THIRD DIVISION

PETER PAUL PATRICK LUCAS, FATIMA GLADYS LUCAS, ABBEYGAIL LUCAS AND GILLIAN LUCAS, Petitioners,	**G. R. No. 178763**
	Present:
- *versus* -	YNARES-SANTIAGO, *J.,* Chairperson, AUSTRIA-MARTINEZ, CHICO-NAZARIO, NACHURA, and PERALTA, *JJ*.
DR. PROSPERO MA. C. TUAÑO, Respondent.	Promulgated: April 21, 2009

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D E C I S I O N

CHICO-NAZARIO, *J*.:

In this petition for review on *certiorari*[1] under Rule 45 of the Revised Rules of Court, petitioners Peter Paul Patrick Lucas, Fatima Gladys Lucas, Abbeygail Lucas and Gillian Lucas seek the reversal of the 27 September 2006 *Decision*[2] and 3 July 2007 *Resolution,*[3] both of the Court of Appeals in CA-G.R. CV No. 68666, entitled "Peter Paul Patrick Lucas, Fatima Gladys Lucas, Abbeygail Lucas and Gillian Lucas v. Prospero Ma. C. Tuaño."

In the questioned decision and resolution, the Court of Appeals affirmed the 14 July 2000 *Decision* of the Regional Trial Court (RTC), Branch 150, Makati City, dismissing the complaint filed by petitioners in a civil case entitled, *"Peter Paul Patrick Lucas, Fatima Gladys Lucas, Abbeygail Lucas and Gillian Lucas v. Prospero Ma. C. Tuaño,"* docketed as Civil Case No. 92-2482.

From the record of the case, the established factual antecedents of the present petition are:

Sometime in August 1988, petitioner Peter Paul Patrick Lucas (Peter) contracted "sore eyes" in his right eye.

On 2 September 1988, complaining of a red right eye and swollen eyelid, Peter made use of his health care insurance issued by Philamcare Health Systems, Inc. (Philamcare), for a possible consult. The Philamcare Coordinator, Dr. Edwin Oca, M.D., referred Peter to respondent, Dr. Prospero Ma. C. Tuaño, M.D. (Dr. Tuaño), an ophthalmologist at St. Luke's Medical Center, for an eye consult.

Upon consultation with Dr. Tuaño, Peter narrated that it had been nine (9) days since the problem with his right eye began; and that he was already taking *Maxitrol* to address the problem in his eye. According to Dr. Tuaño, he performed "ocular routine examination" on Peter's eyes, wherein: (1) a gross examination of Peter's eyes and their surrounding area was made; (2) Peter's visual acuity were taken; (3) Peter's eyes were palpated to check the intraocular pressure of each; (4) the motility of Peter's eyes was observed; and (5) the ophthalmoscopy[4] on Peter's eyes was used. On that particular consultation, Dr. Tuaño diagnosed that Peter was suffering from *conjunctivitis*[5] or "sore eyes." Dr. Tuaño then prescribed *Spersacet-C*[6] eye drops for Peter and told the latter to return for follow-up after one week.

As instructed, Peter went back to Dr. Tuaño on 9 September 1988. Upon examination, Dr. Tuaño told Peter that the "sore eyes" in the latter's right eye had already cleared up and he could discontinue the *Spersacet-C*. However, the same eye developed *Epidemic KeratoConjunctivitis* (EKC),[7] a viral infection. To address the new problem with Peter's right eye, Dr. Tuaño prescribed to the former a steroid-

based eye drop called *Maxitrol*,[8] a dosage of six (6) drops per day.[9] To recall, Peter had already been using *Maxitrol* prior to his consult with Dr. Tuaño.

On 21 September 1988, Peter saw Dr. Tuaño for a follow-up consultation. After examining both of Peter's eyes, Dr. Tuaño instructed the former to taper down[10] the dosage of *Maxitrol,* because the EKC in his right eye had already resolved. Dr. Tuaño specifically cautioned Peter that, being a steroid, *Maxitrol* had to be withdrawn gradually; otherwise, the EKC might recur.[11]

Complaining of feeling as if there was something in his eyes, Peter returned to Dr. Tuaño for another check-up on 6 October 1988. Dr. Tuaño examined Peter's eyes and found that the right eye had once more developed EKC. So, Dr. Tuaño instructed Peter to resume the use of *Maxitrol* at six (6) drops per day.

On his way home, Peter was unable to get a hold of *Maxitrol,* as it was out of stock. Consequently, Peter was told by Dr. Tuano to take, instead, *Blephamide*[12] another steroid-based medication, but with a lower concentration, as substitute for the unavailable *Maxitrol*, to be used three (3) times a day for five (5) days; two (2) times a day for five (5) days; and then just once a day.[13]

Several days later, on 18 October 1988, Peter went to see Dr. Tuaño at his clinic, alleging severe eye pain, feeling as if his eyes were about to "pop-out," a headache and blurred vision. Dr. Tuaño examined Peter's eyes and discovered that the EKC was again present in his right eye. As a result, Dr. Tuaño told Peter to resume the maximum dosage of *Blephamide*.

Dr. Tuaño saw Peter once more at the former's clinic on 4 November 1988. Dr. Tuaño's examination showed that only the periphery of Peter's right eye was positive for EKC; hence, Dr. Tuaño prescribed a lower dosage of *Blephamide*.

It was also about this time that Fatima Gladys Lucas (Fatima), Peter's spouse, read the accompanying literature of *Maxitrol* and found therein the following warning against the prolonged use of such steroids:

WARNING:

Prolonged use may result in glaucoma, with damage to the optic nerve, defects in visual acuity and fields of vision, and posterior, subcapsular cataract formation. Prolonged use may suppress the host response and thus increase the hazard of secondary ocular infractions, in those diseases causing thinning of the cornea or sclera, perforations have been known to occur with the use of topical steroids. In acute purulent conditions of the eye, steroids may mask infection or enhance existing infection. If these products are used for 10 days or longer, intraocular pressure should be routinely monitored even though it may be difficult in children and uncooperative patients.

