CICUTO v DAVIDSON AND OLIVER (1968) ZR 149 (HC)

HIGH COURT
MAGNUS J
8th NOVEMBER 1968

Flynote and Headnote

[1] **Tort - Negligence of professionals - Doctors**

A medical man is not guilty of negligence, if he has acted in accordance with a practice accepted as proper by a reasonable body of medical men skilled in that particular act, merely because there is a body of opinion who would take a contrary view; a wrong diagnosis is not necessarily an unskilled or negligent diagnosis.

Cases referred to:

(1) *Lamphier v Phipos* (1838), 8 C & P 475.

(2) *Rich v Pierpoint* (1862) 3 F & F 35.

(3) *Marshall v Lindsay County Council* [1935] 1 KB 516.

(4) *Whitford v Hunter* (1950) WN 553.

(5) *Bolam v Friern Hospital Management Committee* (1957) 1 WLR 582.

(6) *Crivon v Barnet Group Hospital Management Committee, Times Newspaper,* 18th November, 1958.

(7) *Barkway v South Wales Transport Co*., [1950] AC 185.

(8) *Roe v Ministry of Health* [1954] 2 All ER 131.

A O R Mitchley, for the plaintiff.
May, Q C, and Kemp, for the defendants.

Judgment

Magnus J: The facts in this case are comparatively short and very little in dispute.

During the night of the 30th August, 1967, Mr and Mrs Carlo Julio Cicuto observed that their son, Lulgi Giovanni Cicuto, aged thirteen months, had had a restless night and kept turning himself around in bed all night. As the father put it, he did not actually cry, but he moaned. The child had, up till that point, been a perfectly healthy child. In the morning, that is of Thursday, the 31st August, he seemed to be worse, he was very restless and was also crying, although, his father says, not very much, it was really moaning. Just before the father was about to leave for work, the child dirtied a napkin and he (the father) noticed a spot of blood mixed with the faeces. He took the child to the first defendant at his surgery at Baker House in Livingstone Road, Lusaka. At that time, the first defendant was an assistant in the medical practice carried on by the second defendant in partnership with one Dr Sherwood.

In brief, the defendant examined the child and prescribed for him, but he was brought to the out - patients' department at Lusaka Central Hospital later that evening, where the defendant again examined him and had him admitted to the hospital for observation.

He saw the child again the next day, Friday, the 1st September, after which he went away for the weekend, the treatment of the child being taken over by the second defendant. The ward record book shows that the child had been admitted to the hospital with suspected gastroenteritis. The second defendant saw the child that afternoon, when the child seemed to be worse, but when he saw him again the following morning, there seemed to be an improvement. Later that afternoon, however, the child seemed to take a turn for the worse but, after treatment, he seemed to rally a little. At 5.15 a.m. on the following morning, Sunday, the 3rd September, the child died. A subsequent post - mortem examination showed that the child had suffered a large intussusception involving the terminal ilium, ascending colon and descending colon all being impacted into the pelvic colon and the cause of death was given as shock from intussusception.

