time for review*".

the defendant did not inform the claimant of all relevant risks involved in treatment, namely that TobraDex could cause his symptoms to worsen.

[89] The defendant in essence said he acted with due care and skill as a general practitioner, he did not undertake a task beyond his competence. I have had regard to the fact that he has over 50 years of experience as a general practitioner and he said that he has dealt with other cases involving an eye infection. While it is expected that more experienced professionals will make fewer errors, human frailties means we are all prone to error. Competence in the relevant field in which treatment is provided is what matters and it is clear that the defendant lacked the requisite knowledge of the claimant's condition and of the TobraDex eye drops and lacked the requisite skills to treat the condition. I have noted that the defendant stated that he did the best he could as a general practitioner. Reference is also made in his witness statement to the fact that the claimant could not afford to see a private specialist. It might be that the defendant acted in the genuine belief that his conduct would be in the best interest of the claimant. However, regardless of his intentions, the defendant was bound to act with a reasonable degree of care and skill in diagnosing, advising and treating the claimant. If the defendant failed to inform the claimant of the risks associated with the eye drops or the risk associated with waiting to see if the eye drops would work and of his alternative option to seek specialist care, then the defendant would not have discharged his duty of care to the claimant.

[90] In my opinion, a doctor's duty to exercise reasonable care and skill involves assessing the patient's complaints and the dangers associated with the diagnosed condition, assessing the nature and extent his/her own expertise in treating the diagnosed condition, arranging for tests where necessary, and consulting with or referring the patient to a specialist where the diagnosed condition appears to require specialist care.

[91] The defendant's assessment of the ability of TobraDex to treat the claimant's condition appears to be plainly wrong since it clearly resulted in no improvement

to the claimant's condition even after the prescription was repeated. I am mindful of the fact that the ineffectiveness of the medication could have been due what caused the condition, as seems to have been intimated by Dr Cameron-Swaby. Notwithstanding, in my opinion, a reasonably prudent doctor would be required to re-assess the treatment options and his/her own ability to treat the patient once the medication initially prescribed did not resolve the issue. If the medication did not work as at March 14, 2012, it ought to have been apparent to the defendant that the cause of the condition required further investigation by a specialist who would have better equipment to examine the eye and if necessary, the equipment to do the scrapings required for diagnostic testing. The TobraDex eye drops should not have been prescribed a second time. Instead, the claimant should have been referred to a specialist or a public hospital if he could not afford to see a specialist.

[92] It is noted that the defendant said that he told the claimant to return after one (1) week. In the circumstances, it would seem that, as at March 2, 2012, the defendant appreciated the need for swift treatment and review of the claimant’s condition in one (1) week and that he did not (at that time) believe that a repeat of the TobraDex eye drops would have been required or appropriate. In the circumstances, to prescribe the same medication twelve (12) days later seems imprudent and unreasonable. The defendant’s treatment of the claimant on March 14, 2012 fell below the standard of care expected of a reasonable doctor who is a GP.

[93] Further, applying the principle in the ***Montgomery*** case to the instant case, the claimant was entitled to be told of the material risks in using the eye drops, and he should have been told of the risk of waiting to see if a second prescription for the eye drops would work (when the first did not). The potential benefit of using the eye drops had to be balanced against the risk of the “ulcer” or inflammation spreading throughout the cornea and causing blindness.

[94] The evidence of delay in referring the claimant to a specialist and the evidence that the TobraDex medication was inadequate to address the claimant’s

condition and may have worsened his symptoms are sufficient for me to find on a balance of probabilities that the claimant would not have lost his left eye but for the negligence of the defendant.

[95] Even if I am mistaken as to the impact of the TobraDex on the claimant's condition and the resulting loss of vision, I note that the claimant relies on the doctrine of ***res ipsa loquitur***.

[96] In the case of **Anthony Jackson v Dr. George Donaldson and The Attorney General of Jamaica** (unreported), Supreme Court Jamaica, Suit No. C.L.J 015 of 1995, judgment delivered the 25th day of June 2008, Marsh J analysed the ***res ipsa loquitur*** doctrine and said the following:

> *"This is an exception to the general rule that the claimant bears the burden of proof of the negligence alleged, arising where the facts established are such as that immediate inference arising from that is that the injury complained of was caused by the defendant's negligence; or where the event providing the basis of the negligence, tells its own story of negligence on the part of the defendant, the story so told being clear and unambiguous."*

[97] Having regard to my assessment of the evidence in this case, I find that the claimant's case is clear and unambiguous and that the doctrine of ***res ipsa loquitur*** applies.