Employment of steroid medication in the treatment of herpes simplex requires great caution.

x x x x

ADVERSE REACTIONS:

Adverse reactions have occurred with steroid/anti-infective combination drugs which can be attributed to the steroid component, the anti-infective component, or the combination. Exact incidence figures are not available since no denominator of treated patients is available.

Reactions occurring most often from the presence of the anti-infective ingredients are allergic sensitizations. The reactions due to the steroid component in decreasing order to frequency are elevation of intra-ocular pressure (IOP) with possible development of glaucoma, infrequent optic nerve damage; posterior subcapsular cataract formation; and delayed wound healing.

Secondary infection: The development of secondary has occurred after use of combination containing steroids and antimicrobials. Fungal infections of the correa are particularly prone to develop coincidentally with long-term applications of steroid. The possibility of fungal invasion must be considered in any persistent corneal ulceration where steroid treatment has been used.

Secondary bacterial ocular infection following suppression of host responses also occurs.

On 26 November 1988, Peter returned to Dr. Tuaño's clinic, complaining of "feeling worse."[14] It appeared that the EKC had spread to the whole of Peter's right eye yet again. Thus, Dr. Tuaño instructed Peter to resume the use of *Maxitrol*. Petitioners averred that Peter already made mention to Dr. Tuaño during said visit of the above-quoted warning against the prolonged use of steroids, but Dr. Tuaño supposedly brushed aside Peter's concern as mere paranoia, even assuring him that the former was taking care of him (Peter).

Petitioners further alleged that after Peter's 26 November 1988 visit to Dr. Tuaño, Peter continued to suffer pain in his right eye, which seemed to "progress," with the ache intensifying and becoming more frequent.

Upon waking in the morning of 13 December 1988, Peter had no vision in his right eye. Fatima observed that Peter's right eye appeared to be bloody and swollen.[15] Thus, spouses Peter and Fatima rushed to the clinic of Dr. Tuaño. Peter reported to Dr. Tuaño that he had been suffering from constant headache in the afternoon and blurring of vision.

Upon examination, Dr. Tuaño noted the hardness of Peter's right eye. With the use of a *tonometer*[16] to verify the exact *intraocularpressure*[17] (IOP) of Peter's eyes, Dr. Tuaño discovered that the tension in Peter's right eye was **39.0 Hg**, while that of his left was 17.0 Hg.[18] Since the tension in Peter's right eye was way over the **normal IOP**, which merely ranged from **10.0 Hg to 21.0 Hg**,[19] Dr. Tuaño ordered[20]him to immediately discontinue the use of *Maxitrol* and prescribed to the latter *Diamox*[21] and *Normoglaucon*, instead.[22] Dr. Tuaño also required Peter to go for daily check-up in order for the former to closely monitor the pressure of the latter's eyes.

On 15 December 1988, the tonometer reading of Peter's right eye yielded a **high normal level, *i.e.*, 21.0 Hg**. Hence, Dr. Tuaño told Peter to continue using *Diamox* and *Normoglaucon*. But upon Peter's complaint of "stomach pains and tingling sensation in his fingers,"[23] Dr. Tuaño discontinued Peter's use of *Diamox*.[24]

Peter went to see another ophthalmologist, Dr. Ramon T. Batungbacal (Dr. Batungbacal), on 21 December 1988, who allegedly conducted a complete ophthalmological examination of Peter's eyes. Dr. Batungbacal's diagnosis was *Glaucoma*[25] *O.D.*[26] He recommended *LaserTrabeculoplasty*[27] for Peter's right eye.

When Peter returned to Dr. Tuaño on 23 December 1988,[28] the tonometer measured the IOP of Peter's right eye to be **41.0 Hg**,[29] again, way above normal. Dr. Tuaño addressed the problem by advising Peter to resume taking *Diamox* along with *Normoglaucon*.

During the Christmas holidays, Peter supposedly stayed in bed most of the time and was not able to celebrate the season with his family because of the debilitating effects of *Diamox*.[30]

On 28 December 1988, during one of Peter's regular follow-ups with Dr. Tuaño, the doctor conducted another ocular routine examination ofPeter's eyes. Dr. Tuaño noted the recurrence of EKC in Peter's right eye. Considering, however, that the IOP of Peter's right eye was still quite high at **41.0 Hg**, Dr. Tuaño was at a loss as to how to balance the treatment of Peter's EKC *vis-à-vis* the presence of *glaucoma* in the same eye. Dr. Tuaño, thus, referred Peter to Dr. Manuel B. Agulto, M.D. (Dr. Agulto), another ophthalmologist specializing in the treatment of glaucoma.[31] Dr. Tuaño's letter of referral to Dr. Agulto stated that:

> Referring to you Mr. Peter Lucas for evaluation & possible management. I initially saw him Sept. 2, 1988 because of conjunctivitis. The latter resolved and he developed EKC for which I gave Maxitrol. The EKC was recurrent after stopping steroid drops. Around 1 month of steroid treatment, he noted blurring of vision & pain on the R. however, I continued the steroids for the sake of the EKC. A month ago, I noted iris atrophy, so I took the IOP and it was definitely elevated. I stopped the steroids immediately and has (sic) been treating him medically.
>
> It seems that the IOP can be controlled only with oral Diamox, and at the moment, the EKC has recurred and I'm in a fix whether to resume the steroid or not considering that the IOP is still uncontrolled.[32]

On 29 December 1988, Peter went to see Dr. Agulto at the latter's clinic. Several tests were conducted thereat to evaluate the extent of Peter's condition. Dr. Agulto wrote Dr. Tuaño a letter containing the following findings and recommendations:

> Thanks for sending Peter Lucas. On examination conducted vision was 20/25 R and 20/20L. Tension curve 19 R and 15 L at 1210 H while on Normoglaucon BID OD & Diamox ½ tab every 6h po.
>
> Slit lamp evaluation[33] disclosed subepithelial corneal defect outer OD. There was circumferential peripheral iris atrophy, OD. The lenses were clear.
>
> Funduscopy[34] showed vertical cup disc of 0.85 R and 0.6 L with temporal slope R>L.