Going into these facts little more fully, at the first examination of the child at Baker House, the first defendant, having been told the symptoms as I have described them above, examining the child, looked into his eyes and mouth and examined his rectum and gave him a general abdominal examination. He says he found no abnormal signs and, in particular, no lump. The rectal examination was both visual and digital and he discovered blood on his examining finger on removing it from the child's rectum, which at the time he ascribed to a small tear on the internal anus. He says the abdomen was soft and the bowel sounds normal. The child was well nourished and hydrated. He prescribed a medicine which the father collected from the pharmacy. He describes it as a yellowish liquid. The father says that at that stage the child was still restless and looked sad. He was normally a very happy child.
The father took the child home and went off to work. When he arrived home about 5.30 that evening, he was shown some six napkins which were blood - stained. He collected these and took them with the child to the out - patients' department at the Lusaka Central Hospital, where the nurse phoned the first defendant who arrived about 6.30 p.m. The first defendant examined the child and says that he found no real change from the morning's examination. The abdomen was quite soft and resonant to percussion and no obvious mass was present. The indication, he says, was that there was no obvious surgical condition present. A rectal examination showed a little bleeding *per anum* and, he said in examination in chief, the parents showed him one napkin which had mucus which was very slightly blood - stained. On cross - examination, he amended this statement to seeing possibly two napkins but no more. He said it was not like "redcurrant jelly" (a term to which I shall refer later). Its basic quality was mucus streaked with blood. The quantity in sum total which he saw would be no more than half a teaspoon or rather less than when one cuts one's finger. The parents told him that the child had been restless during the day and they also told him at this stage that the child had been vomiting, which he understood to mean that the child had vomited once only. Indeed, the evidence seems to indicate that, at this stage, this was so. The child was admitted for observation and investigation and the first defendant ordered a stool examination. At this stage, he thought that it was probably a gastroenteritis infection in the broader sense. He prescribed mixture of sulpha guanadin to indicate treatment for this diagnosis pending a stool.
At this stage, he says, it was only the bleeding about which he was concerned. The child's general condition was very good and the temperature normal.
The first defendant saw the child again at about 7.30 on the following morning, Friday, the 1st September. The child was sleeping quietly in bed. His condition seemed peaceful and satisfactory. He prescribed Largactil, which was a sedative and would help to sedate the patient so that he could be observed more easily. He looked at the child but he cannot remember whether he examined his abdomen on that occasion. The ward sister reported that the child had a quiet night and had taken 10 glucose water freely without vomiting. He examined a towel which had been used as a napkin. It contained mucus streaked with blood, but both were in very small quantities. The napkin was wet, but he assumed that this was urine. He asked for a stool specimen (i.e. of the mucus and blood) to be sent to the laboratory. The treatment already prescribed 15 was to be continued. He still did not think there was any need to change the treatment or the form of investigation.
This was the last time that the first defendant saw the child, since he was off for the weekend. He says he had considered intussusception at an early stage. He normally kept this in his differential diagnoses, 20 but on the occasions when he examined the child, he found no evidence in favour of this diagnosis. The father, in evidence, said that, on two occasions, he had asked the first defendant whether the child ought not to be X - rayed, although the reason he gave for this request was because he thought the child might have swallowed a nail. Asked why he did not 25 accede to this request, the first defendant said that this was not something they embarked on lightly, especially where a child was concerned and, indeed, the medical evidence indicates that X - ray treatment where a small child is concerned could be harmful although it might have to be undertaken in certain circumstances.
At 30 about 4.30 on the Friday afternoon, the father says he saw the child at the hospital. The child was much worse and had bruises on his forehead. The nurse said the doctor had

asked her to ask the witness whether the child had fallen. I have not had any real explanation of these remarks, but I do not see anything in the evidence to indicate that it has any bearing on this case. At any rate, the father says that on the Friday afternoon, the child was getting worse and crawling on his stomach all the time. He was very worried and went to the defendants' surgery in Baker House and asked to see the first defendant. The receptionist told him that the first defendant was away for the weekend and the second defendant was in charge. Mrs Cicuto saw the second defendant, who says that, as a result of her visit, he went immediately to the hospital, saw the child and examined him, having, he said, been put in the picture by the first defendant before Mrs Cicuto had called on him. He first inspected the child visually, noticed his position in the bed and on turning him over, he noticed his fretful appearance and his moderate degree of lassitude. He was obviously a sick, and to some extent toxic, child, but not in pain. He was awake but did not cry. There had been no history of vomiting that day and he was told that the child had eaten well. He says he examined the child thoroughly and carefully by listening to his chest and abdomen by palpation and percussion of the chest and abdomen. These were, he says absolutely normal. There was no palpable mass or tenderness. The child was at no time resentful of examination of his abdomen. As a result, he concluded that the child was suffering from an enteritis caused either by organisms or poison. He thought there was bleeding per rectum and knew that there had been some previously, having seen the first defendant's admission notes. He had briefly considered intestinal obstructions but dismissed this possibility as in no such cases had he ever seen one which had eaten and retained food.

He says that he saw the child again at 7.15 a.m. the next day, that is the Saturday morning, 2nd September. His condition had improved, he was not crying. He was awake, there were no signs of pain or reports of crying during the night. He had slept well. This was consistent with his (the defendant's) finding of the child's improvement and the diagnosis of gastro - enteritis and was, he says, strongly inconsistent with the possibility of any form of intestinal obstruction, particularly as there was no evidence of pain. There was no report of the child having vomited. He was well hydrated. Toxicity was less than the night before and he looked generally improved. The witness did not change his colleague's treatment. There was some restlessness, which would be consistent with gastro - enteritis. He was told that the child had retained his diet of the previous day and was taking and retaining glucose water. His temperature had dropped to about normal. It had been slightly raised the night before.

Meanwhile, the father says that he saw the hospital superintendent on Saturday and told him that he was worried about the child. He also told him that if anything serious occurred, he should be informed and he left his name and address. He says that the superintendent spoke to the nurse on duty and said there was nothing wrong with the child that the witness need worry about.

