DCPI 1080/2010

**IN THE DISTRICT COURT OF THE**

**HONG KONG SPECIAL ADMINISTRATIVE REGION**

PERSONAL INJURIES ACTION NO. 1080 OF 2010

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BETWEEN

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| WONG WAN CHOW | Plaintiff |
| and |  |
| SECRETARY FOR JUSTICE FOR AND ON  BEHALF OF THE COMMISSIONER FOR  LABOUR OF THE HONG KONG  SPECIAL ADMINISTRATIVE REGION | Defendant |
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Coram: HH Judge M Wong

Dates of Hearing: 28 to 31 January and 25 March 2013

Date of Judgment: 29 April 2014

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**JUDGMENT**

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*Background*

1. This is a medical negligence claim against the Fanling Occupational Health Clinic (“the Clinic”), which is a government clinic established and managed by the Commissioner for Labour of the Hong Kong Special Administrative Region. The Secretary for Justice, for and on behalf of the Commissioner for Labour, is being sued by virtue of section 13 of the Crown Proceedings Ordinance and section 18 of the Hong Kong Reunification Ordinance.
2. The plaintiff, who was born in 1951 and worked as a newspaper delivery worker prior to late June/early July 2006, first attended the Clinic on 15 December 2006 complaining about bilateral heel pain since March 2006. Radiographs ordered on the same day revealed bilateral plantar and posterior calcaneal spurs, degenerative changes involving osteophyte in the medial malleolus, and soft tissue calcification adjacent to the right lateral talus. The plaintiff was diagnosed by the Clinic to be suffering from plantar fasciitis which was considered to be a work-related disease. She was treated with analgesics to relieve pain. Health education and counseling were also provided on the same day to the plaintiff, which included instructions on the use of ice pads, muscle exercises, the wearing of support shoes, weight reduction and the avoidance of heavy lifting. The plaintiff was further referred to the Prosthetic and Orthotics Department (“P & O Department”) of the North District Hospital (“NDH”) for the provisions of heel pads to her.
3. The plaintiff was fitted with bilateral heel pads on 26 January 2007, which was changed to bilateral insoles on 10 April 2007. She was then referred by the Clinic to physiotherapists on three separate occasions, but she only received physiotherapy on 14 July 2008 for the first time. She consulted the Clinic 10 times from 15 December 2006 to 13 August 2008. She was finally referred by the Clinic to seek treatment at the Orthopaedics Department of NDH on 13 August 2008.
4. The plaintiff’s complaints are that her condition had not been properly treated, there had been an undue delay in referral to specialist treatment so much so that she was deprived of a real chance of recovery and the lack of recovery rendered her unable to resume work. Thus, she claims against the Clinic for damages that flow from the delay.
5. Although there are many particulars of negligence pleaded in the Statement of Claim, Ms Lee for the plaintiff confirms in her closing submissions that the plaintiff’s case is only based on the defendant’s failure to refer the plaintiff to orthopaedic consultation in June 2007 or at the latest in November 2007, as orthopaedic specialists would be able to give the plaintiff steroid injections to treat her heel condition. Apart from that, the plaintiff no longer claims that there was anything wrong with the treatments she received at the Clinic. The plaintiff also accepts that it was not appropriate for the doctors at the Clinic to give steroid injections to her.
6. The Clinic’s defence is that there was no delay in referral, and even if the plaintiff had been referred to orthopaedic consultation earlier, the plaintiff’s heel condition would not have been any better. Further, if there is any inability to return to work, it was caused by the plaintiff’s other medical conditions including congestive heart failure, atrial fibrillation with chronic rheumatic heart disease, and psychological and psychiatric illnesses for which the plaintiff declines treatment.

*The issue*

1. In view of Ms Lee’s confirmation as aforesaid, the main issues concerning liability in this case are as follows:-
2. Whether there was any undue delay on the part of the Clinic in the referral of the plaintiff to orthopaedic consultation; and
3. If there was such a delay, whether the delay has caused “additional damages” to the plaintiff.

*The law*

1. As submitted by Mr Lam for the defendant, the standard of care required of a professional has been succinctly set out in paragraph [380.126] of *Halsbury’s Laws of Hong Kong*, Vol 25(1), 2007 Reissue. The following legal principles cited therein are relevant:-

(1) The standard of care to be expected of a professional must be based on events as they occur in prospect and not in retrospect (per Simon Brown LJ in *Boston & Co v Roberts* (1995) Times, 17 March).

(2) The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art (per McNair J in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 at 586).

(3) An error of judgment will not amount to negligence unless it is one that would not have been made by a reasonably competent professional with the standard and the type of skill of the defendant, acting with ordinary care (*Whitehouse v Jordan* [1981] 1 WLR 246).

(4) Where there are differing and well established professional schools of thought on an issue, a professional will not be regarded as negligent in following one practice rather than another even if the outcome suggests that the wrong choice was made (*Maynard v Midlands Regional Health Authority* [1984] 1 WLR 634).

1. In *Maynard v Midlands Regional Health Authority*, supra, Lord Scarman said this:-

“Differences of opinion and practice exist, and will always exist, in the medical as in other professions. There is seldom any one answer exclusive of all others to problems of professional judgment. A court may prefer one body of opinion to the other: but that is no basis for a conclusion of negligence. … For in the realm of diagnosis and treatment negligence is not established by preferring one respectable body of professional opinion to another. Failure to exercise the ordinary skill of a doctor (in the appropriate specially, if he be a specialist) is necessary.”

1. Also, Lord Browne-Wilkinson in *Bolitho v City and Hackney Health Authority* [1998] AC 232 said this:-

“in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant’s conduct, the defendant can properly be held liable for negligence…. In my judgment that is because, in some cases, it cannot be demonstrated to the judge’s satisfaction that the body of opinion relied upon is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.