Zeiss gonioscopy[35] revealed basically open angles both eyes with occasional PAS,[36] OD.

Rolly, I feel that Peter Lucas has really sustained significant glaucoma damage. I suggest that we do a baseline visual fields and push medication to lowest possible levels. If I may suggest further, I think we should prescribe Timolol[37] BID[38] OD in lieu of Normoglaucon. If the IOP is still inadequate, we may try D'epifrin[39] BID OD (despite low PAS). I'm in favor of retaining Diamox or similar CAI.[40]

If fields show further loss in say – 3 mos. then we should consider trabeculoplasty.

I trust that this approach will prove reasonable for you and Peter.[41]

Peter went to see Dr. Tuaño on 31 December 1988, bearing Dr. Agulto's aforementioned letter. Though Peter's right and left eyes then had normal IOP of **21.0 Hg** and 17.0 Hg, respectively, Dr. Tuaño still gave him a prescription for *Timolol* B.I.D. so Peter could immediately start using said medication. Regrettably, *Timolol* B.I.D. was out of stock, so Dr. Tuaño instructed Peter to just continue using *Diamox* and *Normoglaucon* in the meantime.

Just two days later, on 2 January 1989, the IOP of Peter's right eye remained elevated at **21.0 Hg,**[42] as he had been without *Diamox* for the past three (3) days.

On 4 January 1989, Dr. Tuaño conducted a *visual field study*[43] of Peter's eyes, which revealed that the latter had *tubular vision*[44] in his right eye, while that of his left eye remained normal. Dr. Tuaño directed Peter to religiously use the *Diamox* and *Normoglaucon,* as the tension of the latter's right eye went up even further to **41.0 Hg** in just a matter of two (2) days, in the meantime that *Timolol* B.I.D. and *D'epifrin* were still not available in the market. Again, Dr. Tuaño advised Peter to come for regular check-up so his IOP could be monitored.

Obediently, Peter went to see Dr. Tuaño on the 7th, 13th, 16th and 20th of January 1989 for check-up and IOP monitoring.

In the interregnum, however, Peter was prodded by his friends to seek a second medical opinion. On 13 January 1989, Peter consulted Dr. Jaime Lapuz,

M.D. (Dr. Lapuz), an ophthalmologist, who, in turn, referred Peter to Dr. Mario V. Aquino, M.D. (Dr. Aquino), another ophthalmologist who specializes in the treatment of glaucoma and who could undertake the long term care of Peter's eyes.

According to petitioners, after Dr. Aquino conducted an extensive evaluation of Peter's eyes, the said doctor informed Peter that his eyes were relatively normal, though the right one sometimes manifested maximum borderline tension. Dr. Aquino also confirmed Dr. Tuaño's diagnosis of tubular vision in Peter's right eye. Petitioners claimed that Dr. Aquino essentially told Peter that the latter's condition would require lifetime medication and follow-ups.

In May 1990 and June 1991, Peter underwent two (2) procedures of laser trabeculoplasty to attempt to control the high IOP of his right eye.

Claiming to have *steroid-induced glaucoma*[45] and blaming Dr. Tuaño for the same, Peter, joined by: (1) Fatima, his spouse[46]; (2) Abbeygail, his natural child[47]; and (3) Gillian, his legitimate child[48] with Fatima, instituted on 1 September 1992, a civil complaint for damages against Dr. Tuaño, before the RTC, Branch 150, Quezon City. The case was docketed as Civil Case No. 92-2482.

In their *Complaint*, petitioners specifically averred that as the "direct consequence of [Peter's] prolonged use of *Maxitrol*, [he] suffered from steroid induced glaucoma which caused the elevation of his intra-ocular pressure. The elevation of the intra-ocular pressure of [Peter's right eye] caused the impairment of his vision which impairment is not curable and may even lead to total blindness."[49]

Petitioners additionally alleged that the visual impairment of Peter's right eye caused him and his family so much grief. Because of his present condition, Peter now needed close medical supervision forever; he had already undergone two (2) laser surgeries, with the possibility that more surgeries were still needed in the future; his career in sports casting had suffered and was continuing to suffer;[50] his anticipated income had been greatly reduced as a result of his "limited" capacity; he continually suffered from "headaches, nausea, dizziness, heart palpitations, rashes, chronic rhinitis, sinusitis,"[51] *etc*.; Peter's relationships with his spouse and children continued to be strained, as his condition made him highly irritable and sensitive; his mobility and social life had suffered; his spouse, Fatima, became the breadwinner

in the family;[52] and his two children had been deprived of the opportunity for a better life and educational prospects. Collectively, petitioners lived in constant fear of Peter becoming completely blind.[53]

In the end, petitioners sought pecuniary award for their supposed pain and suffering, which were ultimately brought about by Dr. Tuaño'sgrossly negligent conduct in prescribing to Peter the medicine *Maxitrol* for a period of three (3) months, without monitoring Peter's IOP, as required in cases of prolonged use of said medicine, and notwithstanding Peter's constant complaint of intense eye pain while using the same. Petitioners particularly prayed that Dr. Tuaño be adjudged liable for the following amounts:

> 1. The amount of ₱2,000,000.00 to plaintiff Peter Lucas as and by way of compensation for his impaired vision.
>
> 2. The amount of ₱300,000.00 to spouses Lucas as and by way of actual damages plus such additional amounts that may be proven during trial.
>
> 3. The amount of ₱1,000,000.00 as and by way of moral damages.
>
> 4. The amount of ₱500,000.00 as and by way of exemplary damages.
>
> 5. The amount of ₱200,000.00 as and by way of attorney's fees plus costs of suit.[54]