The second defendant says that he saw the child again about five o'clock that afternoon. He had not been summoned to the child but it was a routine call. However, he found the child had collapsed and was obviously very much worse. He was still conscious but seemed very much more lethargic and when propped up was unable to support his head. He described him as "floppy''. He examined the child as before - his chest, abdomen and his reflex to painful stimuli. He felt a certain fullness in the left iliac possa (the lower left quadrant of the abdomen), i.e. in the region of the terminal point of the descending colon. He felt that it was probably due to constipation. Looking back on what occurred, he considered that it could have been the upper end of a mass situated in the pelvis but there was nothing to suggest that to him at the time. There was no vomiting, the child's hydration was normal, nor did he appear to be in pain, although he was in a condition where certain types of pain might not have been appreciated by the child. It was unlikely that colicky pain was present. The defendant ordered an intra - muscular injection of Tetracyclin and the child did cry immediately on receiving the injection. He ordered this injection because the child did not seem to be responding to Sulphaguanadin. Tetracyclin just kills germs, while sulphonimides prevent them from breeding. He stayed about half an hour, by which time the child seemed a little better. Again, with the advantage of

hindsight, the defendant admitted that this might have been due to the injection pains rather than the effect of the drug.
The father says he saw the child at about 6.30 p.m., when he found him much worse. The spots on his forehead were clearer and they were reddish in colour. The child was still crawling on his stomach. The nurse being absent, he picked up the child, who, he says, was very weak. He could not lift his head, which was collapsing. He also noticed a blue mark around his collar bone. The nurse then came in and chased him out. He waited until about 7 p.m., peeping in through the window. The child's condition seemed really serious, but the nurse said there was nothing serious. He was not allowed into the ward because of possible contamination with typhoid or diarrhoea. He then stayed in the hospital till about 8 p.m. and then went home. His wife was with him.
The second defendant said that he looked in on the child about 7.30 p.m. The child seemed definitely better. He was sleeping and his respiration seemed normal. He admitted that it was possible that this was in fact a sign of a worsening condition, but at this time he was relieved at the apparent improvement and did not consider that there should be any change in treatment.
This defendant, too, mentioned that the father had asked him that morning if the child should be X - rayed, and added that he advised against it. The reason he gave was that, if a child of this age was subjected to X - radiotherapy, the child has to be absolutely still or the X - ray is worthless. It requires not only holding but vigorous and active holding by more than one person. There were no indications for doing an X - ray in the present case.
The ward sister on night duty that night was a Sister Lohan, who said that when she came on duty at about 8 p.m. that night, the child looked very ill and there was still a little blood per rectum. At about 9 or 9.15 p.m. the child started to vomit "coffee grounds" i.e. stale blood which, because of its dark appearance, resembles coffee grounds. She immediately rang Dr O'Sullivan, who was another assistant in the partnership between the second defendant and Dr Sherwood, who was on call that night for the second defendant. She says that she reported the child's condition and asked him to come in. She says that she told him about the vomiting and that the child's temperature was 102º. She says that, in spite of this, Dr O'Sullivan refused to come in but said that there was nothing he could do if he came in and he told her just to observe the child.
Dr O'Sullivan's evidence on the point is that he has no recollection of any such conversation with Sister Lohan but, if she had asked him to come and see the child, he most certainly would have done so, that indeed it would have been the obligation of any practitioner to do so. Furthermore, if she had mentioned "coffee grounds" he would have wanted further information and, whether she had asked him to come in or not, if the child's condition had been described to him in the terms used by Sister Lohan, he would have come to see the child. Sister Jorgensen in her evidence said (and I admitted this statement *de bene esse* only) that Sister Lohan had told her that she had phoned Dr O'Sullivan. If this statement is admissible at all, and I rather doubt that it is, it can only be admissible as evidence of what Sister Lohan told her and certainly not evidence that Dr O'Sullivan had been asked to come in. Sister Alexander, in her evidence, said that if she had telephoned a doctor and asked him to come in and he had refused to do so, she would have put it down in her report. Looking at the report made by Sister Lohan on that occasion, I see she says: "Dr O'Sullivan notified at 9.30 p.m. No further treatment ordered." There is no mention that she asked him to come in and that he refused. I accept that Sister Lohan did telephone Dr O'Sullivan at 9.30 p.m. as she records. I would need far stronger evidence than I have had put before me before I could accept that a doctor told to come to see a dangerously ill child would refuse to do so and can only conclude that Sister Lohan's communication to Dr O'Sullivan did not have the urgency which, in the light of what happened afterwards, Sister Lohan has persuaded herself it had.
At about 5.15 the following morning, the child died. Apparently, the parents were not immediately notified, and the father says that at 11 a.m. on the same day he came to the hospital to find out how the child was. He went straight to the nurse and asked after the child and was then told that the child had died early that morning, asking him whether he had not received a message. I would say that, although this aspect can have no bearing

on the merits of the present case, it was, to say the least, a most unfortunate and regrettable thing to have happened and seems to show some laxity in hospital administration which ought never to be allowed to occur again.

