#### DCPI1055/2006

IN THE DISTRICT COURT OF THE

### HONG KONG SPECIAL ADMINISTRATIVE REGION

PERSONAL INJURIES ACTION NO. 1055 OF 2006

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| BETWEEN | CHUNG TIN KAU | Plaintiff |
|  | And |  |
|  | FONG SHUN TAK | Defendant |

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##### Coram: H H District Judge Marlene Ng in Chambers (Open to the Public)

Date of Hearing: 26th February, 2009

Further written submissions from the Plaintiff : 4th March, 2009

Further written submissions from the Defendant : 9th March, 2009

Date of Handing Down Decision: 16th March, 2009

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DECISION

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###### I. Background

1. This is an application by the Plaintiff to file and adduce a medical report by a neurologist Dr Tsang Kin Lun (“Dr Tsang”) dated 29th December 2008 (“Tsang Report”) for the purpose of assessment of damages. The Defendant opposes the application.
2. It is necessary to start with the history of the present proceedings. On 29th October 2004, the Defendant motorcycle driver negligently knocked down the Plaintiff motorcycle driver who as a result suffered personal injuries (“Accident”).
3. On 20th June 2006, the Plaintiff (who was then legally represented) issued the present proceedings against the Defendant for loss and damages for personal injuries suffered as a result of the Accident. On 28th July 2006, interlocutory judgment was entered against the Defendant for damages to be assessed.
4. The Plaintiff in his witness statement dated 6th November 2006 claimed that after the collision “本人手臂及脛節受傷”, “經醫生診治後，證實本人左脛節、肘部及右掌有多處擦傷，本人經診治後出院。其後本人被轉介往骨科治療並覆診12次”. He claimed he (a) had persistent left shoulder and knee pain aggravated by change of weather, (b) sought treatment from Yan Chai Hospital (“YCH”), Princess Margaret Hospital (“PMH”), GHC Medical Centre, Lady Trench General Outpatient Clinic (“GOPC”) and private doctors, and (c) could not work whilst attending follow up treatment. The Plaintiff further claimed that as a result of the Accident he injured his cervical spine, which caused numbness of the fingers of his left hand, and he could not return to his *pre*-Accident work or find other work because of “手震及無力”.
5. On 25th October 2006, the Plaintiff was granted legal aid, and his solicitors became assigned solicitors.
6. At the Check List Review (“CLR”) on 7th November 2006, Registrar J Ko directed *inter alia* that expert medical evidence be limited to 1 orthopaedic expert for each party, ie Dr Arthur Chiang (“Dr Chiang”) for the Plaintiff and Dr Chun Siu Yeung (“Dr Chun”) for the Defendant, and that their joint orthopaedic expert report be made available on or before 30th April 2007.
7. At the CLR on 10th May 2007, Master C P Pang directed *inter alia* that subject to the directions of the trial judge the joint orthopaedic expert report of Dr Chiang and Dr Chun dated 7th April 2007 (“1st Joint Report”) be adduced at the assessment hearing without oral evidence, and that the action be set down in the running list for assessment of damages not to be warned before 7th August 2007.
8. The Revised Statement of Damages was filed on 11th June 2007, and the Answer thereto on 19th July 2007. In the Revised Statement of Damages, the Plaintiff averred that immediately after the Accident he was sent to YCH’s accident and emergency department (“AED”). Such pleading set out the findings made and treatment given by the Government hospitals and private doctors, and referred to the physical findings and the diagnosis of “soft tissue injury of both elbows and the left shin” by Dr Chiang and Dr Chun in the 1st Joint Report. It averred that the Plaintiff’s persistent symptoms of neck pain, on-and-off numbness of the fingers of the left hand, left upper limb numbness, transient numbness and vision degeneration were caused by the Accident, and that he could not return to his *pre*-Accident work as a dental technician. In the Answer, the Defendant relied on Dr Chun’s findings and opinion to say the Plaintiff could have returned to “all kind of job”.
9. On 7th August 2007, Master C P Pang deferred warning the case for assessment hearing until 7th October 2007 to enable the parties to consider obtaining relevant medical notes/records from the Government hospitals and/or to prepare supplemental witness statement on earnings.
10. On 10th August 2007, the legal aid certificate was discharged. On 9th October 2007, Master C P Pang removed the case from the warned list, and adjourned the CLR scheduled on 8th November 2007 to give the Plaintiff time to look for legal representation.
11. At the CLR on 10th January 2008, Master C P Pang directed the Plaintiff to *inter alia* file/serve his 3rd supplemental List of Documents, which the Plaintiff did on the same day.
12. At the CLR on 11th February 2008, Master K Lo directed *inter alia* that the Plaintiff was to serve copies of all documents that had not yet been served within 14 days, and that the case be set down for assessment of damages on 18th April 2008.
13. On 3rd March 2008, the Plaintiff filed his 4th List of Documents that disclosed *inter alia* the Tsang Report and Dr Tsang’s fee note. On 14th March 2008, the Defendant (who objected to the Tsang Report) applied to restore the case for appropriate directions to be made on medical evidence.
14. At the CLR on 14th April 2008, Master K Lo vacated the assessment hearing scheduled on 18th April 2008, and adjourned the issue of whether leave should be granted to the Plaintiff to adduce further expert medical evidence to 15th July 2008 for argument.
15. On 17th April 2008, the Plaintiff applied for legal aid, but his application was refused. On 11th July 2008, new solicitors came on the record for the Plaintiff.
16. On 15th July 2008, Master C Lee *inter alia* gave leave to the Plaintiff to withdraw the application to adduce the Tsang Report as expert evidence.
17. On 10th September 2008, the court acceded to the parties’ joint application to adjourn the CLR scheduled on 18th September 2008 pending receipt of YCH’s medical notes/records.
18. At the CLR on 11th November 2008, Registrar S T Poon granted leave to the parties to obtain a joint supplemental orthopaedic expert report from Dr Chiang and Dr Chun, and ordered that costs of the preparation of such report be the Defendant’s costs in the cause. On 12th November 2008, Dr Chiang and Dr Chun compiled their joint supplemental orthopaedic expert report (“2nd Joint Report”).
19. On 29th December 2008, the Plaintiff filed Notice to Act in Person.
20. At the CLR on 5th January 2009, the Plaintiff sought an adjournment pending decision by the Medical Council in respect of his complaint against Dr Chiang and Dr Chun for not revealing his neck injury in the 1st and 2nd Joint Reports. He also intimated his wish to substitute the Tsang Report for Dr Chiang’s opinion in the 1st and 2nd Joint Reports notwithstanding previous withdrawal of a similar application to rely on the Tsang Report (see paragraph 16 above). In light of the Defendant’s opposition, Master K Lo directed the Plaintiff to issue an *inter partes* summons for such purpose and scheduled a Pre-Trial Review (“PTR”) both to be heard on 26th February 2009.

*II. Summons*

1. On 12th January 2008, the Plaintiff took out asummons for leave to file the Tsang Report and Dr Tsang’s fee note (“Summons”). In his supporting affirmation, the Plaintiff claimed the Tsang Report was necessary because the 2nd Joint Report was biased/unreliable in that neither orthopaedic expert (including his own) revealed that he suffered neck injury and residual disabilities as a result of the Accident.
2. As evident from the above chronology, this was the Plaintiff’s second attempt to introduce neurological expert evidence following earlier withdrawal of a similar application (see paragraph 16 above) in favour of a joint supplemental orthopaedic report by Dr Chiang and Dr Chun. The Defendant opposed the Summons and served/lodged written submissions for such purpose.
3. At the hearing before me, the Plaintiff, who was not legally represented, applied to substitute the Tsang Report for Dr Chiang’s opinion expressed in the 1st and 2nd Joint Reports. However, this is not a true substitution since Dr Tsang and Dr Chiang are experts from different medical disciplines (ie respectively neurology and orthopaedics). Rather, the questions are (a) whether the Plaintiff should be given leave to adduce expert neurological evidence in the form set out in the Tsang Report, and (b) whether he is entitled to abandon reliance on Dr Chiang’s expert orthopaedic opinion. Since I have reserved decision on (a) above, fairness requires that the Plaintiff be given opportunity to re-consider his position on (b) above after this Decision is handed down.