In rebutting petitioners' complaint, Dr. Tuaño asserted that the "treatment made by [him] more than three years ago has no causal connection to [Peter's] present glaucoma or condition."[55] Dr. Tuaño explained that "[d]rug-induced glaucoma is temporary and curable, steroids have the side effect of increasing intraocular pressure. Steroids are prescribed to treat Epidemic Kerato Conjunctivitis or EKC which is an infiltration of the cornea as a result of conjunctivitis or sore eyes."[56] Dr. Tuaño also clarified that (1) "[c]ontrary to [petitioners'] fallacious claim, [he] did NOT continually prescribe the drug Maxitrol which contained steroids for any prolonged period"[57] and "[t]he truth was the Maxitrol was

discontinued x x x as soon as EKC disappeared and was resumed only when EKC reappeared"[58]; (2) the entire time he was treating Peter, he "continually monitored the intraocular pressure of [Peter's eyes] by palpating the eyes and by putting pressure on the eyeballs," and no hardening of the same could be detected, which meant that there was no increase in the tension or IOP, a possible side reaction to the use of steroid medications; and (3) it was only on 13 December 1988 that Peter complained of a headache and blurred vision in his right eye, and upon measuring the IOP of said eye, it was determined for the first time that the IOP of the right eye had an elevated value.

But granting for the sake of argument that the "steroid treatment of [Peter's] EKC caused the steroid induced glaucoma,"[59] Dr. Tuaño argued that:

> [S]uch condition, *i.e.*, elevated intraocular pressure, is temporary. As soon as the intake of steroids is discontinued, the intraocular pressure automatically is reduced. Thus, [Peter's] glaucoma can only be due to other causes not attributable to steroids, certainly not attributable to [his] treatment of more than three years ago x x x.
>
> From a medical point of view, as revealed by more current examination of [Peter], the latter's glaucoma can only be long standing glaucoma, open angle glaucoma, because of the large C:D ratio. The steroids provoked the latest glaucoma to be revealed earlier as [Peter] remained asymptomatic prior to steroid application. Hence, the steroid treatment was in fact beneficial to [Peter] as it revealed the incipient open angle glaucoma of [Peter] to allow earlier treatment of the same.[60]

In a *Decision* dated 14 July 2000, the RTC dismissed Civil Case No. 92-2482 "for insufficiency of evidence."[61] The decretal part of said *Decision* reads:

> Wherefore, premises considered, the instant complaint is dismissed for insufficiency of evidence. The counter claim (sic) is likewise dismissed in the absence of bad faith or malice on the part of plaintiff in filing the suit.[62]

The RTC opined that petitioners failed to prove by preponderance of evidence that Dr. Tuaño was negligent in his treatment of Peter's condition. In particular, the record of the case was bereft of any evidence to establish that the steroid medication and its dosage, as prescribed by Dr. Tuaño, caused Peter's glaucoma. The trial court reasoned that the "recognized standards of the medical community has not been

established in this case, much less has causation been established to render [Tuaño] liable."[63] According to the RTC:

> [Petitioners] failed to establish the duty required of a medical practitioner against which Peter Paul's treatment by defendant can be compared with. They did not present any medical expert or even a medical doctor to convince and expertly explain to the court the established norm or duty required of a physician treating a patient, or whether the non taking (sic) by Dr. Tuaño of Peter Paul's pressure a deviation from the norm or his non-discovery of the glaucoma in the course of treatment constitutes negligence. It is important and indispensable to establish such a standard because once it is established, a medical practitioner who departed thereof breaches his duty and commits negligence rendering him liable. Without such testimony or enlightenment from an expert, the court is at a loss as to what is then the established norm of duty of a physician against which defendant's conduct can be compared with to determine negligence.[64]

The RTC added that in the absence of "any medical evidence to the contrary, this court cannot accept [petitioners'] claim that the use of steroid is the proximate cause of the damage sustained by [Peter's] eye."[65]

Correspondingly, the RTC accepted Dr. Tuaño's medical opinion that "Peter Paul must have been suffering from normal tension glaucoma, meaning, optic nerve damage was happening but no elevation of the eye pressure is manifested, that the steroid treatment actually unmasked the condition that resulted in the earlier treatment of the glaucoma. There is nothing in the record to contradict such testimony. In fact, plaintiff's Exhibit 'S' even tends to support them."

Undaunted, petitioners appealed the foregoing RTC decision to the Court of Appeals. Their appeal was docketed as CA-G.R. CV No. 68666.

On 27 September 2006, the Court of Appeals rendered a decision in CA-G.R. CV No. 68666 denying petitioners' recourse and affirming the appealed RTC *Decision*. The *fallo* of the judgment of the appellate court states:

> WHEREFORE, the Decision appealed from is AFFIRMED.[66]

The Court of Appeals faulted petitioners because they –

> [D]id not present any medical expert to testify that Dr. Tuano's prescription of Maxitrol and Blephamide for the treatment of EKC on Peter's right eye was not proper and that his palpation of Peter's right eye was not enough to detect adverse reaction to steroid. Peter testified that Dr. Manuel Agulto told him that he should not have used steroid for the treatment of EKC or that he should have used it only for two (2) weeks, as EKC is only a viral infection which will cure by itself. However, Dr. Agulto was not presented by [petitioners] as a witness to confirm what he allegedly told Peter and, therefore, the latter's testimony is hearsay. Under Rule 130, Section 36 of the Rules of Court, a witness can testify only to those facts which he knows of his own personal knowledge, x x x. Familiar and fundamental is the rule that hearsay testimony is inadmissible as evidence.[67]

Like the RTC, the Court of Appeals gave great weight to Dr. Tuaño's medical judgment, specifically the latter's explanation that:

> [W]hen a doctor sees a patient, he cannot determine whether or not the latter would react adversely to the use of steroids, that it was only on December 13, 1989, when Peter complained for the first time of headache and blurred vision that he observed that the pressure of the eye of Peter was elevated, and it was only then that he suspected that Peter belongs to the 5% of the population who reacts adversely to steroids.[68]

Petitioners' *Motion for Reconsideration* was denied by the Court of Appeals in a Resolution dated 3 July 2007.

Hence, this Petition for Review on *Certiorari* under Rule 45 of the Revised Rules of Court premised on the following assignment of errors:

I.