Be that as it may, on the Monday morning the father went to see the second defendant when he told him he would like a post - mortem examination carried out and this the second defendant arranged. This was carried out by the fourth witness for the plaintiff, Dr S. B. Bhagwandeen, whose findings I have already referred to.

The plaintiff, as personal representative of the deceased child, now claims damages against the defendants, alleging negligence in that:

(a) they failed to take any or adequate steps to diagnose the child's illness, namely intussusception of the large bowel;

(b) they failed to obtain an X - ray of the child's stomach, which, the plaintiff says, would have revealed the child's complaint;

(c) they failed to accede to the father's request for an X - ray;

(d) they failed to take any steps to remove or cure the intussusception which was readily and easily curable by surgery; and

(e) they allowed the child to remain without any proper diagnostic or remedial treatment from the morning of the 31st August, 1967, until his death.

They claim, in effect, (1) damages for pain and suffering; (2) damages for loss of expectation of life; and (3) special damage by way of funeral expenses and hospital expenses, none of which is quantified although sum relating to funeral expenses was put forward in evidence by the father.

The defence is a denial of negligence and a plea that the special damage is irrecoverable since no particulars of amounts have been pleaded and no admission is made in regard to these damages.

I have had a considerable volume of evidence presented before me with regard to the medical questions involved. As we have seen, the cause of death was diagnosed as "shock from intussusception". Most of the medical evidence was devoted to this disease and a number of textbooks on the subject quoted, some of which were put at my disposal and I have availed myself of the opportunity. I find the briefest, and to me as a layman in these matters, the clearest, description of the disease in Ellis, *Disease in Infancy and Childhood,* 2nd ed., at page 310 et seq. He described intussusceptions as follows:

> "The invagination of one portion of gut into that immediately distal to it occurs most frequently in the region of the ileo - caecal valve. Here the ileum may either be invaginated through the valve into the caecum and then in the colon (ileo - colic type) or the valve itself may form the apex of the intussusception (ileo - caecal type). An ileal intussusception, in which ileum is invaginated into ileum, is of considerably less frequent occurrence, and a colic intussusception, in which the colon only is affected, is least common of all. In the great majority of cases the intussusception passes in the same direction as the contents of the gut, but occasionally an intussusception occurs in the reverse direction . . . More than one intussusception may occur at the same time."

From the description given in the report on the post - mortem examination, in the present case, the intussusception would appear to be what Dr Ellis describes as the "ileo - colic type".

Dr Ellis goes on to describe the clinical features of intussusception. He says:

> "The history is usually so typical that it immediately suggests the diagnosis. An infant who has previously been well, suddenly screams with pain and draws up its legs. The attack lasts for a matter of seconds, and is followed by complete remission of pain.
>
> Further similar attacks occur, often at about twenty - minute intervals. As these become more severe, each one is accompanied by evidence of shock which may be so severe as to cause transient fainting (an extremely rare phenomenon in infancy). In the early stages, however, the infant quickly appears normal again after the attack has passed. Vomiting usually occurs early, and if the condition is not relieved the infant becomes rapidly dehydrated and toxic.
>
> One or more normal stools may be passed after the onset of pain, representing the faecal matter already in the lower bowel below the intussusception. Subsequently, a small amount of blood or blood - stained serum and

mucus, with little or no faecal matter, is passed. This is an important diagnostic sign, though it should be possible to make the diagnosis before blood appears either on the napkin or on the finger during rectal examination.

On examination of the abdomen there is often no rigidity or tenderness between the spasms of pain if the case is seen early, and it is then possible to feel a tumour, which may harden and soften during palpation."

In Nixon and O'Donnell, *The Essentials of Paediatric Surgery*, 2nd ed., at page 76 et seq., a similar description of the nature and symptoms of intussusception is given. Here, the passage of blood and mucus is described as often having the appearance of redcurrant jelly. They add that, among the symptoms already mentioned, "the abdomen is usually *moderately* distended and on auscultation the heart sounds may be heard clearly between spasms of peristalsis - a sign of distension of the gut. There are almost no bowel sounds. When a spasm comes on the sounds are loud, turbulent, splashy and high pitched." The authors also say (at page 79) that the common imitators of intussusception are gastro - enteritis and upper respiratory infections with colic. Some dysentry in particular may be present with pain, fever and blood from the rectum without diarrhoea. Indigestion, wind and irritability also cause colic in the same age group. I should add that the authors state that intussusception is the commonest cause of intestinal obstruction between the ages of two months and five years, its maximum incidence being between three and eighteen months with a peak at six months.