###### III. Miscellaneous directions

1. In respect of the PTR, I made the following directions at the hearing :
   1. the Plaintiff do within 14 days serve copies of the documents listed in the schedule to the Defendant’s PTR Notice dated 25th February 2009 being items (i) to (vi) thereof;
   2. leave to the Defendant to file/serve further supplemental List of Documents disclosing YCH’s medical notes/records as reviewed by Dr Chiang and Dr Chun for the 2nd Joint Report within 28 days.
2. The Plaintiff claimed he would be ready for the assessment hearing if he could rely on the Tsang Report. Mr Wong confirmed the Defendant would be so ready if I dismissed the Summons, otherwise the Defendant would wish to adduce neurological expert evidence from Dr Edmund Woo in response to the Tsang Report. At first, the Plaintiff did not object to medical examination by Dr Woo if necessary, but by his subsequent written submissions he declined to submit to any further medical examination by any medical expert nominated by the Defendant on the following grounds :
   1. The Plaintiff’s treatment medical reports/records and sick leave certificates (which covered over 500 days of sick leave) were sufficient objective evidence of the injuries he suffered as a result of the Accident.
   2. From his previous experience at YCH, the Plaintiff believed a medical expert nominated by the Defendant would “用電流通過本人身體會使本人身體及精神上帶來無法忍受的極大痛苦”, and he did not wish to suffer further physical/mental pain as a result of having made a legal claim.

*IV. Injuries and treatment*

1. The Plaintiff disclosed various medical reports from YCH dated 7th January 2006, 26th September 2006, 9th October 2006, 11th October 2006 and 19th November 2007, from PMH dated 15th October 2006, and from Dr Fu Wai Kee (“Dr Fu”) dated 11th October 2006. As explained above, Dr Chiang and Dr Chun also reviewed YCH’s medical notes/records (as distinct from YCH’s medical reports) and summarised them in the 2nd Joint Report. I see no reason to disregard such summary (which neither party challenged) even though the Plaintiff disputed the expert opinion given by Dr Chiang and Dr Chun.
2. I summarise the Plaintiff’s injuries/treatment disclosed in the aforesaid documents in some detail in order to put the Plaintiff’s arguments in context and to enable the Plaintiff (who is without legal representation) to better understand the medical documents that he relies.
3. Immediately after the Accident on 29th October 2004, the Plaintiff was sent to YCH’s AED. He complained of left upper limb and lower limb pain; *no neck pain, no back pain*. He claimed to have sustained injuries over both upper limbs and left shin. The doctor recorded the Plaintiff suffered limb injury with pain, *no head injury*, *no loss of consciousness*, and *no vomiting*. Physical findings revealed multiple abrasion over right palm, abrasion over left shin and left ankle region at the malleolar area with decreased range of motion of left ankle, and abrasion wound at the dorsum of the left elbow with no swelling but decreased range of motion. The Plaintiff was referred for outpatient dressing with sick leave given from 29th to 31st October 2004.
4. The Plaintiff returned to YCH’s AED on 31st October 2004 for change of dressing. He complained of persistent wound pain over right elbow and left shin. The doctor recorded there was abrasion on right elbow, right knee and left shin, but the wound was not infected and range of the right elbow was normal. The Plaintiff was given sick leave from 1st to 4th November 2004.
5. The Plaintiff attended YCH’s AED on 20th December 2004 for persistent left elbow pain. The site of pain was at lateral epicondyle region of the left elbow with no swelling, wound or effusion, and the range of motion was full with *normal radial pulse, finger movement, power, sensation, circulation and reflexes*. The Plaintiff was given sick leave from 20th to 22nd December 2004.
6. The referral letter from YCH’s AED to YCH’s department of orthopaedics and traumatology (“DOT”) dated 20th December 2004 stated that :

“……

RTA on 29/10/04

Motor cycle driver

Attend AED that day, XR were normal

C/O persistent L elbow pain

No direct contusion at that time

Sprain nature

Decreased ROM with subjective weakness

PE …… pain at the lat epicondyle region, no obvious swelling or effusion, ROM full, but pain, radial pulse +ve, finger movement normal, power 5/5, sensation normal, circulation normal

XR L elbow: alignment normal, no #.

imp: Persistent L elbow pain.

Please kindly assess the patient in the OPD. ……”