> THE COURT OF APPEALS COMMITTED GRAVE REVERSIBLE ERROR IN AFFIRMING THE DECISION OF THE TRIAL COURT DISMISSING THE PETITIONERS' COMPLAINT FOR DAMAGES AGAINST THE RESPONDENT ON THE GROUND OF INSUFFICIENCY OF EVIDENCE;

II.

> THE COURT OF APPEALS COMMITTED GRAVE REVERSIBLE ERROR IN DISMISSING THE PETITIONERS' COMPLAINT FOR DAMAGES AGAINST THE RESPONDENT ON THE GROUND THAT NO MEDICAL EXPERT WAS PRESENTED BY THE PETITIONERS TO PROVE THEIR CLAIM FOR MEDICAL NEGLIGENCE AGAINST THE RESPONDENT; AND

III.

THE COURT OF APPEALS COMMITTED GRAVE REVERSIBLE ERROR IN NOT FINDING THE RESPONDENT LIABLE TO THE PETITIONERS' FOR ACTUAL, MORAL AND EXEMPLARY DAMAGES, ASIDE FROM ATTORNEY'S FEES, COSTS OF SUIT, AS A RESULT OF HIS GROSS NEGLIGENCE.[69]

A reading of the afore-quoted reversible errors supposedly committed by the Court of Appeals in its *Decision* and *Resolution* would reveal that petitioners are fundamentally assailing the finding of the Court of Appeals that the evidence on record is insufficient to establish petitioners' entitlement to any kind of damage. Therefore, it could be said that the sole issue for our resolution in the Petition at bar is whether the Court of Appeals committed reversible error in affirming the judgment of the RTC that petitioners failed to prove, by preponderance of evidence, their claim for damages against Dr. Tuaño.

Evidently, said issue constitutes a question of fact, as we are asked to revisit anew the factual findings of the Court of Appeals, as well as of the RTC. In effect, petitioners would have us sift through the evidence on record and pass upon whether there is sufficient basis to establish Dr. Tuaño's negligence in his treatment of Peter's eye condition. This question clearly involves a factual inquiry, the determination of which is not within the ambit of this Court's power of review under Rule 45 of the 1997 Rules Civil Procedure, as amended.[70]

Elementary is the principle that this Court is not a trier of facts; only errors of law are generally reviewed in petitions for review on *certiorari* criticizing decisions of the Court of Appeals. Questions of fact are not entertained.[71]

Nonetheless, the general rule that only questions of law may be raised on appeal in a petition for review under Rule 45 of the Rules of Court admits of certain exceptions, including the circumstance when the finding of fact of the Court of Appeals is premised on the supposed absence of evidence, but is contradicted by the evidence on record. Although petitioners may not explicitly invoke said exception, it may be gleaned from their allegations and arguments in the instant Petition.

Petitioners contend, that "[c]ontrary to the findings of the Honorable Court of Appeals, [they] were more than able to establish that: Dr. Tuaño ignored the standard medical procedure for ophthalmologists, administered medication with recklessness, and exhibited an absence of competence and skills expected from him."[72] Petitioners reject the necessity of presenting expert and/or medical testimony to establish (1) the standard of care respecting the treatment of the disorder affecting Peter's eye; and (2) whether or not negligence attended Dr. Tuaño's treatment of Peter, because, in their words –

> That Dr. Tuaño was grossly negligent in the treatment of Peter's simple eye ailment *is a simple case of cause and effect*. With mere documentary evidence and based on the facts presented by the petitioners, respondent can readily be held liable for damages even without any expert testimony. In any case, however, and contrary to the finding of the trial court and the Court of Appeals, there was a medical expert presented by the petitioner showing the recklessness committed by [Dr. Tuaño] – Dr. Tuaño himself. [Emphasis supplied.]

They insist that Dr. Tuaño himself gave sufficient evidence to establish his gross negligence that ultimately caused the impairment of the vision of Peter's right eye,[73] *i.e.*, that "[d]espite [Dr. Tuaño's] knowledge that 5% of the population reacts adversely to *Maxitrol*, [he] had no qualms whatsoever in prescribing said steroid to Peter without first determining whether or not the *(sic)* Peter belongs to the 5%."[74]

We are not convinced. The judgments of both the Court of Appeals and the RTC are in accord with the evidence on record, and we are accordingly bound by the findings of fact made therein.

Petitioners' position, in sum, is that Peter's glaucoma is the direct result of Dr. Tuaño's negligence in his improper administration of the drug *Maxitrol*; "thus, [the latter] should be liable for all the damages suffered and to be suffered by [petitioners]."[75] Clearly, the present controversy is a classic illustration of a medical negligence case against a physician based on the latter's professional negligence. In this type of suit, the patient or his heirs, in order to prevail, is required to prove by preponderance of evidence that the physician failed to exercise that degree of skill, care, and learning possessed by other persons in the same profession; and that as a proximate result of such failure, the patient or his heirs suffered damages.

For lack of a specific law geared towards the type of negligence committed by members of the medical profession, such claim for damages is almost always anchored on the alleged violation of Article 2176 of the Civil Code, which states that:

> ART. 2176. Whoever by act or omission causes damage to another, there being fault or negligence, is obliged to pay for the damage done. Such fault or negligence, if there is no pre-existing contractual relation between the parties, is called a *quasi-delict* and is governed by the provisions of this Chapter.

In medical negligence cases, also called medical malpractice suits, there exist a physician-patient relationship between the doctor and the victim. But just like any other proceeding for damages, four essential (4) elements *i.e.*, (1) duty; (2) breach; (3) injury; and (4) proximate causation,[76] must be established by the plaintiff/s. All the four (4) elements must co-exist in order to find the physician negligent and, thus, liable for damages.

When a patient engages the services of a physician, a physician-patient relationship is generated. And in accepting a case, the physician, for all intents and purposes, represents that he has the needed training and skill possessed by physicians and surgeons practicing in the same field; and that he will employ such training, care, and skill in the treatment of the patient.[77] Thus, in treating his patient, a physician is under a ***duty*** to [the former] to exercise that degree of care, skill and diligence which physicians in the same general neighborhood and in the same general line of practice ordinarily possess and exercise in like cases.[78] Stated otherwise, the physician has the duty to use at least the same level of care that any other reasonably competent physician would use to treat the condition under similar circumstances.