Dr Ellis (at page 312), says that occasionally Henock's purpura or acute dysentry, both of which give rise to blood in the stools, may simulate intussusception.

So much for the textbooks, of which the extracts given by me represent nothing like a complete or comprehensive picture, but which I have given as some sort of guide to an understanding of the problem.

I now come to the evidence of the expert witnesses. The first such witness was Dr Surridhine Brundutt Bhagwandeen, who is a pathologist at the Public Health Laboratories in Lusaka and who conducted the post - mortem examination, at which, I should add, Dr O'Sullivan was present. After giving evidence of the results of the examination and producing the report, which was put in evidence as Exhibit P.5, he said that he thought the intussusception was at least two to three days old although he did add that it could come on suddenly without warning. He said that the intussusception would in effect be a tumour which would distend the abdomen and that such distension would have been there for two or three days but although the abdomen might be distended, one might not be able to identify individual loops. He also said that intussusception was an uncommon condition. He repeated in cross – examination that it was a very rare condition and when told that the Mayo Clinic figures showed that they had had 124 cases in fifty - two years, he said he was not surprised. On the other hand, he agreed that, in Zambia, gastro - enteritis was a common complaint. This, he said, could be used as a generic term covering such diseases as typhoid, dysentery, etc., or as a specific term. He had been a pathologist since 1961 and could recall two other cases of intussusception, all of which were on post - mortem. He had not seen any clinically.

The main symptoms, he said, were those of intestinal obstruction i.e. vomiting, colicky pain and bleeding *per rectum*. The patient would be shocked during periods of attack. One sign would be a palpable mass in the abdomen. In gastro - enteritis one might find blood in the stool but, in intussusception, the form of bleeding was "redcurrant jelly". However, in some cases of gastro - enteritis there might be blood with mucus. In typhoid, the patient might be constipated but could pass blood. There were, he said, many causes of bleeding *per rectum*. In intussusception the colicky pain was intermittent and severe and he agreed that, if there was an absence of colicky pain, no palpable mass in the abdomen, no history of vomiting, bleeding *per rectum* but no "redcurrant jelly" and the patient was taking and retaining food, on his textbook knowledge that would not indicate intussusception but rather the contrary and, on such information, he would not expect a doctor to diagnose intussusception However, his pathological findings did not indicate a late stage. There was considerable oedema in the tissues which suggested chronic strangulation rather than acute strangulation. Oedema, however, could arise rapidly but he did not think it was likely to arise *post mortem*. When he saw the mass, it was very considerable, but when he said that it was of two to three days' standing, he did not mean

that it was static for that period. He had no way of saying what the child's condition was at the beginning or at any particular moment prior to death. There could have been a sudden flare up at the end. Nor could he relate the degree of abdominal distortion to any particular time. It might have been only immediately before death. At the stage at which he saw the intussusception, it could only have been dealt with by the actual removal of that segment of the bowel, i.e. virtually the whole of the large bowel and the terminal part of the small bowel. This would have been a major operation Asked whether he had looked for any other condition, he said that, once he had found the intussusception, he did not look further for cause of death. He did not examine the nervous system or the rectum. On re-examination, he said that intussusception was most prevalent in children under the age of one. Asked what would be the first warning that strangulation had occurred, he said he did not feel qualified to answer this. Asked about X - rays, he said that if a doctor suspected an intussusception, X - rays would be of assistance in confirming the diagnosis, but he added that X - rays on young children should be avoided where possible.

The second medical witness for the plaintiff was Mr James John MacPherson, FRCS (EDIN), who is a surgeon at the Lusaka General Hospital. He said he was a general surgeon and intussusception came within his field. He said that the commonest type of intussusception is in an infant. It involves the lower end of the ileum and this is invaginated into the large bowel through the opening of the junction. Bleeding commences at the stage where congestion obstructs the venous return of blood. If there is a stool present, the channel in the bowel has not been obliterated and it is therefore an early stage. It is not possible to say how long in time any particular stage is arrived at. After that stage, he would only expect to be passed the products of congestion, i.e. mucus and blood. Intussusception was a condition, he said, which is most common in infants and it would be more common in a children's surgical department in hospital than over a general sample of the community. In Zambia, he said, up to about two years ago, he had seen an average of about one a year but he had seen none for the last two to three years. Although it was condition of which all doctors were aware in the course of their training, a doctor could go through his entire professional life without seeing one. It was one of the surgical conditions of infancy in which the speed of surgical treatment was very important. If treated early, there was a high percentage of recovery. If treated late, the mortality was large. Whether intussusception was arrested in time depended on the speed with which the diagnosis was arrived at and this would depend on the presentation of the case. The most significant symptom was the presence of blood and mucus *per rectum* without the presence of a stool. Without an alternative explanation for these symptoms, a doctor should consult surgical opinion as soon as possible. Asked about possible alternative explanations, he said he could think of none. Typhoid could produce severe intestinal inflammation but this was outside the witness's competence. He though it would be extremely rare to have the degree of intussusception shown by the post - mortem without abdominal colic. A characteristic reaction would be crying and the doubling up of the body. Pallor would also be a sign of distress. A lump in the abdomen would. be present, but it might not be felt for several reasons. The child might be unco-operative, or there might be a voluntary tightening of the abdominal muscles or the mass might underlie the liver. In the case of a child of thirteen months, the witness said, the child being otherwise fit, who had passed a stool at night, he would not think there was cause for considering intussusception. If it had passed through the doctor's mind, he would have the child admitted to hospital for observation.