The doctor-patient relationship and patient autonomy

[98] I will now address the issue of whether the claimant contributed to his injuries and to what extent, but I will briefly explain the imbalance in the doctor-patient relationship.

[99] The principle of personal autonomy simply means that a patient can choose not to return to see the doctor although he/she was told to return for a review. In such a case, the patient would have opted to take a risk that his/her treatment and recovery might be compromised. Such conduct would amount to contributory negligence.

[100] By virtue of questions asked in cross-examination, King's Counsel seemed to be suggesting that the failure of a patient to see another general practitioner or specialist if the patient felt that the prescribed medication was not working or that his condition was worsening would amount to contributory negligence. The questions pose an issue for the court of whether the claimant ought reasonably to have sought alternative medical treatment of his own motion. In other words, does a patient owe a duty to take reasonable care for his/her own health and welfare by seeking alternative medical treatment? The answer must be "yes".

[101] The doctor-patient relationship is not usually a balanced one since the patient tends to be vulnerable and dependent on the doctor for assistance with his/her condition. The patient tends to repose trust in the doctor's knowledge, competence, experience, skills and care for the patient. In Jamaica it is fair to say that most patients hold their doctors in high regard and trust their doctors' advice, decisions and actions in terms of diagnosis and treatment.

[102] In **R v Bateman** (1925) 94 LJKB 791, Lord Hewart L.J. said at page 794:

> *"If a person holds himself out as possessing special skill and knowledge and he is consulted, as possessing such skill and knowledge, by or on behalf of a patient, he owes a duty to the patient to use due caution in undertaking the treatment. If he accepts the responsibility and **undertakes the treatment and the patient submits to his discretion and treatment** accordingly, he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment." (*My emphasis)

[103] Yola S. Hamzo Ventresca, Peter W. Kryworuk and Scott D. Chambers, the authors of the Canadian article "With patient rights come patient responsibilities: contributory negligence in medical negligence actions"[10] observed that many jurists have perceived the historical inequality of the physician-patient relationship as being "*premised on the old adage that 'doctor knows best'*". They further observed that this perceived inequality of the physician-patient relationship caused "*many courts to set the standard of care that patients must adhere to at an unreasonably low level, thereby effectively precluding the availability of this defence for defendant-physicians*". The

[10] The Advocates' Quarterly 2007 [Vol. 33] at page 207 at pages 208-209, published online at https://www.lerners.ca/wp-content/uploads/2007/08/With-Patient-Rights-Come-Patient-Responsibilities.pdf.

authors opined in 2007 that along with the courts' recognition of the autonomy of patients, there should be recognition of the patients' responsibilities and obligations.

[104] The reliance on the defence of contributory negligence in medical negligence cases has no doubt increased since the publication of the 2007 Canadian article. However, it seems to me that in the absence of extreme negligence on the part of a claimant, the approach of courts worldwide has been to apportion liability in such a manner that the greater portion is in favour of the claimant. This is presumably due to the fact the doctor is to exercise reasonable care in the management of the patient's treatment (having regard to his/her knowledge and skills) and the resultant inequality of the physician-patient relationship, with the patient still being dependent upon the doctor's expertise.

The approach of the Jamaican courts in medical negligence cases

[105] In the case of **Enid Johnson (Administratrix in the Estate of Yorksladda Johnson, Deceased) v South East Regional Health Authority and The Attorney General Of Jamaica** [2018] JMSC Civ.170, the wife of the deceased brought a claim against the defendants for medical negligence in respect of treatment administered to him by staff at the Kingston Public Hospital between July 1996 and January 1997. Among her complaints was the fact that the delay in surgical intervention caused him to lose his right leg which had not been injured in an accident. The defendants raised the defence of contributory negligence, arguing that the deceased was a chronic smoker for fifty (50) years and smoked ten (10) cigarettes per day, and that although he was advised to stop smoking immediately to prevent vascular complications, he failed to do so. Palmer Hamilton, J. (Ag.) (as she then was) found that "*that the chronic smoking habit of the deceased resulted in the development of his peripheral vascular disease*", and also took into account the "*evidence that the deceased failed to follow up with outpatient care after January 2000, and that he deferred in seeking alternative care, when he realized that the 1st Defendant was*