1. The Plaintiff missed the DOT clinic appointment (see the referral letter dated 24th February 2006 (see paragraph 38 below) which stated “[once] referred to YCH O&T but missed the appt.” and also the record of attendance at YCH’s AED on 7th April 2006 (see paragraph 43 below) which stated “…… referred to ortho but patient defaulted”).
2. On 2nd December 2005, the Plaintiff attended YCH’s AED. The doctor recorded *persistent left elbow pain, also pain at left shoulder for 3 months, increased severity recently, also left hand radial 3 fingers numbness on-and-off especially upon change of weather, “gone today”*. Physical examination showed neck, left shoulder and left elbow movements were full with no neck swelling, bruising or tenderness, and normal upper limb sensation, intrinsic hand muscles and power. Radiologically there were *osteophytes over cervical spine at C4-C6*, but alignment was normal. Sick leave was given from 2nd to 5th December 2004, and the Plaintiff was referred to DOT clinic with appointment on 21st August 2006.
3. The Plaintiff attended YCH’s AED on 27th January 2006. His chief complaint at the triage was *left elbow pain and left neck pain since yesterday after lifting*. The doctor recorded he had *left neck pain and left elbow pain while doing household work 2 days ago, and on-and-off numbness of left thumb to middle and ring fingers*. Examination showed full range of cervical spine motions, tenderness over left olecranon, full passive range of left elbow motions, normal jerks and negative Finkelstein test, and his left handgrip power/sensation was okay. Sick leave was given from 27th to 31st January 2006.
4. On 10th February 2006, the Plaintiff attended PMH’s AED for “neck pain dating back to a traffic accident in November 2004”. Examination revealed the pain was located on the left side of the neck with no local swelling but mild decrease in range of neck movement. PMH’s AED referred him to PMH’s physiotherapy department (“PD”) specialist outpatient clinic for physiotherapy treatment for “cervical spondylosis and left tennis elbow”, and he was given sick leave from 10th to 13th February 2006.
5. The Plaintiff attended YCH’s AED on 15th February 2006 for similar pain, and was given sick leave from 15th to 17th February 2006.
6. The Plaintiff attended YCH’s AED on 24th February 2006 for neck and left hand pain since the Accident in 2004. The doctor noted he complained of neck pain radiating to left upper limb, left elbow pain and numbness at hand with weakness. Physical examination showed pain at C5-C6 region of the neck, tenderness at olecranon, full range of left elbow motions, numbness of median nerve dermatone at hand region. The reflexes and power of the four limbs were normal, and handgrip as well as wrist, elbow and shoulder movement were okay. Sick leave was given from 24th to 27th February 2006.
7. The referral letter dated 24th February 2006 from YCH’s AED to YCH’s DOT noted the Plaintiff’s complaints of neck pain radiating to his left upper limb since the Accident, left elbow pain, and weakness/numbness at left hand. “PE …… neck pain at ~ C5/6 region, Decreased ROM in all direction, but still fair, power 4 limbs ok, reflex and circulation ok. Numbness at median dermatone region at Lt hand, hand grip ok, wrist and elbow and shoulder movement grossly normal. *XR C- spine 12/2/05 show degenerative osteophyte change at C4-6.* Imp: RTA, neck pain radiate to L UL, Lt hand numbness at median nerve dermatone region. Please kindly assess the patient in the OPD in an earlier appointment. ……” (my emphasis)
8. On 3rd March 2006, the Plaintiff attended YCH’s AED still complaining of neck pain, left elbow pain and left arm pain after the Accident with no swelling or redness but decreased range of motion. The doctor recorded the Plaintiff complained of neck pain and left arm pain after the Accident with persistent pain and left hand numbness. Sick leave was given from 3rd to 4th March 2006.
9. On 7th March 2006, the Plaintiff attended YCH’s AED complaining of left arm pain and decreased range of motion after old injury in 2004. The doctor recorded the Plaintiff’s complaint of persistent pain at left side of neck that radiated down to left forearm, and occasional numbness of radial 3 fingers of left hand. Physical examination showed left hand power grade 4/5, claimed increased neck pain, numbness over forearm, and mild tenderness at neck. X-ray cervical spine showed normal alignment and ostoephytes from C3-C6. The Plaintiff was already referred to the DOT clinic with appointment advanced from August to May 2006. Sick leave was given from 7th to 13th March 2006.
10. On 15th March 2006, the Plaintiff attended YCH’s AED for neck pain and left shoulder pain for long time but with “full range of movement, no numbness”. The doctor recorded “can’t sleep tonight, otherwise symptom similar”. Examination showed no local tenderness, swelling or bruising at the neck. Sick leave was given from 16th to 19th March 2006.
11. The Plaintiff consulted Dr Fu on 22nd March 2006, and alleged he had sprained his left leg, left elbow and neck as a result of the Accident. Physical examination revealed tenderness over neck with spasm of left trapezius muscle, and wasting of left forearm and thenar muscle of left hand. The sensation of the left hand was also decreased, but reflexes were normal. Dr Fu’s diagnosis was neck injury with radiculopathy. He suggested continuation with physiotherapy at PMH.
12. The Plaintiff attended YCH’s AED on 7th April 2006 complaining of neck and left hand pain. The doctor recorded “neck pain once referred to ortho but patient defaulted, next new appointment 8/5/2006”, “Claimed decreased vision of left eye after traffic accident 3 months later”, and “Elbow full range of movement, neck mild tender, pain on flexion, upper limbs-handgrip ok, flexion/extension-pain”. Sick leave was given from 7th to 12th April 2006.
13. The Plaintiff attended YCH’s AED on 25th April 2006 for persistent left neck and left shoulder pain. “He stopped analgesics for 5 days pain again, cannot sleep tonight; no increase weakness, no numbness. Examination showed handgrip ok, flexion extension ok, mild tender at left paraspinal muscle”. Sick leave was given from 25th to 29th April 2006.
14. The Plaintiff attended YCH’s AED on 3rd May 2006 for similar pain, and was given sick leave from 3rd to 7th May 2006. At the DOT clinic on 8th May 2006 he complained of neck pain on the left side for 2 years after the Accident, which was worse at night and upon movement and which radiated to left hand with occasional paraesthesia. He claimed the symptoms so severe that he could not resume his work as a dental lab worker. “? Clumsiness, taking regular analgesic, normal ambulation ……” On physical examination, the doctor noted the pain was at left side of neck, “non-tender with no muscle spasm, nearly full range of motions in all directions except rotation towards left side, mild diffused weakness over whole left upper limb 4+/5, no wasting over left hand, vague paraesthesia over radial 3 digits but no objective sensation loss, no muscle wasting over thenar muscles, no mylepathic sign.” The doctor ordered a nerve conduction test and continuation of physiotherapy and analgesics. The medical report noted the diagnosis was cervical spondylosis.
15. The Plaintiff attended Dr Fu’s clinic on 11th May 2006 complaining of persistent pain in neck with numbness of left upper limb. Physical findings were similar to those of the last visit. Dr Fu referred him to the Hospital Authority for further management of his persistent symptoms. “I think he needs further investigation to delineate the exact cause of his symptoms. The prognosis will depend on the finding.”
16. The Plaintiff also attended the GOPC on 31st May, 8th June, 22nd June and 8th August 2006 for neck pain and left shoulder pain/numbness which he claimed were related to the Accident. Physical examination showed bilateral deltoid atrophy with decrease range of movement of both shoulders and elbows. He was offered a total of 6 days of sick leave between 31st May and 9th August 2006.
17. On 16th July 2006, the Plaintiff attended YCH’s AED for persistent neck pain that radiated to left upper limb and he could not elevate his left upper limb fully. He was on physiotherapy, and given sick leave from 16th to 19th July 2006.
18. At the DOT clinic follow up on 21st August 2006, the doctor recorded that the Plaintiff “had stopped physiotherapy, with neck pain, waiting for [nerve conduction test]”. He was granted 1 week of sick leave.
19. On 27th November 2006, the Plaintiff attended YCH’s AED for increased neck pain after “BBQ” which radiated to left arm with weakness. There was tenderness at neck, but power/sensation were normal. He was given sick leave from 27th to 29th November 2006.
20. At the DOT clinic follow up on 18th December 2006, the doctor recorded the Plaintiff defaulted the nerve conduction test (re-booked for 14th August 2007). His condition was the same, mainly neck pain and left radial 3 digits paraesthesia. 5 days of sick leave were given.
21. At the DOT clinic follow up on 16th April 2007, the doctor recorded persistent pain and clumsy left hand. Physical examination showed good power, decreased sensation C6/C7, and decreased left biceps jerks (noted by physiotherapist).
22. On 11th June 2007, the DOT clinic doctor recorded pain, numbness and weakness pending nerve conduction test.
23. At the DOT clinic follow up on 31st August 2007, the DOT clinic doctor recorded that the symptoms were similar with some increased numbness which involved all 5 finger tips, power of upper limb was grade 4-/5, handgrip power was 4-/5. The nerve conduction test did not show any significant pathology of the hand, and there was no definite carpal tunnel syndrome. Sick leave was given until the next follow up.
24. On 21st December 2007, the DOT clinic recorded “shoulder pain, similar pain decreased a bit; left shoulder elevation 0-100 degrees. Sick leave given.”
25. On 1st February 2008, the DOT clinic noted “ NCT [nerve conduction test] : no CTS [carpel tunnel syndrome], complained of increased left shoulder pain. Sick leave given.”
26. On 11th April 2008, the DOT clinic recorded “persistent neck pain & left shoulder pain; left shoulder abduction about 70 degrees, elevation about 70 degrees; private MRI report: degenerative changes, mild disc protrusion C4/5, C5/6 and C6/7. Sick leave given.”
27. On 9th May 2008, the DOT clinic recorded “pending physiotherapy, Hoffman’s sign –ve, 10 second test-clumsiness+, finger escape sign negative. Sick leave granted till next follow up.”
28. On 20th June 2008, the DOT clinic recorded : “ask for opinion from YCH. He was asked to bring original MRI films & report to us.”