This standard level of care, skill and diligence is a matter best addressed by expert medical testimony, because the standard of care in a medical malpractice case is a matter peculiarly within the knowledge of experts in the field.[79]

There is ***breach*** of duty of care, skill and diligence, or the improper performance of such duty, by the attending physician when the ***patient is injured*** in body or in health [and this] constitutes the actionable malpractice.[80] Proof of such breach must likewise rest upon the testimony of an expert witness that the treatment accorded to the patient failed to meet the standard level of care, skill and diligence which physicians in the same general neighborhood and in the same general line of practice ordinarily possess and exercise in like cases.

Even so, proof of breach of duty on the part of the attending physician is insufficient, for there must be a causal connection between said breach and the resulting injury sustained by the patient. Put in another way, in order that there may be a recovery for an injury, it must be shown that the "injury for which recovery is sought must be the legitimate consequence of the wrong done; the connection between the negligence and the injury must be a direct and natural sequence of events, unbroken by intervening efficient causes";[81] that is, the negligence must be the ***proximate cause*** of the injury. And the proximate cause of an injury is that cause, which, in the natural and continuous sequence, unbroken by any efficient intervening cause, produces the injury, and without which the result would not have occurred.[82]

Just as with the elements of duty and breach of the same, in order to establish the proximate cause [of the injury] by a preponderance of the evidence in a medical malpractice action, [the patient] must similarly use expert testimony, because the question of whether the alleged professional negligence caused [the patient's] injury is generally one for specialized expert knowledge beyond the ken of the average layperson; using the specialized knowledge and training of his field, the expert's role is to present to the [court] a realistic assessment of the likelihood that [the physician's] alleged negligence caused [the patient's] injury.[83]

From the foregoing, it is apparent that medical negligence cases are best proved by opinions of expert witnesses belonging in the same general neighborhood and in the same general line of practice as defendant physician or surgeon. The deference of courts to the expert opinion of qualified physicians [or surgeons] stems from the former's realization that the latter possess unusual technical skills which laymen in most instances are incapable of intelligently evaluating;[84] hence, the indispensability of expert testimonies.

In the case at bar, there is no question that a physician-patient relationship developed between Dr. Tuaño and Peter when Peter went to see the doctor on 2 September 1988, seeking a consult for the treatment of his sore eyes. Admittedly, Dr. Tuaño, an ophthalmologist, prescribed*Maxitrol* when Peter developed and had recurrent EKC. *Maxitrol* or *neomycin/polymyxin B sulfates/dexamethasone* ophthalmic ointment is a multiple-dose anti-infective steroid combination in sterile form for topical application.[85] It is the drug which petitioners claim to have caused Peter's glaucoma.

However, as correctly pointed out by the Court of Appeals, "[t]he *onus probandi* was on the patient to establish before the trial court that the physicians ignored standard medical procedure, prescribed and administered medication with recklessness and exhibited an absence of the competence and skills expected of general practitioners similarly situated."[86] Unfortunately, in this case, there was absolute failure on the part of petitioners to present any expert testimony to establish: (1) the standard of care to be implemented by competent physicians in treating the same condition as Peter's under similar circumstances; (2) that, in his treatment of Peter, Dr. Tuaño failed in his duty to exercise said standard of care that any other competent physician would use in treating the same condition as Peter's under similar circumstances; and (3) that the injury or damage to Peter's right eye, *i.e.*, his glaucoma, was the result of his use of *Maxitrol*, as prescribed by Dr. Tuaño. Petitioners' failure to prove the first element alone is already fatal to their cause.

Petitioners maintain that Dr. Tuaño failed to follow in Peter's case the required procedure for the prolonged use of *Maxitrol*. But what is actually the required procedure in situations such as in the case at bar? To be precise, what is the standard operating procedure when ophthalmologists prescribe steroid medications which, admittedly, carry some modicum of risk?

Absent a definitive standard of care or diligence required of Dr. Tuaño under the circumstances, we have no means to determine whether he was able to comply with the same in his diagnosis and treatment of Peter. This Court has no yardstick upon which to evaluate or weigh the attendant facts of this case to be able to state

with confidence that the acts complained of, indeed, constituted negligence and, thus, should be the subject of pecuniary reparation.

Petitioners assert that prior to prescribing *Maxitrol*, Dr. Tuaño should have determined first whether Peter was a "steroid responder."[87] Yet again, petitioners did not present any convincing proof that such determination is actually part of the standard operating procedure which ophthalmologists should unerringly follow prior to prescribing steroid medications.

In contrast, Dr. Tuaño was able to clearly explain that what is only required of ophthalmologists, in cases such as Peter's, is the conduct of standard tests/procedures known as "ocular routine examination,"[88] composed of five (5) tests/procedures – specifically, gross examination of the eyes and the surrounding area; taking of the visual acuity of the patient; checking the intraocular pressure of the patient; checking the motility of the eyes; and using ophthalmoscopy on the patient's eye – and he did all those tests/procedures every time Peter went to see him for follow-up consultation and/or check-up.

We cannot but agree with Dr. Tuaño's assertion that when a doctor sees a patient, he cannot determine immediately whether the latter would react adversely to the use of steroids; all the doctor can do is map out a course of treatment recognized as correct by the standards of the medical profession. It must be remembered that a physician is not an insurer of the good result of treatment. The mere fact that the patient does not get well or that a bad result occurs does not in itself indicate failure to exercise due care.[89] The result is not determinative of the performance [of the physician] and he is not required to be infallible.[90]

Moreover, that Dr. Tuaño saw it fit to prescribe *Maxitrol* to Peter was justified by the fact that the latter was already using the same medication when he first came to see Dr. Tuaño on 2 September 1988 and had exhibited no previous untoward reaction to that particular drug. [91]

Also, Dr. Tuaño categorically denied petitioners' claim that he never monitored the tension of Peter's eyes while the latter was on *Maxitrol*. Dr. Tuaño testified that he palpated Peter's eyes every time the latter came for a check-up as part of the doctor's ocular routine examination, a fact which petitioners failed to

rebut. Dr. Tuaño's regular conduct of examinations and tests to ascertain the state of Peter's eyes negate the very basis of petitioners' complaint for damages. As to whether Dr. Tuaño's actuations conformed to the standard of care and diligence required in like circumstances, it is presumed to have so conformed in the absence of evidence to the contrary.