Having dealt at some length on how he thought a doctor should have dealt with a case having the characteristics of the present one, the witness did say that there was a distinction between a specialist and a general practitioners in being able to understand symptoms. In cross - examination, the witness agreed that the principle symptoms of intussusception were one, colicky pain, present in 100 *per cent* of cases, two, a palpable mass in the abdomen, in about 80 *per cent* of cases, three, vomiting, also in about 80 *per cent* of cases. He also agreed that a not unusual feature was the passage of blood and mucus, but this comes at a later stage and its presence would depend upon how early the case arrived at the treatment centre. The mucus would probably come first and with

increasing congestion would come blood. He said ho would not expect a child with well - established intussusception to take and retain its normal food and fluid intake. He also admitted that children in surgical wards often developed gastro - enteritis, but added that a general practitioner would see more of this and of the enteric fevers than he did.
The next medical witness for the plaintiff was Dr Desmond Eugene Donovan, who is a Government paediatrician on the Copperbelt. As to the incidence of intussusception, he began by stating that at the Children's Medical Centre in Boston, USA, they had had 700 cases in twenty years. He later corrected this to 700 cases in the forty - two years from 1908. It was the leading children's hospital in Boston, but there was also a medical school and at least one other hospital. His own personal experience of intussusception was an average of two or three cases a year but this had become less recently. He said that when, with reasonable confidence he suspected an intussusception, he would refer it to a surgeon. He had come across thirty to forty cases in his experience, which had begun in 1952. He added that it was true to say that quite a considerable number of cases were never finally accurately diagnosed and if they appeared to be improving there would be no final diagnosis. The question of a child being in hospital for a period and then dying of intussusception could happen if the presentation had been sufficiently unusual to make a diagnosis of intussusception difficult. He said that bleeding might not occur until the intussusception was present for some hours. In cross - examination, he said that, to a general practitioner, intussusception must be a comparatively rare complaint and he would expect knowledge of intussusception and the approach to it to be different between a general practitioner and a paediatrician, who was likely to be more aware of it. He agreed the four main symptoms already mentioned. In the case of a small child, in association with the colicky pain, the child would have a shocked appearance but, sometime afterwards, the child might look better. The pain was usually made obvious by a sharp, loud cry and by a doubling up or arching of the back. This was the classic case and was manifest in about 60 *per cent* of cases. The great majority (well on 80 per cent) had vomiting. The mass was always there and it was palpable in the great majority (about 70 per cent) of cases. The bleeding *per rectum*would be "redcurrant jelly" and dehydration was a further symptom. It would be surprising if the child retained food, even glucose water. If the child did retain it, this would be an indication that it was not suffering from intussusception
Dealing with enteric fevers, he agreed that they could generically be included loosely in the term "gastro - enteritis" although he preferred himself not to do so. Typhoid was one of the enteric fevers. The symptoms of gastro - enteritis could include vomiting and abdominal pains, very frequently there was restlessness and typhoid had slowly rising temperature. Passage of blood and mucus could occur as an isolated incident but it was not characteristic. He was referred to an article by Dr A. B. Christie in the *British Medical Journal*, dated the 4th May, 1968, which I have also seen, in which the author, describing Flexner and Shiga dysentery, states:

"Diarrhoea is severe and the stool consists of blood and mucus."

He agreed that, when the first defendant saw the child on the Thursday, none of the classic symptoms of intussusception were present except bleeding and that, at that stage, the presentation was atypical. It was, he said, reasonable at that stage not to treat for intussusception. That evening, the only difference was that there had been vomiting and, if the bleeding at that stage was in small amounts, he would have been inclined to think of inflammation of the lower bowel. As there was no palpable mass and an examination had failed to confirm the presence of intussusception, at that stage one would keep the possibility in mind without necessarily doing anything about it. He considered the entry in the record card "stool examination . . . intussusception considered" as reasonable, especially if the child seemed reasonably well. Unless a change had taken place, there was no reason for a call before the next morning. He thought that what the first defendant did and the treatment prescribed by him reasonable at this stage.
When the second defendant saw the child at 5p.m. on the Friday, there was nothing in the report to suggest intussusception. It was reasonable to keep the child under observation.