*V. 1st and 2nd Joint Reports*

1. In the 1st Joint Report, Dr Chiang and Dr Chun listed all medical reports and sick leave certificates they had reviewed, and set out the Plaintiff’s personal history (including his past health, his *pre*-Accident work, his account of the Accident, his injuries/treatment, and his current complaints), their physical examination findings, their review of the sick leave certificates, and their medical opinion. For the 2nd Joint Report, Dr Chiang and Dr Chun reviewed YCH’s medical notes/records.
2. In the 1st Joint Report, the Plaintiff described that he had neck and left elbow pain immediately after the Accident. Upon his discharge from hospital, he returned to YCH’s AED 2-3 times for dressing the wound, and thereafter he performed the dressing himself. It took about 10+ to 20 days for the wound to heal. He further described referral to YCH’s DOT clinic for treatment during visits to YCH’s AED after the Accident, but said the 1st orthopaedic visit was about 8 months later. He claimed to have received physiotherapy at PMH for about a year, and whilst receiving physiotherapy his symptoms improved temporarily for a few days, but after finishing the course his condition was better than initially by about 60-70%. Further, splintage was prescribed for the paraesthesia for his left thumb, index and middle fingers, which he claimed started about a month after the injury.
3. The Plaintiff complained that his left upper limb symptoms prevented him from making dentures in his *pre*-Accident work as a dental technician. He tried a delivery job between the PRC and Hong Kong for a very short time, but not other work. He could not swim, but hiked and performed neck/limb exercises daily.
4. At the time of the 1st Joint Report, the Plaintiff complained of (a) pain in his neck, (b) pain (6-7 out of 10) when he moved more or with movements of larger magnitude, (c) occasionally developing neck pain if he slept for several hours, (d) on-and-off numbness in the fingers of the left hand, (e) numbness in the left upper limb when he slept on the left side, (f) transient numbness lasting about 10-30 minutes several times a day, and (g) worse eyesight after the Accident.
5. Physical examination by Dr Chiang and Dr Chun noted no deformity, muscle spasm, trapezius tightness or signs of complex region pain syndrome I in the left upper limb, and no muscle atrophy in both shoulders. The flexion, extension, left sided rotation, right sided rotation, left sided flexion and right sided flexion of the neck against normal values were 30º(50º), 20º(60º), 40º(60º-80º), 50º(60º-80º), 25º(45º) and 25º(45º) respectively. The Plaintiff showed generalised weakness in the whole left upper limb ranging from grade 3+ to 4, but no weakness in the right upper limb. The range of movement of the left elbow and left shoulder was good.
6. X-rays of the cervical spine showed partial loss of cervical lordosis, mild degenerative changes in the form of anterior marginal osteophytes at C4, C5 and C6, and mild narrowing of the C5/6 intervertebral disc space.
7. Review of the sick leave certificates by Dr Chiang and Dr Chun showed that the stated diagnoses (a) for sick leave from 29th October to 4th November 2004 given by YCH’s AED were both elbow injury and left leg injury, and multiple abrasion to right elbow, left shin and right knee, (b) for sick leave from 20th to 22nd December 2004 and from 2nd to 5th December 2005 by YCH’s AED was left elbow pain, (c) for sick leave from 27th to 30th January 2006 and from 10th to 13th February 2006 by YCH’s AED and PMH’s AED was respectively neck and left elbow pain, (d) for intermittent sick leave between 24th February and 29th November 2006 from YCH’s AED, PMH’s AED and the GOPC included neck pain, left hand numbness, left arm pain and left upper limb pain, (e) for sick leave from 18th to 22nd December 2006 by YCH’s DOT clinic was neck pain, and (f) for intermittent sick leave between 7th January 2005 to 14th May 2006 by private doctors included left elbow pain and weakness, left elbow injury and neck injury. I pause to note that subsequent to the 1st Joint Report, YCH’s DOT clinic gave the Plaintiff sick leave from 11th June to 31st August 2007 for neck pain and from 31st August 2007 to 15th February 2008 for cervical spondylosis.
8. Dr Chiang and Dr Chun noted that some parts of the history given by the Plaintiff did not correspond entirely with the description in the treatment medical reports/records :
   1. On 29th October 2004, there was no record of neck or back pain, and the recorded injuries mainly involved both upper limbs (mainly elbow area), left shin and left ankle. On 20th December 2004, there was left elbow pain at lateral epicondyle, but finger movement, power sensation and reflexes were normal with no mention of neck symptoms or development of paraesthesia in the left 3 digits. The above did not correspond to the Plaintiff’s description of neck pain after the injury with paraesthesia of the thumb and fingers being noted in/about a month later.
   2. The Plaintiff first complained of left hand numbness (radial 3 fingers) to YCH’s AED on 2nd December 2005 (ie more than a year after the Accident), and x-ray cervical spine was ordered because the attending doctor thought the diagnosis of cervical spondylosis caused the left hand numbness. The x-ray findings were compatible with cervical spondylosis.
   3. During that visit to YCH’s AED on 2nd December 2005, the Plaintiff also first complained of left shoulder pain for 3 months, which meant such symptom would have first appeared around September 2005.
   4. The Plaintiff first complained of neck pain to YCH’s AED on 27th January 2006 – “left neck pain since yesterday after lifting” and “left neck pain and left elbow pain while doing household work 2 days ago”.
   5. The 1st Joint Report claimed the Plaintiff first alleged his neck pain resulted from the Accident when he attended YCH’s AED on 24th February 2006. But I pause to note that he in fact so complained to PMH’s AED on 10th February 2006, which in any event was consistent with the observation by Dr Chiang and Dr Chun that it was more than a year after the Accident.
   6. On 7th April 2006, the Plaintiff first complained to YCH’s AED of decreased eye vision 3 months after the Accident.
9. Dr Chiang and Dr Chun observed that the above did not sit well with the Plaintiff’s description of having neck pain immediately after the Accident. In taking a collective view from all these findings, they opined that the main site of involvement (ie the neck) had symptoms arising from cervical spondylosis, which caused radiating symptoms to the left shoulder and the left hand that first appeared about a year after the Accident. They further opined that the complaint of paraesthesia in the left thumb, index and middle fingers only developed a year later and was likely to be related to the cervical spondylosis.
10. Dr Chiang and Dr Chun further noted YCH’s medical reports/records showed the Applicant was referred to the DOT clinic after 2nd December 2005 (ie more than a year after the Accident) with the first appointment scheduled for 21st August 2006 (and subsequently advanced to 8th May 2006). They took the view that this did not correspond with the Plaintiff’s description of referral to the DOT clinic during his visits to the AED in the early stage after the Accident.
11. I pause to note that YCH’s AED actually referred the Plaintiff to YCH’s DOT in December 2004 for persistent left elbow pain but not neck pain (see paragraph 31 above), but he missed the appointment (see paragraph 32 above). In any event, Dr Chiang and Dr Chun were correct in observing that the Plaintiff did not seek medical treatment between December 2004 and December 2005 as evidenced by the absence of sick leave certificates during such period and by the Tsang Report which stated the Plaintiff attended the DOT clinic 15 months (ie 8th May 2006) after the referral (ie 20th December 2004) (see paragraph 78 below).
12. Dr Chiang and Dr Chun further noted the Plaintiff was not given physiotherapy until more than a year after the Accident. They opined that the diagnoses stated in the referral, which included cervical spondylosis and left tennis elbow, appeared to be orthopaedic diseases not directly related to the bilateral elbow and left shin injuries sustained in the Accident, and were discrepant with the Plaintiff’s description to them.
13. Bearing in mind that (a) the injury sustained from the Accident appeared to be confined to soft tissue injury of both elbows and the left shin, (b) the generally good prognosis for soft tissue healing, (c) the mild degree of injury from the Accident as reflected to some extent by the short periods of sick leave required followed by a year of absence of need to visit doctors, and (d) the subsequent symptoms a year after the Accident being quite different from those recorded in the treatment period immediately after the Accident, Dr Chiang and Dr Chun opined it was likely that the injuries sustained in the Accident were confined to soft tissue injuries of both elbows and left shin (or multiple superficial abrasion wounds on both elbows, left shin, and left ankle region) and no neck injury.
14. Dr Chiang and Dr Chun further opined that the soft tissue injury of the elbows and left shin had likely acquired reasonably satisfactory healing at the end of December 2004, and no further treatment was required. They agreed the prognosis was good, and the Plaintiff should be able to return to his *pre*-Accident work with a satisfactory capacity. Dr Chun further opined there was no permanent impairment or disability from the abrasion injury, and the Plaintiff was independent with his activities of daily living and able to resume his *pre*-injury work without limitation or restriction due to the Accident.
15. Dr Chiang considered that the sick leave required for the Accident-related injuries were about 2 months whilst Dr Chun opined that intermittent sick leave up to 22nd December 2004 was reasonable. Dr Chun took the view that further sick leave given after 22nd December 2004 should be unrelated to the Accident.
16. Dr Chiang and Dr Chun were of the view that most or almost all of the Applicant’s current complaints were from the cervical spondylosis and not residues arising from the Accident. The presence of some osteophytes and mild decrease in cervical lordosis in the x-rays and the decrease in the range of movement of the neck were compatible with cervical spondylosis, which could be reasonably managed conservatively by physiotherapy, self neck exercise, and attention to neck postures. The symptoms relating to cervical spondylosis possibly developed at a later date (probably at or before 2nd December 2005), and the numbness or paraesthesia in the left upper limb not reported in the early treatment period after the Accident was probably part of the radiating symptoms from the cervical spondylosis and thus unlikely to be related to the Accident. Dr Chiang and Dr Chun concluded that the Plaintiff’s subsequent complaints of neck pain, left shoulder pain, left hand numbness and left eye decreased vision were not caused by the Accident.
17. Dr Chiang and Dr Chun found it difficult to interpret the diffuse weakness in the left upper limb since weakness for cervical spondylosis with impingement on the cervical nerve roots would often be confined to more localised areas of the upper limb (a specific myotome) instead of involving the whole of the upper limb. Dr Chun pointed out that in the presence of normal reflexes, such global weakness was inappropriate and could not have been genuine.