I emphasise that in my view it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence. As the quotation from Lord Scarman makes clear, it would be wrong to allow such assessment to deteriorate into seeking to persuade the judge to prefer one of two views both of which are capable of logically supported. It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the benchmark by reference to which the defendant’s conduct falls to be assessed.”

1. The plaintiff has no dispute with the authorities referred to by the defendant as set out above. In fact, the test as laid down in *Bolam v Friern Hospital Management Committee*, supra, is also relied upon by the plaintiff as the standard with which this case ought to be adjudged.
2. The plaintiff agrees that in every case of medical negligence that goes to trial, there is bound to be opposing evidence from experts for the difference parties, and how these opposing views are to be assessed is set out by Lord Browne-Wilkinson in *Bolitho v City and Hackney Health Authority*, supra, as follows:-

“the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant’s treatment or diagnosis accorded with sound medical practice. In the *Bolam* case itself, McNair J. [1957] 1 WLR 583, 587 stated that the defendant had to have acted in accordance with the practice accepted as proper by a “*responsible* body of medical men.” Later, at p. 588, he referred to “a standard of practice recognized as proper by a competent *reasonable* body of opinion.” Again, in the passage which I have cited from *Maynard’s* case [1984] 1 WLR 634, 639, Lord Scarman refers to a “respectable” body of professional opinion. The use of these adjectives – responsible, reasonable and respectable – all show that the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter.”

1. The plaintiff further adopts the following citation from *Hucks v Cole* [1993] 4 Med LR 393 as mentioned in *Bolitho*, supra: -

“When the evidence shows that a lacuna in professional practice exists by which risks of grave danger are knowingly taken, then, however small the risk, the court must anxiously examine that lacuna – particularly if the risk can be easily and inexpensively avoided. If the court finds, on an analysis of the reasons given for not taking those precautions that, in the light of current professional knowledge, there is no proper basis for the lacuna, and that it is definitely not reasonable that those risks should have been taken, its function is to state that fact and where necessary to state that it constitutes negligence. In such a case the practice will no doubt thereafter be altered to the benefit of patients. On such occasions the fact that other practitioners would have done the same thing as the defendant practitioner is a very weighty matter to be put on the scales on his behalf; but it is not, as Mr. Webster readily conceded, conclusive. The court must be vigilant to see whether the reasons given for putting a patient at risk are valid in the light of any well-known advance in medical knowledge, or whether they stem from a residual adherence to out-of-date ideas.”

1. The standard of care in medical negligence cases has also been summarized by Suffiad J in *Lai Wing Cheung v Yep Chau Chung and Lin Hin Wu*, HCPI 43 of 2005, as follows:-

“Applying that test laid down in *Bolam’s* case, a plaintiff, in order to establish medical negligence, must prove (i) there is a normal practice which is applicable to the case; (ii) the defendant has not adopted it; and (iii) the course taken by the defendant was one which no professional man of ordinary skill would have taken, had he been taking ordinary care.”

1. Thus, the law requires the plaintiff to prove that based on the events as they occurred in prospect, the doctors at the Clinic have not exercised the ordinary care and skill of an ordinary competent general medical practitioner in not referring the plaintiff to orthopaedic consultation in June 2007 or at the latest in November 2007 before she can establish negligence on the part of the Clinic.