Even if we are to assume that Dr. Tuaño committed negligent acts in his treatment of Peter's condition, the causal connection between Dr. Tuaño's supposed negligence and Peter's injury still needed to be established. The critical and clinching factor in a medical negligence case is proof of the causal connection between the negligence which the evidence established and the plaintiff's injuries.[92] The plaintiff must plead and prove not only that he has been injured and defendant has been at fault, but also that the defendant's fault caused the injury. A verdict in a malpractice action cannot be based on speculation or conjecture. Causation must be proven within a reasonable medical probability based upon competent expert testimony.[93]

The causation between the physician's negligence and the patient's injury may only be established by the presentation of proof that Peter's glaucoma would not have occurred but for Dr. Tuaño's supposed negligent conduct. Once more, petitioners failed in this regard.

Dr. Tuaño does not deny that the use of *Maxitrol* involves the risk of increasing a patient's IOP. In fact, this was the reason why he made it a point to palpate Peter's eyes every time the latter went to see him -- so he could monitor the tension of Peter's eyes. But to say that said medication conclusively caused Peter's glaucoma is purely speculative. Peter was diagnosed with *open-angle* glaucoma. This kind of glaucoma is characterized by an almost complete absence of symptoms and a chronic, insidious course.[94] In open-angle glaucoma, halos around lights and blurring of vision do not occur unless there has been a sudden increase in the intraocular vision.[95] Visual acuity remains good until late in the course of the disease.[96] Hence, Dr. Tuaño claims that Peter's glaucoma "can only be long standing x x x because of the large C:D[97] ratio," and that "[t]he steroids provoked the latest glaucoma to be revealed earlier" was a blessing in disguise "as [Peter] remained asymptomatic prior to steroid application."

Who between petitioners and Dr. Tuaño is in a better position to determine and evaluate the necessity of using *Maxitrol* to cure Peter's EKC *vis-à-vis* the attendant risks of using the same?

That Dr. Tuaño has the necessary training and skill to practice his chosen field is beyond cavil. Petitioners do not dispute Dr. Tuaño's qualifications – that he has been a physician for close to a decade and a half at the time Peter first came to see him; that he has had various medical training; that he has authored numerous papers in the field of ophthalmology, here and abroad; that he is a *Diplomate* of the Philippine Board of Ophthalmology; that he occupies various teaching posts (at the time of the filing of the present complaint, he was the Chair of the Department of Ophthalmology and an Associate Professor at the University of the Philippines-Philippine General Hospital and St. Luke's Medical Center, respectively); and that he held an assortment of positions in numerous medical organizations like the Philippine Medical Association, Philippine Academy of Ophthalmology, Philippine Board of Ophthalmology, Philippine Society of Ophthalmic Plastic and Reconstructive Surgery, Philippine Journal of Ophthalmology, Association of Philippine Ophthalmology Professors, *et al.*

It must be remembered that when the qualifications of a physician are admitted, as in the instant case, there is an inevitable presumption that in proper cases, he takes the necessary precaution and employs the best of his knowledge and skill in attending to his clients, unless the contrary is sufficiently established.[98] In making the judgment call of treating Peter's EKC with *Maxitrol*, Dr. Tuaño took the necessary precaution by palpating Peter's eyes to monitor their IOP every time the latter went for a check-up, and he employed the best of his knowledge and skill earned from years of training and practice.

In contrast, without supporting expert medical opinions, petitioners' bare assertions of negligence on Dr. Tuaño's part, which resulted in Peter's glaucoma, deserve scant credit.

Our disposition of the present controversy might have been vastly different had petitioners presented a medical expert to establish their theory respecting Dr. Tuaño's so-called negligence. In fact, the record of the case reveals that petitioners'

counsel recognized the necessity of presenting such evidence. Petitioners even gave an undertaking to the RTC judge that Dr. Agulto or Dr. Aquino would be presented. Alas, no follow-through on said undertaking was made.

The plaintiff in a civil case has the burden of proof as he alleges the affirmative of the issue. However, in the course of trial in a civil case, once plaintiff makes out a *prima facie* case in his favor, the duty or the burden of evidence shifts to defendant to controvert plaintiff's *prima facie*case; otherwise, a verdict must be returned in favor of plaintiff.[99] The party having the burden of proof must establish his case by a preponderance of evidence.[100] The concept of "preponderance of evidence" refers to evidence which is of greater weight or more convincing than that which is offered in opposition to it;[101] in the last analysis, it means probability of truth. It is evidence which is more convincing to the court as worthy of belief than that which is offered in opposition thereto.[102] Rule 133, Section 1 of the Revised Rules of Court provides the guidelines for determining preponderance of evidence, thus:

> In civil cases, the party having the burden of proof must establish his case by a preponderance of evidence. In determining where the preponderance or superior weight of evidence on the issues involved lies the court may consider all the facts and circumstances of the case, the witnesses' manner of testifying, their intelligence, their means and opportunity of knowing the facts to which they are testifying, the nature of the facts to which they testify, the probability or improbability of their testimony, their interest or want of interest, and also their personal credibility so far as the same legitimately appear upon the trial. The court may also consider the number of witnesses, though the preponderance is not necessarily with the greater number.