neglectful in their treatment of his injuries". He was therefore found to be partially responsible for his injuries, and in particular, the amputation of his right leg. The learned judge apportioned liability on a 90% to 10% ratio in favour of the deceased.

The approach of the English courts in medical negligence cases

[106] In the decision of **Dalton v Southend University Hospital NHS Foundation Trust** [2019] EWHC 832 (QB), an opinion was expressed by a judge of the England and Wales High Court of Justice that contributory negligence is rarely successful in clinical negligence cases. Based on the structure of the National Health Service in England, a general practitioner is usually a patient's first point of contact with the health service and it is the general practitioner who refers the patient to specialists within the service. The claimant Mrs Dalton was concerned about a lump in her breast and went to her general practitioner who referred her to a specialist who conducted some tests but omitted to do a biopsy. Mrs Dalton was told that the tests did not reveal any concern. She returned to her general practitioner about a year later, reporting that the lump had grown. She was advised that there would be no further referral to the specialist unless there was a notable change. Two years later a change was observed in the form of puckering of the skin and at that time she was diagnosed with cancer. She filed a claim alleging that the delayed diagnosis and management of the cancer were due to negligence. The defendant denied that there was a breach of the duty of care owed to her and disputed causation. The defendant initially pleaded contributory negligence alleging that Mrs Dalton failed to seek an earlier re-referral, but at the trial, this contention was abandoned. As a result of evidence of the standardized practice and formulae used in clinical assessments and imaging, and by virtue of expert evidence to the effect that a biopsy would have been ineffective in diagnosing the cancer at the time of the initial investigations, Justice Yip ruled that Mrs Dalton failed to prove a breach of duty by the defendant. Notwithstanding, the judge criticized

the allegation of contributory negligence and expressed the following opinion, at paragraph 33:

> *"I consider that the circumstances in which a finding of contributory negligence can properly be made in a clinical negligence claim will be rare*. Certainly, they do not arise here. ... However, I commend Mr Kennedy for not persisting with it and make it clear that I find Mrs Dalton blameless."

[107] In the decision of **Otu v Datta** [2022] EWHC 2388 (KB)[11], Mr Otu had intermittent bowel problems and in 2014 he was seen at the defendant's clinic and diagnosed with an anal fissure. The defendant is a colorectal surgeon. Despite being "sure" that the fissure was the cause of Mr Otu's symptoms, the defendant wrote a discharge letter to Mr Otu's general practitioner (copying same to Mr Otu): "*I think at some point, because he has change in bowel habit, he ought to have a colonoscopy and we will arrange this in a few weeks' time*". However, the colonoscopy was never arranged. Mr Otu died of colon cancer in 2019 after being diagnosed in 2016. His wife brought a claim in negligence against the defendant, who admitted a breach in failing to arrange a colonoscopy in 2014, but disputed whether an earlier diagnosis would have altered Mr Otu outcome. The defendant alleged that Mr Otu had been contributorily negligent in that he failed to follow up and request a colonoscopy appointment. The defendant argued that medical treatment is not a matter for the doctor alone and relied on the concept of patient autonomy. At the trial, causation was established and the allegations of contributory negligence were dismissed. The judge held that Mr Otu had reasonably understood the colonoscopy proposed was to have been a precautionary, not urgent or not particularly important investigation since he was never informed of the possibility of the presence of cancer. Further, the judge held that the administrative responsibility for the follow-up investigation was that of the defendant alone.

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[11] See case summary in Cancer and contributory negligence: who is the objectively reasonable patient? by Nicholas Jones (Barrister) at published in 1 Crown Office Row - Quarterly Medical Law Review, Issue 13, July 2023 at https://www.1cor.com/london/wp-content/uploads/sites/2/2023/07/1COR-QMLR-Issue-13-2023-Spring.pdf.