*The plaintiff’s case*

1. The plaintiff has given evidence herself and called an expert witness, Dr Chan King Pan, to give evidence on her behalf. The plaintiff also produces many medical notes and records to support her case. There is not much dispute about the plaintiff’s treatment history. The plaintiff had complained of heel/sole pain since March 2006 and had been receiving various treatments for some time before she first attended the Clinic on 15 December 2006.
2. During the 1st consultation at the Clinic on 15 December 2006, x-rays were taken of the plaintiff and these showed plantar and posterior calcaneal spurs and degenerative changes in her right ankle. The x-ray report was explained to the plaintiff during the 2nd consultation at the Clinic on 12 January 2007. She was then referred to P & O Department of NDH for the provision of heel pads. She attended P & O Department of NDH on 26 January 2007 where bilateral heel pads were prescribed. The heel pads were changed to bilateral terraflex insoles on 10 April 2007 for pressure distribution, but the new hard heel pads caused her enormous pain.
3. The plaintiff consulted the Clinic for the 3rd time on 13 April 2007 and told the doctor at the Clinic about the continuing pain. She was advised that she should continue with the heel pads for them to take effect. There is no dispute about this advice, as the plaintiff’s own expert, Dr Chan, also agrees that the insoles ought to be given time to work and it was appropriate not to refer the plaintiff to orthopaedic consultation at this point of time.
4. The plaintiff attended P & O Department of NDH again on 11 June 2007. It was recorded in her patient record that the bilateral terraflex insoles were considered better than the heel pads and there was claimed improvement of 30%. She was then discharged from P & O Department of NDH. However, the words “advice ORTH consultation” also appeared in the plaintiff’s patient record, ie the plaintiff was advised to have orthopaedic consultation.
5. On 12 June 2007 the plaintiff had the 4th consultation at the Clinic. Although it was noted by the health advice nurse that the plaintiff complained of sole pain, it was recorded in the progress note that her sole pain was better. The plaintiff, however, contends that the doctors at the Clinic were aware that she had been discharged from P & O Department of NDH and was advised to have orthopaedic consultation. In this regard, the plaintiff relies on the evidence of the defendant’s expert witness, Dr Ip Wing Yuk. According to Dr Ip, who is familiar with the Hospital Authority system, the advice from P & O Department of NDH must have been communicated to the treating doctor at the Clinic. Thus, the plaintiff contends that the treating doctor at the Clinic should have referred the plaintiff to orthopaedic consultation. Dr Chan also advises that this should have been done then. Nevertheless, referral did not take place.
6. It is therefore the plaintiff’s case that the Clinic was negligent in not referring her to orthopaedic consultation in June 2007.
7. The plaintiff had the 5th consultation at the Clinic on 4 September 2007. She had similar foot pain and was referred to physiotherapy. The treatments given to her remained unchanged, ie analgesics, exercises and health advice.
8. On 13 November 2007 the plaintiff attended the Clinic for the 6th time. It was recorded in her progress note that she still had bilateral foot pain and when changed to do a sewing job the day before, the pain increased. When seen by the health advice nurse, the plaintiff complained that the pain at both soles had increased. Physiotherapy was arranged for her in February 2008, but her treatment at the Clinic remained unchanged. There was no referral to orthopaedic consultation.
9. The plaintiff contends that as her foot/sole pain had increased, she should have been referred to orthopaedic consultation at the latest by this time in November 2007, and the Clinic was negligent in not doing so.
10. On 15 January 2008 the plaintiff was seen at the Clinic for the 7th time. It was recorded in the progress note that she still had bilateral sole pain and her condition was similar. Her treatment was also similar. However, she complained to the health advice nurse that she had severe heel pain.
11. The plaintiff was admitted to the Prince of Wales Hospital and the Shatin Hospital from 2 February 2008 to 23 February 2008 for chronic rheumatic heart disease. She missed the physiotherapy appointment in February 2008.
12. On 25 March 2008 she consulted the Clinic for the 8th time and her heel pain was similar. She was again referred to physiotherapy. Her treatment remained unchanged with no referral to orthopaedic consultation.
13. Her 9th consultation at the Clinic was on 3 June 2008. She still had heel pain and her condition was similar. She was referred for physiotherapy again with early appointment requested. There was also a referral for prosthesis and orthotic services. It was recorded in the progress note that referral to orthopaedics & traumatology should be considered if bilateral heel pain was not improved. Thus, it was almost a full year after P & O Department of NDH wrote the remark “advise ORTHO consultation”, 18 months after the plaintiff was first seen and 27 months after the symptoms had manifested that the doctors at the Clinic started to consider referring the plaintiff to Orthopaedics & Traumatology experts for consultation.
14. Finally at the 10th consultation on 13 August 2008, the plaintiff was referred by the Clinic to the Department of Orthopaedics & Traumatology of NDH and an early appointment was requested. During all this time her condition of bilateral plantar fasciitis persisted and her pain did not go away.
15. It is Dr Chan’s opinion that a prolonged history of sufferings and ineffective treatments prior to the plaintiff’s 1st consultation at the Clinic should have alerted the Clinic to take her cause more seriously and start more aggressive treatment sooner and earlier, such as physiotherapy and topical steroid injection. When standard/routine treatment had been given a short trial by the Clinic and shown to be ineffective, prompt and early referral to other disciplines – physiotherapy and orthopaedic specialist – should be effected.
16. Dr Chan is of the view that when a patient’s condition does not improve, the standard or reasonable time for the trial of different tiers of treatment before the patient is referred by a non-specialist clinic to a specialist clinic is usually from 6 weeks to 12 weeks or sometimes up to 6 months, depending on the prevailing severity of the symptoms and the intensity of the different tiers of treatment. Thus, there was undue delay of some 21 months from the time when the plaintiff had the 1st consultation at the Clinic to the time when she had the orthopaedic specialist consultation.

*The defendant’s case*

1. Apart from Dr Ip, who is the defendant’s expert witness, the defendant has also called Dr Lam Wai Yip as a factual witness. Dr Lam is an acting senior medical officer and the division head of the Occupational Medicine Division (Clinical Services) of the Labour Department, which operates the Clinic. He was not one of the treating doctors of the plaintiff and was not yet in charge of the Clinic when the plaintiff received consultation and treatment from 15 December 2006 to September 2009. However, he has access to the plaintiff’s clinical notes and records kept by the Clinic and he has studied them for the purpose of these legal proceedings. His evidence is basically that, as revealed by the medical records, the plaintiff’s medical condition fluctuated during the period when she received medical treatments at the Clinic, but her medical condition was managed properly and according to the usual practice by the Clinic, and that the treatments and advice provided to the plaintiff by the Clinic were commensurate with the general competence and standard of occupational physicians.
2. As Dr Lam was not a treating doctor of the plaintiff and has not been called as an expert witness, his evidence is not really important to the central issues of this case. Dr Ip’s evidence, on the other hand, is more crucial for the determination of this case.
3. According to Dr Ip’s evidence, the cause of plantar fasciitis is multi-factorial. It might be related to the plaintiff’s job of newspaper delivery over 11 years. However, aging, obesity, lack of exercise are also factors that contributed to the symptoms. The plaintiff was treated conservatively with various modalities including life style modifications, weight reduction, medications, physiotherapy and insoles prescribed by the Clinic. Dr Ip is of the view that this line of treatment was appropriate. According to a medical paper by Toomey EP (2009), it was reported that “no matter what you do, time seems to be as important as treatment modalities” and “no one treatment modality was proven itself far superior to other”. Thus, Dr Ip opines that it was fair for the doctors at the Clinic to try out various treatment modalities before referring the plaintiff to an orthopaedic specialist.
4. In another paper “A Clinical Practice Guideline Revision 2010” by Thomas et al, it was reported that tier 1 treatment options included patient-directed treatment options, oral anti-inflammatives, padding & strapping, corticosteroid injection and weight loss. If tier 1 treatment options did not achieve satisfactory improvement, tier 2 treatment options including night splints, subsequent injections, orthotic device and immobilization should be added. Tier 3 treatment options including surgery and shock wave should be adopted if tier 2 options did not achieve good result. Dr Ip is of the view that as the plaintiff had reported “better” at the 2nd and 4th consultation, it was reasonable to wait for the result of physiotherapy before proceeding to another treatment tier.
5. Dr Ip comments that it was unfortunate that physiotherapy was delayed until 14 July 2008 as the plaintiff had required in-patient care since 2 February 2008 for her congestive heart failure caused by rheumatic heart disease and her heart condition was more severe compared to the plantar faciitis. Dr Ip also opines that as the plaintiff was taking Warfarin for her rheumatic heart disease, local injection of steroid was contra-indicated due to the risk of bleeding. In fact, when the plaintiff was seen by an orthopaedic specialist on 20 September 2009, the diagnosis was unchanged and the treatment modalities were similar to those offered by the Clinic. No steroid injection was applied.
6. As the treatments offered by the Clinic to the plaintiff were similar to those offered by an orthopaedic specialist, Dr Ip is of the view that the treatments provided by the Clinic did not fall below the standard of a proper and acceptable standard of treatment.
7. Nevertheless, Dr Ip also opines that it is reasonable to refer a patient to a specialist clinic after at least 3 months’ conservative treatment with no improvement.