###### VI. Tsang Report

1. Dr Tsang examined the Plaintiff on 23rd and 28th February 2008. The Tsang Report was based on such examinations and confined to assessment of the Plaintiff’s neurological impairments.
2. Dr Tsang recorded that the Plaintiff gave a history of the Accident whereby he was knocked down to the ground and landed on his left side. The Plaintiff described that *his helmet broke* and *he recalled transient loss of consciousness on the spot*. There was *immediate pain on his neck and left arm*. He was then brought to YCH’s AED. He was not hospitalised but was followed up at YCH’s AED, and with a referral he attended the DOT 15 months later. At the time of the Tsang Report, he was still being followed up by YCH’s DOT with sick leave given until the next follow up.
3. Dr Tsang noted the Plaintiff described he suffered the following neurological symptoms and disabilities :
   1. Neck pain with limited neck movements and arm pain : The pain, which was constant and of moderate severity, was at the back of the neck radiating through the left trapezius muscle down to his left upper limb with a sense of “pulling” along the whole path. The pain would be much worse when he lied on his left side, and he needed to regularly take painkillers as prescribed by YCH. Physiotherapy only helped partially.
   2. Weak left upper limb : The Plaintiff’s left upper limb strength was impaired and he could not raise his left upper limb above the shoulder fully. Power at the elbow, wrist and fingers was weak, and he could not make a full grip. The weakness interfered with his daily activities, and he had learnt to use his right upper limb solely in most of the tasks requiring both hands.
   3. Spasm of the left upper limb : The Plaintiff’s left upper limb often went into spasm and he needed to wear a wrist splint all the time.
   4. Sleep problem : The Plaintiff had great difficulty in going into sleep which was disrupted by frequent awakening due to pain in the left upper limb.
4. The Plaintiff told Dr Tsang he did not have any significant illness prior to the Accident. The Plaintiff previously worked as a dental technician, but could not resume his previous duty (which required fine motor functions and coordination of both hands) after the Accident due to the largely non-functional left upper limb.
5. Dr Tsang noted the Plaintiff was calm and cooperative during physical examination, and did not attempt to exaggerate his symptoms and disabilities. He was in mild to moderate pain and was wearing left wrist splint. Neck movement was limited (30º-45º less than normal) in all directions with local tenderness over back of lower neck and left trapezius muscle. The muscles in the painful region were tight. Movement of left shoulder, elbow and wrist were of grade 4+/5 power. Left fingers abduction and adduction power was grade 4/5. Sensation was decreased (20-30% subjective reduction) over the left outer side of left arm and forearm. Reflexes showed signs by myelopathy with reverse supinator and positive finger jerks.
6. MRI cervical spine done on 25th February 2008 showed left 3-4mm paracentral and lateral recess disc protrusion at C5/6 level. Left side of the cervical spinal cord was compressed. Similar 1mm disc protrusions were noted at C4/5 and C6/7 levels. The disc protrusions were associated with osteophytes.
7. Dr Tsang opined as follows :

“13. In the incident on October 29th, 2004, [the Plaintiff] suffered from moderate neck injury, resulting in limited neck movements, arm pain and persistent neck pain.

14. Recent MRI confirmed cervical spine herniations corresponding to his symptoms. Since he was asymptomatic before the event, it was very likely that the lesion was a result from the injury.”

1. Dr Tsang referred to the AMA Guides and stated that the Plaintiff’s percentage of permanent impairment of the whole person was estimated to be 15%. He added that the Plaintiff would need to *consult a neurologist or an orthopaedic surgeon* for treatment. Continuation of physiotherapy was recommended. Since the Plaintiff’s disease had lingered on for more than 3 years, Dr Tsang expected a prolonged treatment course. He opined that the prognosis was fair and full recovery might not be possible, and ultimately the Plaintiff might need surgical intervention for his herniated disc.

*VII. Legal principles*

1. Expert medical evidence can and should be admitted into evidence if it is necessary, relevant and of probative value (see *Arfan Muhammad v MPS Engineering Ltd* HCPI 457/2003 (unreported, 30th June 2005) at para.6 where Deputy High Court Judge Muttrie referred to the observation by Suffiad J in *Chan Kwok Ming v Hitachi Electric Service Ltd* HCPI322/2002 (unreported)).
2. In *Wong Hoi Fung v American International Assurance Company (Bermuda) Ltd & anor* [2007] 3 HKLRD 507, 511-512, Chu J articulated the principles for admission or exclusion of expert medical evidence and on the requirement of “relevance” as follows :

“11. Modern judicial authorities recognize that the court has inherent power to rule on the admissibility of expert evidence at a pre-trial stage : ***Woodford and Ackroyd v Burgess*** [2000] CP Rep 79*,* ***Ko Chi Keung v Lee Ping Yan*** [2001] 1 HKLRD 829 and *Lee****Kin Yee & Others v Lee Wing Kim & Another***(unrep., HCA No 9522 of 1997, [2001] HKEC 1546). Where the proposed expert evidence is plainly inadmissible or irrelevant, the court ought to exercise its discretion to refuse the admission of such evidence. But where the court cannot form a clear view on the relevance of the proposed expert evidence or where it considers that the proposed evidence is clearly relevant, then it should grant leave for the evidence to be adduced at the trial : ***Ko Chi Keung v Lee Ping Yan at p.833***and *Lee K****in Yee & Others v Lee Wing Kim & Another*** at p.15.

12. In deciding whether certain proposed expert evidence should be received, the relevant test has been stated to be a two-stage one. Firstly, the evidence has to be admissible as "expert evidence" for the purpose of s.58 of the Evidence Ordinance (Cap.8). Secondly, the evidence must be relevant, in the sense that it is helpful to the court in arriving at its decision on one or more of the issues to be resolved : ***Barings plc (in Liquidation) & Another v Coopers and Lybrand & Others* (unrep., 9 February 2001)**,**** Evans-Lombe J at paras.44-45.”