The approach of the Canadian courts in medical negligence cases

[108] The Canadian decision of **Anderson (Litigation Guardian of) v. Nowaczynski** [1999] O.J. No. 4485 (QL), is a case in which the court opined that the patient could be found to be contributorily negligent where the failure to follow the doctor's instructions subsequently caused of the patient's injuries. Dicta from the judgment referencing a general duty of a patient to "*act in their own best interests*", was cited by the authors of the 2007 Canadian article cited above[12] as follows at pages 219 to 220:

> *… Commenting on this failure, the court observed:*
>
>> *"The onus of proving contributory negligence rests with the defendant physician.* ***Patients have a general duty to follow instructions and to generally act in their own best interests. If they do not do so, and if the breach of this standard is the factual and proximate cause of their injuries, they can be found to be contributorily negligent*** *…. Ms. Anderson failed to follow Dr. Nowaczynski's instructions to seek further medical attention when the problem worsened. In fact, the evidence is that in the late summer of 1995, Ms Anderson suffered a serious episode of shortness of breath, which required her to lie down for approximately one hour. That episode would have reasonably constituted a serious warning upon which Ms. Anderson regrettably did not act... Although Dr. Nowaczynski's diagnosis of costochondritis would obviously have been quite reassuring to Ms. Anderson, it does not excuse the sad reality that Ms. Anderson had some responsibility to act prudently in her own best interests by re-attending at Dr. Nowaczynski's office or at another physician's office [should her condition deteriorate].*
>
> *Based on the foregoing, the court held that had negligence been found against the physician, the court would have apportioned liability at 75% to the defendant and 25% to the plaintiff."*

Contributory negligence – did the claimant contribute to his injuries?

[109] The defendant bears the burden of proof to show that the claimant was in fact contributorily negligent and that such conduct on the part of the claimant was a substantial or material co-operating cause. The defendant relies on the fact that the claimant applied a skin cream around his eye, and he also relies on the fact

[12] Article "With patient rights come patient responsibilities: contributory negligence in medical negligence actions" supra.

that the claimant waited over twenty-eight (28) days before seeking alternative medical treatment from another general practitioner or hospital.

[110] Section 3(1) of the **Law Reform (Contributory Negligence) Act** states:

> *"Where any person suffers damage as the result partly of his own fault and partly of the fault of another person or persons, a claim in respect of that damage shall not be defeated, but the damages recoverable in respect thereof shall be reduced to the extent as the court thinks just and equitable having regard to the claimant's share in the responsibility of damage..."*

Misuse of the medication by the claimant

[111] The expert evidence confirms that Terbicare cream is an antifungal medicine prescribed for fungal skin infections such as Tinea Versicolor and Terbisil may be taken orally as treatment for Keratitis. It is therefore clear that the defendant did not prescribe these to treat the claimant's eye condition. The box in which the Terbicare cream was dispensed was put into evidence as Exhibit 2. Although the print on the back is small, the following words can be seen "*[f]or cutaneous use.* Cutaneous means "relating to the skin" and therefore as indicated by Dr McDaniel Dickson, the cream was only to be used topically and may be used around the eye, which the claimant said he did.

[112] The claimant has admitted that he incorrectly assumed that the cream was to be applied around the eye. While this is negligence on his part, there is no evidence to suggest that this caused him to lose sight in the eye. The claimant was never asked if, or when he ceased to apply the Terbicare cream around his eye. However, it is his evidence that he was told by the defendant on March 14, 2012 that the cream was not to be used around the eye and it is presumed that he ceased using it from that date. Dr. Cameron-Swaby said that medication would cause an "irritation" but ""*it has not been associated with the worsening of a pre-existing corneal ulcer*". I am satisfied that the Terbicare cream did not contribute to the claimant's loss of vision in his left eye.

Delay on the part of the claimant

[113] I do not accept the defendant's account that he advised the claimant to return after one (1) week. If that was the case, when he saw the claimant on March 14, 2012 he ought to have immediately referred him to a specialist as there was no improvement in his condition. I therefore do not find that the claimant delayed in returning to see the defendant between March 2, 2012 and March 14, 2012.