*Was there an undue delay in referral?*

1. The plaintiff contends that as it is Dr Ip’s opinion that a patient should be referred after 3 months’ conservative treatment and there had been no significant alleviation in the plaintiff’s condition since December 2006, the plaintiff should have been referred to an orthopaedic specialist earlier instead of only in August 2008.
2. However, Dr Ip also said in her evidence that there is no hard and fast rule in referrals. If the treating doctor thinks that he cannot give adequate treatment, he can write to refer. Dr Ip acknowledges that in the public hospital system in Hong Kong one could wait for a year to see a specialist. She accepts that the plaintiff’s condition was fluctuating and her feet were painful at each and every consultation. However, as plantar fasciitis is not a life threatening illness and in fact there was improvement in her condition, it was fair for the doctors at the Clinic to wait for the result of physiotherapy before referral.
3. I accept Dr Ip’s evidence in this regard. Thus, her opinion that it is reasonable to refer a patient to a specialist clinic after at least 3 months’ conservative treatment with no improvement must be qualified by her aforesaid evidence. In fact, under cross-examination, Dr Chan also agrees that the doctors at the Clinic were entitled to wait for the outcome of physiotherapy, though not for too long, and that there is no hard and fast rule in referrals.
4. The plaintiff’s case is actually based on Dr Chan’s opinion that steroid injection is so effective that if she was referred earlier to an orthopaedic specialist, she could have steroid injection to cure her pain and she would have suffered less. Dr Chan does not suggest that the plaintiff should receive other invasive treatment modalities such as surgery or any other kind of conservative treatments such as prefabricated foot orthoses or customized functional foot orthoses from an orthopaedic specialist. Thus, the sole purpose of the contended early referral in June 2007 or at the latest in November 2007 is to enable the plaintiff to have steroid injection administered by an orthopaedic specialist as the Clinic cannot provide such a treatment.
5. The plaintiff invites the court to consider whether the doctors at the Clinic, having exhausted their “aggressive conservative treatment modalities” and the plaintiff’s condition was no better, ever took prompt steps to refer the plaintiff to other treatment modalities which they are not capable of administering. The plaintiff also asks these questions: “By holding onto the patient and allowing her condition to languish in the hope that some distant event might prove helpful had the doctors in the Clinic exercised their clinical judgment to a standard which would appear to be competent and acceptable?” and “Was it reasonable, responsible and logical to say that it was fair to wait and refer in August 2008?”
6. I think all these questions were based on the wrong assumption that the plaintiff’s condition was no better during the period when she was treated by the doctors at the Clinic. Although the plaintiff has given evidence that she is still in serious pain and denied any improvement during the period when she was treated by the doctors at the Clinic, I do not find her evidence credible. In fact, under cross-examination, the plaintiff admitted that after taking medication in December 2006, she reported that her condition was “better” when she visited the Clinic on 12 January 2007.
7. The plaintiff claims that when she saw the orthotist on 11 June 2007, she reported severe pain, but the corresponding orthotist’s record indicates that there was a claimed improvement of about 30%. She also stated in her own witness statement that she told the orthotist that the pain should have decreased, but she cannot explain why she stated that in the witness statement. Instead, she became aggressive and abusive when she was cross-examined about this matter. The fact that the orthotist saw fit to discharge her also indicates that she had become better. On the next day, ie 12 June 2007, when she attended the Clinic, the medical note recorded that her sole pain was better, but she again denied this in the witness box.
8. I believe that these medical records were based on the information provided by the plaintiff to the orthotist on 11 June 2007 and to the doctor at the Clinic on 12 June 2007, and they are more reliable than what the plaintiff claims now.
9. Moreover, under cross-examination, the plaintiff denied telling the physiotherapists that she had 30%, 40% or 50% improvement after physiotherapy, when such improvements were clearly stated in the physiotherapists’ records. This again shows that the plaintiff is not being truthful about her condition.
10. Thus, I do not find it true that the plaintiff did not get any better during the time when she was treated by the Clinic. It is also not true that the Clinic had exhausted all the conservative treatment modalities for the plaintiff in June 2007 or at the latest in November 2007, as physiotherapy was clearly an option open to the plaintiff at that time. The aforesaid questions raised by the plaintiff are all based on the wrong footing and not worth to be answered.
11. However, the plaintiff contends that steroid injection is also a kind of tier 1 conservative treatments and should be applied together with other therapy measures. In this regard, the plaintiff relies on the medical journals (exhibits “D2” and “D5”) produced by Dr Ip to support her contentions. The plaintiff also relies on another medical journal (exhibit “D1”) to show that steroid injections were amongst the top frequently used conservative treatment modalities.
12. Nevertheless, Dr Ip explains that it is up to individual authors as to how they interpret the research, and the frequency of the use of steroid injections mentioned in the literature is not conclusive on whether they should be more frequently used. I accept Dr Ip’s explanation. In fact, whether steroid injection is a tier 1 or tier 2 treatment, the main question is still whether it should be administered before the other conservative treatments are exhausted.
13. The main difference in opinion between Dr Chan and Dr Ip stems from their different views and perceptions as to the effectiveness and possible side effects of steroid injection. Dr Chan is of the view that topical steroid injection has a success rate of over 90% which will result in over 90% improvement of condition caused by plantar fasciitis. The relapse rate is below 2% and it carries little risk of side effect. Thus, Dr Chan suggests that steroid injection should be administered at an early stage of treatment. Dr Ip, however, opines that steroid injection for heel pain has only short-term effect and little is known about its side effect at cellular level. She is of the view that steroid injection is a preferred option when more conservative management is unsuccessful.
14. Dr Chan’s opinion is mainly based on his personal experience as an orthopaedist in private practice, although he also had experience working in Queen Mary Hospital from 1967 to 1971. Nevertheless, he has not sought to support his opinion by way of medical literature. He also qualifies his opinion by saying that the low relapse rate is dependent on patients paying heed to doctor’s advice and changing their lifestyle, eg through weight control, so as not to overuse the foot, and that in the case of the plaintiff, the risk is higher because of the rheumatic heart disease suffered by her.
15. On the other hand, Dr Ip’s opinion is well supported by scientific research reported in high level medical literature, which can be summarized as follows:-