The symptoms, going back over the previous two days, with no dehydration, presented a pattern unlikely to occur in intussusception. It was a material factor that the child had taken and retained a full diet on Friday. By 5 p.m. that day, the child was obviously very sick, but otherwise there was no new feature - no vomiting, no palpable mass and no dehydration. It was a matter for judgment of the doctor on the spot. If he found a serious state of toxicity which responded to treatment and he was sure that there was an improvement and had an explanation of what it was, then he was justified in continuing the line of treatment and observation.
On the question of X - ray, the witness agreed that an unnecessary X - ray of a small child was undesirable and one should limit its use. One tried to avoid unnecessary handling of a sick child. A negative X - ray would not exclude intussusception. One treated the patient, not the X - ray.
The previous medical witness, Mr MacPherson, agreed that in some respects the present case was atypical. There was no palpable mass or abdominal pain. He largely agreed with Dr Donovan that, on the presentation at each stage, there might be no reason to suspect intussusception and also agreed that, as surgeon, he was more conscious of the dangers of intussusception than a general practitioner might be or than he might expect him to be.
Both the defendants gave evidence on the medical aspects of the present case, but, in view of the evidence given on behalf of the plaintiff, I need not go into their evidence in any detail. The second defendant did raise one possibility. He gave it as his opinion that the child did suffer from gastro - enteritis but that the intussusception from which he died was a late development which arose as a complication of the gastro - enteritis. Some support for this theory came from Dr Bhagwandeen, who said that, although he thought the condition had been present for two or three days, it could come on suddenly without warning, or, as Dr Donovan put it, it could fulminate.

[1] I now come to consider the plaintiff's charge of negligence against the defendants. The care and skill required of a professional man was summed by Tindal, CJ, many years ago in *Lamphier v Phipos* [1]:

"Every person who enters into a learned profession undertakes to bring to the exercise of it a reasonable degree of care and skill. He does not undertake, if he is an attorney, that at all events you shall gain your case, nor does a surgeon undertake that he will perform a cure; nor does he undertake to use the highest possible degree of skill. There may be persons who have higher education and greater advantages than he has, but he undertakes to bring a fair, reasonable and competent degree of skill."

As Charlesworth puts it in his work on *Negligence*, 4th ed., at paragraph 1001:

"It follows that an action for negligence will lie for damages caused by the failure to exercise due care and skill by proving either that the defendant did not possess the requisite skill or by showing that, although he possessed it, he did not exercise it in the particular case."

In the case of medical practitioners the standard of care and skill required is that of the ordinary competent medical practitioner *Rich v Pierpoint* [2], and it is a defence to show that the practitioner acted in accordance with general and approved practice (*Marshall v Lindsay County Council* [3]), that is to say, the practice approved at the date when he is alleged to have been negligent (*Whitford v Hunter* [4]). A medical man is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular act merely because there is a body of opinion who would take a contrary view, *Bolan v Friern Hospital Management Committee* [5]. It has been held that a wrong diagnosis is not necessarily an unskilled or negligent diagnosis, *Crivon v Barnet Group Hospital Management Committee* [6], nor will a practitioner be liable for a mere error of judgment on a difficult point (*Bolan v Friern Hospital Management Committee* [5]; *Whiteford v Hunter* [4].)
Mr Mitchley, on behalf of the plaintiff, has argued that the mere fact that the child died of intussusception and that this was not diagnosed or treated by the defendants raises a *prima facie* presumption of negligence on their part or *res ipsa loquitur*. This maxim was referred to by Lord Radcliffe in *Barkway v South Wales Transport Co.* [7] as follows:

"I find nothing more in that maxim than a rule of evidence, of which the essence is that an event which in the ordinary course of things is more likely than not to have been caused by negligence is by itself evidence of negligence."

On this, Somervell, LJ, observed in *Roe v Ministry of Health* [8] at page 136:

"In medical cases, the fact that something has gone wrong is very often not in itself any evidence of negligence."

And Denning, LJ (at page 137) observes: "Once the accident is explained, no question of *res ipsa loquitur* arises."
Morris, LJ (at page 139) says

"This convenient and succinct formula possesses no magic qualities, nor has it any added virtue, other than that of brevity, merely because it is expressed in Latin. When used on behalf of a plaintiff it is generally a short way of saying: 'I submit that the facts and circumstances that I have proved establish a *prima facie* case of negligence against the defendant'. It must depend on all the individual facts and the circumstances of a particular case whether this is so. There are certain happenings that do not normally occur in the absence of negligence and on proof of these a court will probably hold that there is a case to answer."