[114] However, the conduct of the claimant after March 14, 2012 is of concern. Although the claimant demonstrated that he tried to get treatment by visiting the defendant on three occasions, I am of the opinion that he should have acted with alacrity in trying to see a different doctor privately or at a public hospital when he realised that the medication was not working as at March 14, 2012. The average reasonable person would have found it prudent to question the repeat TobraDex prescription, since it had not worked in 12 days. I found the claimant to be an intelligent man. In the circumstances, I find that he ought to have sought medical assistance from another doctor after March 14, 2012 after being prescribed the same medication. I do not accept that the defendant told him to be patient on March 14, 2012.

[115] That said, I am cognizant of the fact that it might not have occurred to the claimant to question the prescribed drug or the defendant's competence in prescribing the drug for a second time, simply because the claimant "trusted" the defendant, and because he was never informed of the risks involved in delaying specialist care. Notwithstanding, based on his evidence, it was apparent that the eye drops were not working. At paragraph 6 of his witness statement he said this:

> *"About a week and a half later I noticed that the prescription was not working and my eye was getting worse"*

[116] During cross-examination, King's Counsel enquired of the claimant of the reason he did not seek medical assistance or advice from another doctor. The claimant's response was that the defendant was his "home doctor" and

someone he had known since he was an adolescent. The line of cross-examination brings into question the issue of patient autonomy and the fact that a patient has the right to choose who he seeks medical assistance from and to move on from one medical practitioner if he was not satisfied that he was seeing results in his treatment. Whilst the claimant did have that autonomy, the claimant indicated that he had known the defendant for years, having first been a patient of his when he was an adolescent.

[117] It is fair to say that the claimant "submitted" to the direction of the defendant as regards to use of the TobraDex eye drops. However, I have observed a further delay on the claimant's part in seeking specialist care. I note that even after he went to Dr Brooks on April 2, 2012 and got the referral letter to take to the KPH, he delayed a further three (3) days before going there, even though he said *"Dr. Brooks … advised me that my said left eye was in a very serious condition"* (paragraph 13 of his witness statement).

[118] I am mindful of the fact that the court should take a witness as it finds him. In this case the claimant reposed trust in the defendant. Also, I am mindful that the claimant does not seem to be very exposed to doctors and medical treatment. The very fact that he erroneously applied the ointment to his eye suggests that he is not well exposed. Notwithstanding, I note that the infection in his eye caused him pain from as early as March 2, 2012 when he filled the prescriptions. In such circumstances, I believe that it was unreasonable for him to sit waiting for thirty (30) days before trying to see another doctor and a further three (3) days before visiting KPH, even if he did not have the funds to see a specialist.

[119] The quality of care and success of the medical treatment which a patient receives will in part depend on how quickly he seeks medical assistance and how he cooperates or complies with directions/advice on the use of medication.

[120] Having regard to the length of time that he had the eye infection, the delicate nature of the eye, the fact the eye drops were not working, and because he was in pain, I believe that the claimant ought to have more swiftly sought treatment

elsewhere after March 14, 2012, to prevent his condition worsening. I therefore find him contributorily negligent and apportion the degrees of fault on a ratio of 90% to the defendant and 10% to the claimant. The reasons for my decision to apportion liability in this manner are that:

i) The relationship between doctor and patient is an imbalanced one and the doctor owes a duty of care to the patient;

ii) The defendant failed to refer the claimant to a specialist on March 14, 2012. Based on the expert report of Dr Waite and to some extent Dr Cameron-Swaby, it is this delay which is most relevant to the outcome in this matter, and which caused the claimant to lose vision in his left eye;

iii) The defendant failed to appreciate that the medication was not working and that the claimant needed more specialist care and/or investigation such as scrapes to determine the cause of the eye infection and to determine the best treatment;

iv) The defendant failed to inform the claimant of all relevant risks in waiting to see if medication would work, namely that he could become blind as a result.