(a) *Steroid injection for heel pain: evidence of short-term effectiveness. A randomized controlled trial* (1999 British Society for Rheumatology) (Exhibit “D3”): A statistically significant reduction in pain was detected in the first month after steroid injection, but thereafter no differences could be detected.

(b) *The real risks of steroid injection for plantar fasciitis, with a review of conservative therapies* (Exhibit “D5”): When more conservative management is unsuccessful, steroid injection is a preferred option. Although steroid injection is the mainstay for the management of many hyper inflammatory disorders, there is little known about steroid effect at the cellular level and, consequently, little about the etiology of the risks of connective tissue rupture after the same. Fascial rupture and fat pad atrophy are especially serious complications as they can lead to intractable complications. Fascial rupture interrupts the intrinsic windlass mechanism of the foot and can promote further inflammation in the surrounding tissue, thus promoting pain. In addition, plantar fat pad atrophy diminishes subcalcaneal cushioning, availing the plantar fascia to further insult and, hence, more pain. A study showed that symptomatic rupture occurred in approximately 10% of subjects.

(c) *A systematic review of treatments for the painful heel* (1999 British Society for Rheumatology) (Exhibit “D1”): The authors of the paper conducted a systematic review of the published and unpublished literature on various treatment methods (including steroid injection), and concluded that although much has been written about the treatments of plantar heel pain, the few randomized controlled trials involved small populations of patients and do not provide robust scientific evidence of treatment efficacy. As the natural evolution of heel pain is not fully understood, all trials included in the review reported some improvement in patients’ mean pain scores in both treated and non-treated populations. It is possible that the observed effects can be explained by placebo effect.

(d) *Heel Pain – Plantar Fasciitis: Clinical Practice Guidelines* (Journal of Orthopaedic & Sports Physical Therapy, Vol 38, Number 4, April 2008) (Exhibit “D4”): There is limited evidence to support the use of steroid injection to provide short-term pain relief. A major concern with steroid injection has been the risk of subsequent plantar fascia rupture and plantar fat pad degeneration. More recent studies have reported minimal to no risk for fascia rupture following a steroid injection.

(e) *Plantar fasciitis – to jab or to support? A systematic review of the current best evidence* (Journal of Multidisciplinary Healthcare 2011:4) (Exhibit “D2”): Both customized functional foot orthoses and corticosteroid injections can lead to reduction in pain associated with plantar fasciitis. While customized functional foot orthoses may increase the functional outcomes in patients with plantar fasciitis, corticosteroid injections may have side effects (especially pain as a result of the injection), which may limit its acceptability.