Evans-Lombe J added that the court could still exclude expert evidence if it was of the view that calling such evidence would not be helpful to the court in resolving any issue in the case justly, eg where the issue to be decided was one of law or one on which the court could come to an informed decision without such expert evidence.

1. Where expert medical evidence is both necessary and desirable, it is the duty of the expert, as succinctly expressed by Lord President Cooper in *Davie v Edinburgh Magistrates* [1953] SC 34, 40, “to furnish the judge or jury with the necessary scientific criteria for testing the accuracy of their conclusions, so as to enable the judge or jury to form their own independent judgment by the application of these criteria to the facts proved in evidence”. Proper discharge of such duty facilitates the judge in interpreting the factual evidence on the basis of the expert’s special skill and experience not possessed by ordinary laymen. In *Davie*, the court rejected the proposition that a judge or jury was bound to adopt the views of even an un-contradicted expert, and held it was ultimately a matter for decision by a judicial tribunal.

*VIII. Discussion*

*(a) Orthopaedic vs neurological expert evidence*

1. Orthopaedic specialists are experts in the branch of medicine concerned with diseases, injuries and conditions of the human musculoskeletal system that includes ligaments, tendons, joints and nerves, so they are in a position to assist the court on how a mode of injury will impact on an individual’s musculoskeletal structure and (where appropriate) on the causation of injuries to the musculoskeletal system.
2. I note at the outset that apart from the AED attendances the Plaintiff received treatment from YCH’s DOT and PMH’s PD (which worked closely with the orthopaedic doctors in rendering physiotherapy treatment), and from Dr Fu (who is a private orthopaedic surgeon). There is no evidence that the Plaintiff received treatment from neurologists. Indeed, the Plaintiff approached Dr Tsang to arrange MRI cervical spine (because the waiting time for such investigation in the public sector was too long) and to examine him for preparing the Tsang Report.
3. Both parties (under legal advice) jointly obtained orthopaedic expert evidence by way of the 1st and 2nd Joint Reports. For such purpose, the Plaintiff chose to retain Dr Chiang as his orthopaedic expert. Although the present proceedings were commenced in June 2006, the issue of neurological evidence was not raised until some time in March 2008. A question therefore arises as to whether neurological expert evidence is “necessary” for the present case.
4. In my view, the Plaintiff’s injuries/treatment shown in the treatment medical reports/records were largely of the orthopaedic category. The recorded initial injuries from the Accident suggest abrasion or soft tissue injury to the Plaintiff’s limbs with left elbow pain. Plainly, orthopaedic experts can properly give opinion on such injuries pursuant to their specialist knowledge and expertise.
5. Beyond such initial injuries, there is little dispute that some time later the Plaintiff complained to his attending doctors about neck pain, left shoulder pain, weak left upper limb, left hand numbness, sleep problem and left eye decreased vision. The claimed ongoing disabilities in relation to the neck and left shoulder/hand were evidenced by x-ray (arranged by YCH and the orthopaedic experts) and MRI (arranged by Dr Tsang) findings :
   1. YCH noted degenerative osteophyte change at C4-C6 (see paragraphs 38 and 40 above);
   2. Dr Chiang and Dr Chun noted partial loss of cervical lordosis and mild degenerative change in the form of anterior marginal osteophytes at C4-C6 with mild narrowing of the C5/6 intervetebral disc space (see paragraph 65 above);
   3. Dr Tsang noted left 3-4mm paracentral and lateral recess disc protrusion at C5/6 and similar 1mm disc protrusion at C4/5 and C6/7 associated with osteophytes and compression of left side cervical spinal cord (see paragraph 82 above).
6. But the key question in relation to the claimed ongoing disabilities is their causal relationship (if any) with the Accident. In my view, irrespective of whether neurological specialists can also address such subject, orthopaedic experts are well placed to give opinion on this issue since they are experts in the workings and function of the musculoskeletal system (including the spine), its articulations and associated structures, and in identifying, diagnosing and treating injury to any component of the musculoskeletal system. Indeed, Dr Tsang suggested that the Plaintiff should seek treatment for his claimed ongoing disabilities from either a neurologist or an orthopaedic surgeon (see paragraph 84 above), which is an implicit acknowledgement that an orthopaedist is well capable of dealing with (and, *a fortiori*, giving expert opinion on) the Plaintiff’s claimed ongoing disabilities.
7. In the circumstances, given that both parties have already obtained orthopaedic expert evidence that has already canvassed the issue of the causal relationship (if any) between the Plaintiff’s claimed ongoing disabilities and the Accident, the court leans against any suggestion that neurological expert evidence is “necessary” for addressing the same or similar subject. The court has a duty to restrict expert evidence to what is reasonably required for proper adjudication. I bear in mind the trenchant reminder by Seagroatt J in *Wong Hin Pui v Mok Ying Kit & anor* [2000] 1 HKLRD 856, 874-875, against proliferation of expert medical evidence which are not essential.

*(b) Criticism of Dr Chiang and Dr Chun*

1. However, the Plaintiff submitted that he should be allowed to file and adduce the Tsang Report because the opinion of Dr Chiang and Dr Chun was biased and unreliable. I need say no more about Dr Chun, who was retained by the Defendant, since Mr Wong assured me the Defendant still abided by Dr Chun’s findings and opinion in the 1st and 2nd Joint Reports.
2. The Plaintiff submitted that he had lodged complaint with the Medical Council against Dr Chiang and Dr Chun for failing to properly assess his leg and neck injuries in accordance with his treatment medical reports/records from the Government hospitals, and the Medical Council would process such complaint. In my view, this is insufficient support of his serious allegation of unfair bias. However, the handling of such complaint is a matter for the Medical Council, and I say no more on that.
3. I reject the Plaintiff’s further attack on the 1st and 2nd Joint Reports that the opinion expressed therein was discrepant with the treatment medical reports/records. In respect of the leg injury, both Dr Chiang and Dr Chun not only referred to the treatment medical reports/records which mentioned injury to the left shin and left ankle, they accepted there was soft tissue and abrasion injury to the left shin and left ankle as a result of the Accident. In respect of the alleged neck injury, both Dr Chiang and Dr Chun recorded the Plaintiff’s complaints and summarised the treatment medical reports/records with respect to his claimed ongoing disabilities. But as explained above, the treatment medical reports/records revealed that such complaints by the Plaintiff to his attending doctors were made more than a year after the Accident, and the diagnoses by the attending doctors were degenerative osteophytes and cervical spondylosis.
4. The sole basis the Plaintiff put forward for requiring substitution of the Tsang Report for Dr Chiang’s written opinion in the 1st and 2nd Joint Reports was Dr Chiang’s failure to attribute the Plaintiff’s claimed ongoing disabilities to the Accident in accordance with the Plaintiff’s treatment medical reports/records from the Government hospitals (see paragraph 21 above) rather than concern over Dr Chiang’s expertise as an orthopaedic specialist or his manner of conducting medical examination of or taking history from the Plaintiff. However, as seen above, Dr Chiang’s opinion is not far different from the diagnosis of cervical spondylosis by the Plaintiff’s attending doctors at the Government hospitals.
5. What the Plaintiff effectively purports to do now is to resile from the opinion of Dr Chiang (whom he has selected as his orthopaedic expert) when he discovered that Dr Chiang did not support the case he was advancing to the full extent he thought justified and/or when Dr Chiang’s conclusions proved less favourable to him than he anticipated. This gives a strong flavour of “expert shopping” which is undesirable and which the court seeks to discourage.
6. I bear in mind that the court has to deal with the case justly, and that the value of the Plaintiff’s claim may be affected by Dr Chiang’s opinion. But there is nothing in the circumstances that I have related above and in the discussion below to show that injustice will be suffered by declining to allow neurological evidence in the form of the Tsang Report.
7. In coming to this view, I do not lose sight of the expert’s role in civil litigation. Not only do they owe a duty to exercise reasonable care and skill to those who instruct them, they have a duty to help the court on matters within their area of expertise that overrides any obligation to the party who instructs them or pays their fees. The *Ikarian Reefer* principles require that expert evidence presented to the court should be, and should be seen to be, the independent product of the expert uninfluenced as to form and content by the exigencies of litigation. Thus, an expert should not become an advocate for the viewpoint of the party who instructs him, and his report made for the benefit of the court must be independent, objective and non-partisan.
8. It therefore follows that when a party appoints an expert, there is no certainty that the report by such expert will necessarily be favourable. It further follows that an unfavourable report does not of itself amount to any sufficient basis for allowing a potentially more favourable report to be adduced. In my view, the Plaintiff’s criticisms of Dr Chiang’s opinion in the 1st and 2nd Joint Reports do not lend weight to his application.