Fortunately, I do not have to decide in this case on whom the burden lies, in consequence of the view I take of the evidence.
It is clear from the medical evidence that there are several signs and symptoms which are almost invariably associated with intussusception. Both the witnesses and the medical authorities cited agree that in almost 100 *per cent* of cases, there is intermittent severe colicky pain which can be expected to be obvious since it makes the patient cry out - as Dr Ellis puts it in his book, the infant suddenly screams with pain. The evidence in this case is that the child was not crying - it was rather "moaning", as the father put it. At no time did he seem to be suffering from the severe colicky pain which all the authorities agree is typical of the complaint.
There is, in 80 *per cent* of cases (so the witnesses say), a palpable mass. Here no palpable mass was at any material time detected. Mr MacPherson did explain how the mass could be present without being detected but, the fact remains, no such mass was detected.
There is usually vomiting which continues throughout the course of the illness. Here, the parents reported one instance of vomiting and, until Sister Lohan detected the "coffee grounds" at 9.30 on Saturday night, few hours before the child died, there was no other instance of vomiting reported.
The other usual symptom is bleeding *per rectum*, but this usually takes the form of "redcurrant jelly", i.e. mixture of blood and mucus of a jelly - like consistency. Here, there is bleeding *per rectum* with a slight amount of mucus, but not enough to justify the description "redcurrant jelly".
Furthermore, dehydration is often a symptom. Here the child was well hydrated.
In short, the medical witnesses all agreed that this case was atypical. They also agreed that, in all the circumstances, the treatment decided on by each defendant, the stage at which he was responsible for the

child, was not unreasonable at the time in view of the symptoms and without the advantage of hindsight, with which the witnesses gave their evidence before me. Each defendant said, and in fact stated in the notes which were before me, that he had the possibility of intussusception in mind but rejected this diagnosis on the symptoms as presented to him.
I therefore find that neither defendant was personally negligent in his treatment of the child while the child was in that particular defendant's care.
There are, however, two further allegations against the defendants. The first was that the father had requested that X - rays be taken of the child and the defendants failed to have them taken. The father explained that he had asked for the X - rays, not because he suspected intussusception or any organic disease, but because he feared the child might have swallowed a nail. It is for the medical practitioner to exercise his skill and judgment in deciding on the treatment of a patient. We have heard the evidence of all the medical

witnesses that X - rays must be treated with great care so far as a young child is concerned. Not only may the extra handling involved be harmful but unnecessary exposure to radiation should be avoided. One does not, therefore, lightly decide on this treatment for a small child. It is not the doctor's duty simply to accede to the request of a layman, even though he may be the child's father, just because the request is made. It is for him to decide whether it is in the patient's interest and I find that, in the circumstances of the case, the defendants acted reasonably in not ordering X - rays at the time.

The second point was that Dr O' Sullivan, who was employed by the second defendant as an assistant medical practitioner, should have come to see the child on the Saturday night when Sister Lohan says she asked him to come in. I have already dealt with that aspect in considering the evidence and I find that, although Sister Lohan may have convinced herself that she asked Dr O' Sullivan to come in, Dr O' Sullivan was not, in fact, asked in so many words or given sufficient information on which he might himself have reached a decision that it was necessary for him to see the child. I accept Dr O' Sullivan's own evidence that if he had had such information, he would have come to see the child, whether he had been asked to do so or not. Furthermore, in the light of the post - mortem report, there is a very strong probability that, by that stage, there was very little likelihood of saving the child.

This is a distressing case and I am sure that I am not alone in expressing our deepest sympathy with the parents in the present case. Here was a child, in apparent good health on the Wednesday, who was dead by the early morning of the following Sunday. Although we heard phrases in evidence of the intussusception being "long - standing", at the most it was of no more than two or three days' duration, so that the development was very rapid indeed. I have already expressed my view of the casual way in which the unfortunate parents were informed of the death of their child and sincerely trust that this sort of thing will not happen again.

However, the position was aptly summed up by Denning, LJ, in *Roe v Ministry of Health*, *supra*, at page 139. In that case, two plaintiffs claimed damages for paralysis brought on by a contaminated spinal anaesthetic. The learned Lord Justice said:

"These two men have suffered such terrible consequences that there is a natural feeling that they should be compensated. But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure."

I think every word applies to the present case. The unfortunate parents have suffered a bereavement in circumstances which deserve our deepest sympathy. But misadventure must not be condemned as negligence.

There will, therefore, be judgment for the defendants with costs to be taxed unless agreed.

Judgment for the defendants.