1. It is clear from the above medical literature that studies on treatments of plantar fasciitis (including steroid injection) have not been conclusive enough to form any consensual opinion in the medical professional as to how best plantar fasciitis should be treated. Nevertheless, the medical literature does show that steroid injection may produce only short term effect, there could be serious risk of subsequent plantar fascia rupture and plantar fat pad degeneration, the observed effects of treatment methods (including steroid injection) may be due to placebo effect, and steroid injection may not be superior to other treatment methods, such as customized functional foot orthoses.
2. It is also Dr Ip’s evidence that other medical literature suggest that only approximately half of the patients respond positively to steroid injection. For the patients who respond positively, steroid injection may produce 70% to 80% pain relief, but 50% of the patients who respond positively to steroid injection suffer from relapse in 6 to 12 month’s time. Dr Ip therefore takes the view that it was reasonable for the doctors at the Clinic to have attempted non-invasive conservative treatments such as physiotherapy before considering steroid injection. Dr Ip also said that a general practitioner is equally competent as an orthopaedist in the monitoring of physiotherapy, and it is in fact the duty of a general practitioner to monitor the progress of physiotherapy so that the specialist clinic would not be unnecessarily burdened.
3. I accept Dr Ip’s evidence entirely. I find that her opinion is very reasonable and responsible as well as logically supported by medical literature as aforesaid. Thus, I see nothing wrong for the doctors at the Clinic to wait for the outcome of the other conservative treatments including physiotherapy before referring the plaintiff to an orthopaedic specialist for steroid injection. More importantly, in view of Dr Ip’s evidence, I do not find that there is such a normal or standard practice for any doctor of ordinary skill to refer a patient to orthopaedic specialist for steroid injection before the other conservative treatments including physiotherapy have been exhausted.
4. Although the plaintiff attacks Dr Ip’s opinion by saying that her personal clinical experience does not support the prevalence of the complications associated with steroid injection such as infection, fascial rupture, fat pad atrophy, bleeding and the steroid being absorbed by other parts of the body, and Exhibit “D2” also indicates that there was no evidence to support such complications, I do not think that it is necessary for Dr Ip to have personal experience of such complications before she can form such an opinion. She can form the opinion based on her medical knowledge and medical literature. When Exhibit “D2” mentions that there was no evidence to support the complications, it only refers to the included studies. Exhibit “D5” clearly shows that there is such a risk of complications such as fascial rupture and fat pad atrophy, and a study did show that symptomatic rupture occurred in approximately 10% of subjects.
5. The plaintiff relies very much on the note “advised ORTHO consultation” from the orthotist in June 2007 to contend that the plaintiff should have been referred to orthopaedic consultation then. Even assuming that the treating doctor at the Clinic was aware of this note, it does not mean that the treating doctor was bound by this note to refer the plaintiff to orthopaedic consultation. The treating doctor is entitled to make his own professional judgment in this regard. As the plaintiff’s condition was actually recorded as better, I see no reason why the treating doctor had to give up the other conservative treatments which were working for the plaintiff at that time. As aforesaid, I do not accept that there is such a normal or standard practice to refer the plaintiff to an orthopaedic specialist at this point of time when her condition had some improvement after receiving the other conservative treatments.
6. Dr Chan points out that the plaintiff had been given strong analgesics to treat her condition, and that these would bring about a lessening of symptoms. However, if the prescription of strong analgesics had helped the plaintiff’s condition, there was also no reason to refer the plaintiff to orthopaedic consultation then.
7. Although it is recorded that the plaintiff’s condition had worsened in November 2007 when she had severe pain after working for one day, I also find nothing wrong for the treating doctors at the Clinic to refer the plaintiff to physiotherapy. In fact, even Dr Chan agrees that physiotherapy is a treatment that can be used after the other conservative treatments were found to be ineffective. The fact that the plaintiff was subsequently found to have rheumatic heart disease and hence missed her physiotherapy session in February 2008 cannot be used to judge the correctness of the referral to physiotherapy as such a matter was not in the contemplation of the treating doctor in November 2007. As aforesaid, the standard of care to be expected of the treating doctor at the Clinic cannot be based on events occurred in retrospect (*Boston & Co v Roberts*, supra). Thus, the doctors at the Clinic cannot be criticized for referring the plaintiff to physiotherapy instead of orthopaedic consultation.
8. The plaintiff submits that in deciding whether it was fair to wait for the outcome of physiotherapy before referral to orthopaedic consultation for steroid injection, the court should bear in mind the words of Lord Browne-Wilkinson in *Bolitho* as set out above and ask this question: Is this a defensible conclusion and have the experts directed their minds to the question of comparative risks and benefits? I have no doubt that the answer to this question must be affirmative. Dr Ip has clearly considered the risks of steroid injection such as plantar fascial rupture and plantar fat pad degeneration and the benefits of steroid injection being just short-term. As aforesaid, I find her opinion being reasonable, responsible and logical. Thus, her conclusion that the plaintiff should wait for the outcome of physiotherapy is a defensible one.
9. However, the plaintiff also submits that Dr Ip is aware and by analogy the doctors at the Clinic must have also been aware that waiting time upon referral is long. A referral for physiotherapy in September 2007 only got the plaintiff an appointment in February 2008. Likewise a referral for orthopaedic specialist treatment would also take time. Thus, the plaintiff’s treatment would be stagnated by waiting for the result of physiotherapy. It is unreasonable and illogical for the plaintiff to wait for another half a year or more for her condition to be treated in the event that physiotherapy did not work.
10. I cannot agree with this submission at all. It is not a case that the doctors at the Clinic did not prescribe any treatment for the plaintiff and simply asked the plaintiff to wait. Physiotherapy was prescribed and could be an effective treatment. The waiting time is beyond the control of the doctors. There was no reason for the doctors at the Clinic to assume that physiotherapy would not work. As aforesaid, steroid injection carries with it certain risks and is of short-term effect only. So it is reasonable and logical to let the plaintiff try out physiotherapy first.
11. The plaintiff raises a side issue that as she had been suffering from the same symptoms since March 2006, referring her early would enable her to be assessed by a specialist at a time when her condition demanded proper attention. It would avert the risk of the condition becoming intractable. The sufferings that she had to endure could be inexpensively avoided.
12. It is true that the plaintiff had received treatments without success from Town Health Centre and Kwong Wah Hospital, prior to seeking treatment at the Clinic in December 2006. It should however be noted that the plaintiff was given nothing more than analgesics in Town Health Centre and Kwong Wah Hospital. Even Dr Chan agrees that it was reasonable for doctors at the Clinic to have started conservative treatments afresh. Thus, there is no reason to suggest that there is anything wrong for the Clinic to try out physiotherapy first even though the Clinic is aware of the plaintiff’s previous treatment history.
13. Another side issue raised by the plaintiff is that as she was diagnosed with chronic rheumatic heart disease, Dr Cheung Tak Fai, a private orthopaedic surgeon who saw the plaintiff 5 times from May 2008 onward, told her that due to her heart condition she was deemed unfit to receive topical steroid injection treatment for her plantar fasciitis. Also, when the plaintiff was seen at the Clinic for the last time on 28 September 2009, it was recorded that she could not have steroid injection due to chronic rheumatic heart disease. Thus, due to the lack of referral before the diagnosis of chronic rheumatic heart disease, the plaintiff had been deprived of the opportunity to have steroid injection.
14. It is undisputed that the plaintiff suffered from chronic rheumatic heart disease, but since it is a chronic disease, the plaintiff was likely to have already suffered from the disease prior to February 2008, though the disease was not manifested until then. Although chronic rheumatic heart disease increases the risk of steroid injection, it is undisputed that injection may still be administered if necessary, provided that extra precautions are taken (such as prescription of prophylactic antibiotics, cardiologist be consulted and injection be carried out in a hospital). Even though the plaintiff was taking Warfarin for her chronic rheumatic heart disease, steroid injection is still not an absolute contra-indication. The drug Warfarin may be temporary suspended, or replaced for a short period by another drug. Thus, it is not a case that the plaintiff cannot take steroid injection at all because of her chronic rheumatic heart disease.
15. In any event, even assuming that the chronic rheumatic heart disease did prevent the plaintiff from having steroid injection, she was diagnosed with chronic rheumatic heart disease only in February 2008. The doctors at the Clinic cannot be judged by this event retrospectively in June or November 2007 (*Boston & Co v Roberts*, supra). Thus, the chronic rheumatic heart disease suffered by the plaintiff is irrelevant to the issue of liability herein.
16. Based on the information available to the doctors at the Clinic in June or November 2007, and applying the test laid down in the *Bolam* case. supra, I am satisfied that the doctors at the Clinic had already exercised the ordinary skill and care of an ordinary competent general practitioner in prescribing the correct treatments for the plaintiff without referring her to an orthopaedic specialist for steroid injection, as I accept Dr Ip’s evidence that steroid injection should be considered after the other conservative treatments, including physiotherapy, have been unsuccessful. Thus, I do not find that there is any delay in referral to orthopaedic consultation as alleged by the plaintiff.
17. Even assuming Dr Chan’s opinion is correct, ie steroid injection should be administered earlier or in conjunction with other conservative treatments, it does not mean that the doctors at the Clinic were negligent. As held in the *Maynard* case, supra, where there are differing and well established professional schools of thought on an issue (such as the one advocated by Dr Chan and the other by Dr Ip) a professional will not be regarded as negligent in following one practice rather than another even if the outcome suggests that the wrong choice was made. An error of judgment will not amount to negligence unless it is one that would not have been made by a reasonably competent professional with the standard and the type of skill of the defendant, acting with ordinary care (*Whitehouse v Jordan*, supra). As I find that Dr Ip’s opinion is reasonable, responsible and logical, the practice of waiting for the outcome of physiotherapy before considering steroid injection is one that would have been made by a reasonably competent general practitioner. Thus, the doctors at the Clinic cannot be liable for negligence at all.