*(c) Case management considerations*

1. In considering whether to allow the Tsang Report to be adduced, case management considerations cannot be ignored. Part of the duty to manage cases properly is to ensure that expense is saved and the case progresses expeditiously to adjudication. In my view, if the Plaintiff were allowed to add or change horses at this stage of the proceedings, the Defendant will be procedurally prejudiced.
2. Bearing in mind that this case has been set down twice for assessment hearing but was aborted on both occasions, any addition or substitution of medical expert now will obviously delay the proceedings. It may also increase costs since Mr Wong intimated that the Defendant might need expert opinion from Dr Edmund Woo to deal with the Tsang Report. I shall return to this below in light of the Plaintiff’s current stance of refusing to undergo further medical examination.
3. There are also some special features in this case which suggest that the court should not exercise its discretion in favour of the Plaintiff. In fact, it was the Plaintiff’s initial proposal for joint orthopaedic expert report (see the Plaintiff’s CLR Notice dated 25th October 2006) that led to the directions in paragraph 6 above and the 1st Joint Report. Notwithstanding the “unfavourable” nature of Dr Chiang’s opinion in light of the Plaintiff’s witness statement that asserted he suffered neck injury and claimed ongoing disabilities as a result of the Accident, the Plaintiff by his CLR Notice dated 3rd May 2007 further proposed that the 1st Joint Report be adduced at the assessment hearing without oral evidence and this led to the directions in paragraph 7 above.
4. No attempt was made to resile from Dr Chiang’s opinion or to adduce other expert medical evidence until 11th January 2008 when for the second time the case was set down for assessment hearing on 18th April 2008. With the date of the assessment hearing looming imminently, the Plaintiff in February 2008 took a decision, as it were, behind the back of the Defendant’s solicitors to instruct another expert (ie Dr Tsang) to proceed with preparation of the Tsang Report, and then disclosed it in early March 2008 shortly before the scheduled assessment hearing.
5. In my view, the court should not endorse such attempt by the Plaintiff to reopen medical issues already canvassed in the 1st Joint Report (which both parties agreed could be adduced without oral evidence) and to force the court’s hand by commissioning and producing the Tsang Report without seeking permission to rely on another or further expert.
6. But the present case goes further. The Plaintiff after having obtained the Tsang Report has already made one attempt to adduce such report, but retracted such application in favour of a joint supplemental orthopaedic expert report from Dr Chiang and Dr Chun. Two points can be made. First, the Plaintiff by that stage well knew the “unfavourable” nature of Dr Chiang’s opinion and had access to the Tsang Report, yet he chose to request further opinion from Dr Chiang. Secondly, since leave was given to both parties to obtain the 2nd Joint Report, it is difficult to appreciate why the Defendant having accommodated the delay caused by and having incurred cost in obtaining the 2nd Joint Report should be required to incur further delay and costs to enable the Plaintiff to have a second bite of the cherry. As explained above, the fact that Dr Chiang did not change his mind in the 2nd Joint Report does not of itself give rise to any sufficient basis for adducing further or other expert medical evidence.
7. In summary, the case management considerations do not point to any cogent reason for allowing the Plaintiff to rely on the Tsang Report.