DAMAGES

[121] The principles applicable to the assessment of damages are well-established. When assessing damages, the court endeavours to provide a claimant with compensation for the damage, loss or injuries sustained. The aim is that the award of general damages should put the claimant in the same position as he would have been if he had not sustained the injury, so far as money can compensate him (see **Livingstone v Rawyards Coal Co** [1880] 5 App Cas. 25, per lord Blackburn at page 39). To ensure that the award is reasonable, appropriate and consistent with previous awards, a comparative approach is adopted whereby regard is had to similar cases. Lord Hope of Craighead in **Wells v Wells** [1998] 3 All ER 481 said the following at page 507:

> *"the amount of award for pain and suffering and loss of amenities cannot be precisely calculated. All that can be done is to award such sum within the broad criterion of what is reasonable and in line with similar awards in comparable cases as represents the court's best estimate of the claimant's general damages."*

[122] When assessing general damages for personal injuries, the court must be guided by certain factors as set outby Wooding CJ in the landmark case of **Cornilliac v St. Louis** (1965) 7 WIR 491. These are:

(i) the nature and extent of the injuries sustained;

(ii) the nature and gravity of the resulting physical disability;

(iii) the pain and suffering which had been endured;

(iv) the loss of amenities suffered; and

(v) the extent to which pecuniary prospects have been affected.

The nature and extent of the injuries sustained

[123] The injuries suffered by the claimant are listed at paragraph 19 of the Particulars of claim as follows:

> *"i. Left corneal abscess perforated*
> *ii. Left eye removed*
> *iii. Post Traumatic Stress*
> *iv. Clinically and legally blind in the left eye*
> *v. 25% impairment of the visual system which equates to 24% impairment of the whole person.*
> *vi. Future surgery for prosthetic eye."*

[124] The claimant has lost vision in the left eye with the "*cornea and contents of the left eyeball [being] surgically removed*"[13]. Dr Waite indicated that he will require future surgery and prosthetic eye "*to aid in the cosmetic appearance of his face and also his self confidence*". The whole person impairment rating was significant. In addition, the claimant was noted to have become depressed immediately after the loss of his eye, and had to be referred to the Psychiatry

[13] See Exhibit 8 - Medical Report dated September 6, 2018 at page 1.

Clinic at the KPH, where he was prescribed Diazepam 5mg and was referred to the outpatient Psychiatry clinic for follow up.

The pain and suffering endured and loss of amenities suffered

[125] The Medical Reports dated July 16, 2014 (Exhibit 6) and Jul 11, 2016 (Exhibit 7) are instructive of the nature and extent of the claimant's ordeal from April 2 to April 27, 2012 when the surgery for the evisceration of the left eye was done.

[126] It is clear that he endured significant physical and emotional pain while under the defendant's care and then again during the eighteen (18) days in which he was initially admitted to the KPH, and endured further and more severe pain following his discharge and readmittance to KPH due to the perforation and the prolapsed of the contents of the eye through the perforation. He again endured pain following the evisceration of the eye. He was observed to be depressed and referred for psychiatric counselling and a follow-up appointment.

[127] The claimant gave evidence of having blurred vision in his right eye and having to wear sunglasses everywhere because he no longer feels comfortable. The injury has affected his self-confidence as well as his appearance and he is afraid to remove the sunglasses.

The extent to which his pecuniary prospects have been materially affected

[128] In the case of **Angeleta Brown v Petroleum Company of Jamaica Limited and Juici Beef Limited** (unreported) Supreme Court, Jamaica, Claim No. 2004HCV1061, judgment delivered 27 April, 2007, McDonald-Bishop J (Ag.) (as she then was) stated at paragraph 34 that a claimant is "*entitled to an award for any prospective pecuniary losses that are reasonably likely to flow from the injuries* sustained". In the instant case, the claimant's pleadings indicated that he claimed loss of future earnings. I am guided by the principles in the cases of **Smith v Manchester City Council** (1974) 17 K.I.R 1 and **Moeliker v A. Reyrolle & Co Ltd** [1977] 1 W.L.R. 132.

[129] I have considered the claimant's evidence and that of his witness Mr Bell as regards the claimant's earning capacity as an aspiring entertainer. However, I must find that there was a dearth of evidence to support the claimant's contention listed at paragraph 19 of the Particulars of Claim that he was earning significant sums at the time he lost his vision and that he suffered financial loss, to wit:

> *"Loss of income from Star Trail Records*
> *l. $250.000 per song at 70 songs $17,500,000*
> *2. $3,000.00 U.S currency per show for 90 shows $270,000.00 (US)*

[130] Mr Bell's evidence suggested that the claimant earned on an ad hoc basis and he was not paid for all the songs produced. I must also find that no evidence was adduced to show that he is likely to suffer financial damage because of a disadvantage in the labour market, as a result of the loss of vision in his left eye. In the circumstances, I make no award for loss of future earnings.