*Did any alleged delay in referral result in “additional” damage to the plaintiff?*

1. Assuming that the plaintiff manages to establish that the doctors at the Clinic had unduly delayed in referring her to specialist orthopaedic treatment (which is not my finding), she still needs to prove that the delay did cause injuries to her before she could establish liability against the defendant (see *Bonnington Castings Ltd v Wardlaw* [1956] AC 613 and *Wilsher v Essex Area Health Authority* [1988] 1 AC 1074).
2. It is undisputed that the treatments provided by orthopaedists at NDH and Prince of Wales Hospital were substantially similar to that provided by the doctors at the Clinic. In particulars, the orthopaedists have not given the plaintiff any steroid injection at all. Thus, the plaintiff has not established that the orthopaedists would have treated her differently had she been referred to them earlier. There is of course the argument that she could not receive steroid injection because of her heart problem. However, as aforesaid, with certain precautions, she could still receive steroid injection. Furthermore, it is Dr Chan’s firm evidence that it would make no difference whether the steroid injection is given now, or at any previous moment in time. Any undue delay in referral on the part of the Clinic (which is not my finding) has therefore not caused any “additional” damage to the plaintiff at all.
3. Nevertheless, in his supplemental report, Dr Chan contends that the alleged delay in referral has caused: (a) prolonged and aggravated sufferings of pain and other symptoms; (b) complications of symptoms and signs akin to post traumatic stress disorder (PTSD); (c) the plaintiff’s psychiatric symptoms being exacerbated, or not being averted; (d) rapid worsening of the bony spur at the heel bone and degenerative changes of the ankle; (e) delay in resumption of work; and (f) increased restriction of the types of work that she is capable of.
4. As aforesaid, the orthopaedists did not treat the plaintiff differently from the Clinic upon referral. So the plaintiff cannot establish that she could have received steroid injection earlier if she was referred earlier. None of the “additional” damage mentioned above could be caused by the alleged delay. Moreover, point (f) above is inconsistent with Dr Chan’s evidence in court in that Dr Chan has confirmed clearly that there is no difference between the plaintiff being given steroid injection now and at any point of time before.
5. Also, Dr Chan is not a psychiatrist and he cannot give any expert evidence in the psychiatric field. So points (b) and (c) above cannot be established by his evidence. In fact the psychiatric report of the plaintiff reveals that the plaintiff suffers from delusional disorder, not PTSD, and her psychiatric problems were apparently caused by a multitude of factors not including foot pain.
6. As to point (d) above, Dr Chan said under cross-examination that it was only his “impression” from comparing the x-rays taken in December 2006 with that taken in June 2011 that the spur “seemed” to have grown. He however could not tell by how much the spur had grown. Dr Ip deposed that no change can be detected from the x-rays. In any event, it cannot be said that the spur and degenerative changes have rapidly worsened. It is also undisputed that the main cause of the plaintiff’s foot pain is her plantar faciitis, not her spur or degenerative changes at the ankle. Any worsening of conditions in the spur and/or ankle is therefore immaterial to the present proceedings. Thus, point (d) is also not established.
7. In the circumstances, I do not find that the plaintiff has established any “additional” damage caused by the alleged delay in referral (even assuming there was such a delay which is not my finding).