*(d) Relevance and probative value of the Tsang Report*

1. Even if I were to grant leave to the Plaintiff to adduce neurological expert evidence (which I disagree), is the opinion in the Tsang Report relevant and of probative value in the sense that it will be helpful to the court in its adjudication?
2. I should say at the outset that any comment I make below concerning the Tsang Report is not any criticism of Dr Tsang. There is no evidence before me whether Dr Tsang was called upon to give advice on the Plaintiff’s medical condition or to give opinion to be relied on for court proceedings. In the former case, considerations of relevancy and probative value to the litigation do not come into play. But as the Plaintiff intends to adduce the Tsang Report at the assessment hearing, the court must scrutinise the opinion expressed in the report to see if it is properly admissible as expert medical evidence.
3. I reiterate what has been said in *Davie* (see paragraph 87 above), ie the medical expert is to assist the court by providing independent opinion and by furnishing the necessary scientific criteria for testing the accuracy of their conclusions. The court is not bound to accept that expert evidence but is obliged to assess all the evidence before it (including that expert evidence) and decide whether to prefer that expert evidence over any other evidence. For the court to do so and for the medical expert to discharge his duty, he must (a) identify and articulate the facts and assumptions on which his opinion rest, and (b) explain the scientific basis or identify the scientific reasoning on which he reached his opinion. Failing to do so goes to the relevancy and probative value (and hence admissibility) of such expert’s evidence.
4. Following from such duty, a medical expert who renders opinion for use in court proceedings should take into account all material facts. The *Ikarian Reefer* principles require that (a) an expert witness should not omit to consider material facts which could detract from his concluded opinion, and (b) expert opinion should not be presented as final and unqualified if it is in fact provisional/qualified or where the expert considers more information is required (which fact must be clearly indicated).
5. The Plaintiff orally submitted at the hearing that he had provided Dr Tsang with his sick leave certificates and his treatment medical reports/records for preparing the Tsang Report. But the Tsang Report did not refer to such documents. Instead it stated that the report was based on Dr Tsang’s medical examination of the Plaintiff on 23rd and 28th February 2008.
6. As the Plaintiff acknowledged, the treatment medical reports/records from the Government hospitals (eg YCH, PMH and the GOPC) and private doctors (eg Dr Fu) are plainly relevant to any expert opinion on the Plaintiff’s injuries/disabilities following from the Accident. If they have been given to Dr Tsang, the Tsang Report suggests that he has omitted to consider them. If he has considered them, the report is misleading and the court takes a dim view of omission of “off-the-record” instructions. If they have not been given to Dr Tsang, there is no evidence that Dr Tsang has requested for them even though he knew the Plaintiff received treatment from Government hospitals (see paragraph 78 above). On any count, there is clearly doubt as to the probative value of the Tsang Report.
7. The duty to consider material information that may detract from the claim requires a medical expert giving opinion for court proceedings to outline or argue the basis for his opinion, and consider alternative explanations or range of opinion on the aetiology of a medical condition. On this, there is clear contrast between the 1st and 2nd Joint Reports on one hand and the Tsang Report on the other. In the 1st and 2nd Joint Reports, Dr Chiang and Dr Chun recounted the history taken from the Plaintiff and considered such history against the treatment medical reports/records, highlighting and analysing the consistencies and inconsistencies, and formed their opinion by applying orthopaedic knowledge and expertise. For the Tsang Report, Dr Tsang took history from the Plaintiff and rendered opinion on the basis of the Plaintiff’s description.
8. As an example, the Plaintiff gave history that he suffered neck injury and neck pain at the time of the Accident. In paragraph 13 of the Tsang Report, Dr Tsang gave opinion on such assumption of fact based on the Plaintiff’s description (see paragraph 83 above) without, as Dr Chiang and Dr Chun did, testing such allegation against the contemporaneous treatment medical records.
9. In fact, although the Plaintiff described to Dr Tsang that at the time of the Accident his helmet broke and he recalled transient loss of consciousness on the spot, YCH’s medical records of his condition on arrival at the AED noted no head injury, no loss of consciousness and no vomiting. Further, although the Plaintiff described immediate neck pain when the Accident occurred, YCH’s medical reports/records did not note any left hand numbness or left shoulder pain until December 2005 (shoulder pain for 3 months) or neck pain until January 2006 (after lifting or doing household work 2 days ago) respectively. The first record of any alleged correlation between the neck pain and the Accident was in February 2006, and of any decreased eye vision was in April 2006. The treatment medial reports/records also showed that the Plaintiff did not receive physiotherapy treatment until February 2006 and did not attend YCH’s DOT until May 2006. Quite simply, there is no consideration or discussion of these matters in the Tsang Report for a balanced opinion.
10. Moreover, as explained in paragraph 92 above, there is no dispute that the x-ray and MRI investigations reveal the presence of osteophytes at the cervical spine. The MRI investigation further reveals disc protrusions and spinal cord compression. Since osteophytes are bony outgrowths associated with what the Government doctors referred to as cervical spondylosis (ie a spinal disorder in which degenerative changes occur in the intervertebral discs) as early as in February 2006, it is unclear why Dr Tsang did not consider/discuss the merits or demerits of degenerative disorder as an alternative explanation for the Plaintiff’s claimed ongoing disabilities, eg whether underlying degeneration can be asymptomatic or necessarily symptomatic, and whether the onset of symptoms in the cervical region can result from degenerative changes or necessarily from trauma.
11. This is significant because as from December 2005 the working diagnoses of the Government doctors/physiotherapists were degenerative osteophyte changes at the cervical spine and degenerative cervical spondylosis (see paragraphs 33, 35 and 38 above). Indeed, after having sight of the MRI report in April 2008, the doctor at YCH’s DOT still noted there were “degenerative” changes (see paragraph 57 above), and the diagnosis stated in sick leave certificates for the period from 31st August 2007 to 15th February 2008 was cervical spondylosis (see paragraph 66 above).
12. In light of the above, I disagree with the Plaintiff’s submission that the contents of the Tsang Report are wholly consistent with the treatment medical reports/records from the Government hospitals.
13. Dr Tsang’s conclusion in paragraph 14 of the Tsang Report that it was likely that the spine lesion was a result of injury at the time of the Accident was made without the benefit of considering and arguing (a) the injuries/complaints recorded in the treatment medical reports/records shortly after the Accident which were quite different from the claimed ongoing disabilities in/after December 2005 and (b) the alternative explanation of degenerative spinal disorder. I am not persuaded that the Tsang Report is relevant and of probative value.
14. Further, in concluding that the cervical spine lesion was a result of injury from the Accident from (a) an assumption of fact being the Plaintiff’s description of neck injury as a result of the Accident and (b) the temporal factor of the Plaintiff becoming symptomatic after the event (see paragraph 83 above), I am not satisfied that specialised neurological knowledge and expertise was brought to bear on such conclusion. Expert opinion requires demonstration or examination of the scientific or intellectual basis of the conclusion reached, and the report must explicitly explain how the expert applied his specialised knowledge to the assumed facts. The credibility of the Plaintiff’s account in (a) above and the temporal factor in (b) above are things that the court can readily take into account for assessing the evidence before it without the aid of any medical expert. What the Tsang Report falls shy of doing is to deal with the alternative possibility of degenerative spinal disorder being asymptomatic initially but gradually developing symptoms with progression of the disease, especially when the Plaintiff himself acknowledged in oral submissions at the hearing that there was gradual development of neck pain and left hand numbness.

*(d) Further medical examination*

1. Mr Wong indicated that if I were to allow the Tsang Report to be filed and adduced (which he disagreed), the Defendant would wish to obtain neurological expert evidence from Dr Edmund Woo in response thereto and would consequently require the Plaintiff to be medically examined by Dr Woo.
2. Although at the hearing the Plaintiff was agreeable to such medical examination, he later changed his mind. His objection was not specifically against Dr Woo. Rather he argued that the treatment medical reports/records and sick leave certificates would be sufficient for effective adjudication at the assessment hearing.
3. In my view, assuming that the Tsang Report contained necessary and relevant expert neurological evidence that was of probative value and leave were granted for the Plaintiff to adduce the same in addition to his treatment reports/records, fairness would require that the Defendant be allowed to similarly adduce expert neurological evidence if he so wished, and for such purpose medical examination of the Plaintiff might reasonably be required (see discussion in my decision in *Ma Oi Lin Irene v Ma Hiong Ming & anor* DCPI2488/2007 (unreported, 17th September 2008) paras.34-43). After all, Dr Tsang examined the Plaintiff twice before compiling the Tsang Report. I do not see why, if the Plaintiff were able to rely on the Tsang Report, a just determination of the cause requires constricting the Defendant’s preparation of his case by denying him opportunity to obtain proper neurological report due to the Plaintiff’s stated intention of refusing to undergo further medical examination. As for the Plaintiff’s other ground of objection, ie that medical examination by medical expert nominated by the Defendant involves investigation that causes unbearable pain, there is no evidence that Dr Edmund Woo will necessarily require a nerve conduction test or any other invasive/painful examination. After all, Dr Tsang did not so require. Consequently, the Plaintiff’s wholesale anticipatory refusal to undergo medical examination by medical expert nominated by the Defendant must be a relevant factor against the exercise of discretion for him to file and adduce the Tsang Report.

###### IX. Conclusion

1. I am not persuaded that the Tsang Report is necessary, relevant or of probative value for the purpose of the present proceedings. I therefore dismiss the Summons.
2. The case is ready for assessment of damages. I therefore order that the case be set down for assessment of damages in the fixture list at 9:30am on 26th May 2009 before a bilingual Master of the District Court in court at Court No.45 with an estimated length of hearing of 1 day.
3. I further direct the Defendant to (a) compile the assessment bundle pursuant to paragraph 16 of Practice Direction 18.1 to be lodged and served 7 days before the aforesaid hearing date, and (b) draw up the orders made at the hearing on 26th February 2009 and herein in Chinese and serve the same on the Defendant. After 14 days from perfection of the order in relation to the Summons, the Defendant’s solicitors do collect the PTR bundle from the court for re-use.
4. Following from paragraph 23 above, I also reserve the issue of whether leave should be granted to the Plaintiff to abandon reliance on Dr Chiang’s opinion in the 1st and 2nd Joint Reports to the Master at the assessment hearing.
5. There is no reason why costs should not follow event in respect of the Summons. I therefore grant a costs order *nisi* that the Plaintiff do pay the Defendant costs of the Summons including half of the costs of the hearing before me on 26th February 2009 to be taxed if not agreed. In respect of half of the costs of the hearing on 26th February 2009 that concerned the PTR, I grant a costs order *nisi* that costs be in the cause of the assessment of damages.
6. As explained to the parties at the hearing, this Decision is prepared in English because the 1st and 2nd Joint Reports and the Tsang Report are in the English language. However, I have instructed my clerk to inform the Defendant that if he so requires a court translator will be arranged to verbally translate [this](http://lrs.jud.hksarg/lrs/common/search/#ctx1) Decision into punti language for him at the Wanchai Law Courts at a mutually convenient date and time.

# (Marlene Ng)

District Court Judge

Representation:

The Plaintiff in person and present.

Mr Benny Wong of Messrs Lau, Chan & Ko for the Defendant.