[131] I have considered the cases relied on by counsel for the parties. The most comparable cases are listed below. The Consumer Price Index ("CPI") for March 2024 is 135.1. The awards made in these cases would update as follows:

i) **Ruel Ellis v Tristan Wiggins** (unreported), Supreme Court of Jamaica, 2007HCV04918, judgment delivered on December 8, 2010 – $3,500,000.00 awarded on December 8, 2010 when the CPI was 64.4 updates to $7,342,391.30.

ii) **Roxanne Peart (bnf Venice Peart) v Shameer Thomas (bnf Angella Thomas) and others** [2017] JMSC Civ 60 – $4,000,000.00 awarded on April 28, 2017 when the CPI was 91.7 updates to $5,893,129.77

iii) **Audley Gilbert v The Attorney General of Jamaica** [2017] JMSC Civ 165 – $5,000,000.00 awarded on November 3, 2017 when the CPI was 94.7 updates to $7,133,051.74

iv) **Desmond Hepburn v Attorney General of Jamaica** [2023] JMSC Civ. 27 – $8,000,000.00 awarded on March 2, 2023 when the CPI was 128 updates to $8,443,750.

[132] I find that the decision in **Dr Veon Wilson v Victor Thomas** is the most apt comparison, having regard to the similarities in the two cases and the nature and extent of the suffering endured post-surgery. There, the award of $4,500,000.00 in June 2012 was upheld. This award updates to $8,635,653 today. However, I am inclined to make an award similar to that in the **Wilson** case but to increase it slightly on account of the weeks of suffering endured by the claimant from March 2, 2012 to April 27, 2012 (when the cornea was removed) and the mental anguish, depression or PTSD he experienced as a result of not being referred to the specialist at the earliest opportunity on March 2, 2012. I feel an appropriate sum would be $9,000,000.00. However, the award will be reduced by 10%, having regard to the finding of contributory negligence on the part of the claimant.

Future medical care

[133] Paragraph 19 of the Particulars of claim indicates that the claimant proposes to have surgery to be fitted with a prosthesis. The cost of this future surgery and prosthetic eye (or ocular prosthesis) was estimated at US$2,500.00 as at the date of Dr Waite's report dated September 6, 2018. I have no doubt that the cost has increased since that date, having regard to general prices increases worldwide since the covid-19 pandemic in 2020. However, no revised estimate was provided. I am prepared to increase the award in respect of the cost of future surgery and prosthesis by 15% or US$375 to attempt to reflect general rising costs.

Special Damages

[134] In addition to loss of earnings (referred to above), the claimant also claimed the following as special damages:

> *"a. Expenditure during hospitalization $100,000.00 …*
> *c. Legal Retainer $450,000.00 …*
> *e. Cost of Medical Report of Dr. Kevin Waite $90,000.00"*

[135] Receipts were produced to satisfy the court of the payments made to Dr. Waite. Although $100,000.00 was said to have been expended during his stay at the KPH, only a receipt in the sum of $4,000.00 was produced to the court as evidence of a payment to the hospital for the preparation of the medical reports.

ORDERS

[136] Judgment for the claimant.

[137] Damages are assessed in favour of the claimant against the defendant.

i) General damages are awarded to the claimant as follows:

(a) Pain and suffering and loss and amenities in the sum of $8,100,000.00 plus interest at the rate of 3% per annum from November 11, 2014 to May 14, 2024.

(b) Cost of future medical care in the sum of USD $2,875.00

ii) Special damages are awarded to the claimant in the sum of $94,000.00 plus interest at the rate of 3% per annum from April 27, 2012 to May 14, 2024.

iii) Costs to the claimant to be agreed or taxed.

iv) Stay of execution granted for a period of 14 days from the date hereof.

………………………………..

N. Hart-Hines

Puisne Judge