*Quantum*

1. Since I have decided the 2 main issues against the plaintiff, the defendant is not liable to the plaintiff’s claim for damages at all. However, as the parties have disputes over the quantum and for the sake of completeness, I will deal with the quantum below.
2. For pain, suffering and loss of amenities, the plaintiff submits that her painful condition had been unnecessarily prolonged due to the delay in referral. Although she was and is still suffering from plantar fasciitis which was not caused by the defendant, she had nevertheless been deprived of the chance of early recovery. Dr Chan assesses her impairment of the whole person due to the painful condition to be 8% impairment of the whole person and her loss of earning capacity to be 6%. The plaintiff accepts that no comparable case of someone suffering from plantar fasciitis alone had been found. Bearing in mind that the condition was not caused by the Clinic, but only aggravated and prevented from being properly treated, the plaintiff submits that the amount of general damages should be in the region of $100,000 to $150,000, taking into account that the impairment of the whole person from the condition has been assessed at 8%.
3. The plaintiff relies on the following cases in her submission: -

(a) *Chan Ming v Wayfine Investment Limited (trading as Wayfine Warehousing Company)*, HCPI 148 of 1997: The claimant suffered a fracture of his left lateral malleolus. He had open reduction, internal fixation and bone grafting and his left ankle was in a plaster for about 2 months and he attended physiotherapy. For a considerable time after the accident he had stiffness and pain after prolonged periods of walking or standing. The fracture healed well with good alignment but with a residual limitation in the dorsiflexion, eversion and inversion of the left ankle. He still has mild pain in the ankle and difficulty standing for longer than an hour at a time. Sitting, squatting or lifting heavy weights for long periods of time would also cause a measure of discomfort in the affected leg. Impairment of the whole person was assessed at 3%. General damages were awarded at $200,000.

(b) *To Ying-wa v Cargo-Land (Warehouse) Development Limited*, HCPI 441 of 2000: The claimant suffered fractures to the right 4th and 5th metacarpals of the right foot and these were treated with close reduction and K-wire fixation. He was given a plaster cast over the right foot. He had sick leave of just under 3 months. The fractures healed quite satisfactorily although there was still swelling and tenderness over the fractured sites. 1% permanent impairment was assessed and general damages were $200,000.

(c) *Lau Kin Wai Danny Chan Wai Sang and Li Ah Man trading as Kin Sang Engineering Company (a firm)*, HCPI 1007 of 2000: The claimant suffered fracture of the right calcaneum. This was treated conservatively. The fracture probably healed without a trace and the right ankle had recovered a good range of motion, full muscle power and good function. There was only some residual discomfort and mild residual stiffness and weakness. Prognosis was good. Impairment of the whole person was assessed at 2% and general damages were $150,000.

(d) *Muhammad Ismail v Or Wah trading as Ying Wah Decoration Materials Engineering Company and/or Ying Wah Decoration Materials & Construction Company*, DCPI 293 of 2003: The claimant suffered a wound of about 2 mm over the medial side of his right ankle with swelling and a foreign body in the right ankle and superficial abrasion over his right wrist. He had sick leave of 5 months and follow up treatment during the same period. He could walk well and ankle movement was normal though he still experienced pain over the ankle. There was no bone or joint deformity. General damages were $80,000.

(e) *Choy Wai Chung v Chun Wo Construction & Engineering Company Limited*, HCPI 605 of 1999: The claimant suffered a sprained ankle which did not require extensive hospitalization or complicated operation. There is likely to be intermittent pain and a degree of permanent stiffness but the claimant was found to be able to walk without the assistance of a walking stick. He was also found to be able to return to work, at least doing an indoor job which he failed to do. General damages were $250,000.

1. The above authorities are not really relevant as they are not concerned with plantar fasciitis. The plaintiff’s case, putting it to the highest, is that there was a delay of referral for 14 months from 12 June 2007 to 13 August 2008, during which the plaintiff suffered heel pain. I would assess the general damages under this heading to be in the sum of $80,000 (assuming liability was established which is not the case here).
2. As to the pre-trial loss of earnings and MPF, there is no dispute that the plaintiff used to earn $6,000 a month as a newspaper delivery worker until she had to resign due to her bilateral foot pain. The plaintiff claims that to this day she had not been able to return to work. Although she found work as a sample seamstress in November 2007, in answer to the defendant’s cross examination she agreed that assuming she had no problem and could continue with newspaper delivery and selling goods at her store, she would not have gone back to sewing work. Thus it would be appropriate that she should claim a loss of earnings based on $6,000 a month, not $9,000 as pleaded.
3. It is in fact Dr Chan’s evidence that, after steroid injection (even now), the plaintiff should be able to get close to 100% improvement, very close to being completely cured. She should be able to resume normal activities, including stepping on sewing machines, though she may not be able to resume her job as a newspaper deliverer. However, as the plaintiff only claims the loss of pre-trial earnings based on the amount of $6,000 per month, this amount would be used to calculate the loss of earnings. As aforesaid, putting the plaintiff’s case to the highest, there was only a period of 14 months for the alleged delay. Thus, the loss of pre-trial earning would be a sum of $84,000. The plaintiff would also be entitled to the loss of MPF at 5% of her earnings, ie $4,200.
4. In view of Dr Chan’s evidence that the plaintiff could have close to 100% improvement after steroid injection, it is unlikely that the plaintiff would suffer any loss of future earnings and MPF or any loss of earning capacity due to the alleged delay. Thus, there would not be any award under these heads in any event.
5. As to special damages, the plaintiff is now claiming only the following items of special damages totaling $22,932.40 in her closing submissions, which are not disputed by the defendant: -

Town Health Centre $1,200

Acupuncturist $13,929.40

Travelling expenses to the Clinic $300

Travelling expenses to NDH $380

X-ray examination $500

Shoe insoles $500

Consultation at Town Health Centre $5,583

Travelling expenses to Kwong Wah Hospital $400

Travelling expenses to Prince of Wales Hospital $140

1. Thus, putting the plaintiff’s case to the highest and assuming the plaintiff was liable for the delay in referral for 14 months, the total damages would be assessed at $191,132.40. However, as aforesaid, the plaintiff has failed to establish any liability against the defendant and hence no award of damages will be made.

*Conclusion*

1. By reasons aforesaid, the plaintiff’s claim is hereby dismissed. I also grant a costs order nisi for the plaintiff to pay costs of the action to the defendant with certificate for counsel to be taxed if not agreed, and the plaintiff’s own costs be taxed in accordance with the Legal Aid Regulations.

(Michael Wong)

District Judge

Ms Christina Lee instructed by Messrs Kwok, Ng & Chan for the plaintiff

Mr Simon K C Lam instructed by the Department of Justice for the defendant