Herein, the burden of proof was clearly upon petitioners, as plaintiffs in the lower court, to establish their case by a preponderance of evidence showing a reasonable connection between Dr. Tuaño's alleged breach of duty and the damage sustained by Peter's right eye. This, they did not do. In reality, petitioners' complaint for damages is merely anchored on a statement in the literature of *Maxitrol* identifying the risks of its use, and the purported comment of Dr. Agulto – another doctor not presented as witness before the RTC – concerning the prolonged use of *Maxitrol* for the treatment of EKC.

It seems basic that what constitutes proper medical treatment is a medical question that should have been presented to experts. If no standard is established

through expert medical witnesses, then courts have no standard by which to gauge the basic issue of breach thereof by the physician or surgeon. The RTC and Court of Appeals, and even this Court, could not be expected to determine on its own what medical technique should have been utilized for a certain disease or injury. Absent expert medical opinion, the courts would be dangerously engaging in speculations.

All told, we are hard pressed to find Dr. Tuaño liable for any medical negligence or malpractice where there is no evidence, in the nature of expert testimony, to establish that in treating Peter, Dr. Tuaño failed to exercise reasonable care, diligence and skill generally required in medical practice. Dr. Tuaño's testimony, that his treatment of Peter conformed in all respects to standard medical practice in this locality, stands unrefuted. Consequently, the RTC and the Court of Appeals correctly held that they had no basis at all to rule that petitioners were deserving of the various damages prayed for in their *Complaint*.

WHEREFORE, premises considered, the instant petition is **DENIED** for lack of merit. The assailed *Decision* dated 27 September 2006and *Resolution* dated 3 July 2007, both of the Court of Appeals in CA-G.R. CV No. 68666, are hereby **AFFIRMED**. No cost.

SO ORDERED.

MINITA V. CHICO-NAZARIO
Associate Justice

WE CONCUR:

CONSUELO YNARES-SANTIAGO
Associate Justice
Chairperson

MA. ALICIA AUSTRIA-MARTINEZ
Associate Justice

ANTONIO EDUARDO B. NACHURA
Associate Justice

DIOSDADO M. PERALTA
Associate Justice

ATTESTATION

I attest that the conclusions in the above Decision were reached in consultation before the case was assigned to the writer of the opinion of the Court's Division.

CONSUELO YNARES-SANTIAGO
Associate Justice
Chairperson, Third Division

C E R T I F I C A T I O N

Pursuant to Article VIII, Section 13 of the Constitution, and the Division Chairman's Attestation, it is hereby certified that the conclusions in the above Decision were reached in consultation before the case was assigned to the writer of the opinion of the Court's Division.

REYNATO S. PUNO
Chief Justice

[1] *Rollo*, pp. 9-48.

[2] Penned by Court of Appeals Associate Justice Marina L. Buzon with Associate Justices Regalado E. Maambong and Japar B. Dimaampao concurring; Annex "A" of the Petition; id. at 49-69.

[3] Annex "B" of the Petition; id. at 70-72.

[4] Ophthalmoscopy is a test that allows a health professional to see inside the back of the eye (called the fundus) and other structures using a magnifying instrument (ophthalmoscope) and a light source. It is done as part of an eye examination and may be done as part of a routine physical examination (http://www.webmd.com/eye-health/ophthalmoscopy).

[5] Conjunctivitis, also known as pinkeye, is an inflammation of the conjunctiva, the thin, clear tissue that lies over the white part of the eye and lines the inside of the eyelid (http://www.webmd.com/eye-health/eye-health-conjunctivitis).

[6] The generic name of *Spersacet-C* ophthalmic drops is *Sulfacetamide*. It is prescribed for the treatment and prophylaxis of conjunctivitis due to susceptible organisms; corneal ulcers; adjunctive treatment with systemic sulfonamides for therapy of trachoma (http://www.merck.com/mmpe/lexicomp/sulfacetamide.html).

[7] *Epidemic kerato conjunctivitis* is a type of adenovirus ocular infection. (http://emedicine.medscape.com/article/1192751-overview).

[8] *Neomycin/polymyxin B sulfates/dexamethasone* is the generic name of Maxitrol Ophthalmic Ointment. It is a multiple dose anti-infective steroid combination in sterile form for topical application (http://www.druglib.com/druginfo/maxitrol/).

[9] Exhibit "A"; records, p. 344.

[10] Apply 5-6 drops for 5 days; then 3 drops for 3 days; and then a minimum of 1 drop per day.

[11] TSN, 27 September 1993, pp. 18-19.

[12] *Blephamide* Ophthalmic Suspenion contains *Sulfacetamide/Prednisolone.* This medication contains an antibiotic (*sulfacetamide*) that stops the growth of bacteria and a corticosteroid (*prednisolone*) that reduces inflammation (http://www.webmd.com/drugs/drug-6695-Blephamide+Opht.aspx?drugid=6695&drugname=Blephamide+Opht).

[13] Exhibit "H"; records, p. 346.

[14] TSN, 27 September 1993, p. 40.

[15] TSN, 3 May 1995, p. 14.

[16] A tonometer is an instrument for measuring the tension or pressure, particularly intraocular pressure (http://medical-dictionary.thefreedictionary.com/tonometer).

[17] Intraocular Pressure (IOP) is the pressure created by the continual renewal of fluids within the eye (http://www.medterms.com/script/main/art.asp?articlekey=4014).

[18] Exhibit "1-a"; records, p. 618-A.

[19] Normal IOP is measured in millimeters of Mercury (Hg).

[20] See note 19.

[21] The generic name of Diamox, for oral administration, is *acetazolamide.* This medication is a potent carbonic anhydrase inhibitor, effective in the control of fluid secretion(http://www.drugs.com/pro/diamox.html).

[22] The active ingredient of Normoglaucon is *Metipranolol hydrochloride*. It is used for the reduction of intraocular pressure in patients with glaucoma (open, closed angle) in situations in which monotherapy with pilocarpine or beta-blockers are insufficient (http://www.angelini.it/public/schedepharma/normoglaucon.htm).

[23] TSN, 11 October 1993, p. 7.

[24] Exhibit "1-a"; records, p. 618-A.

[25] Glaucoma is an eye condition which develops when too much fluid pressure builds up inside of the eye. The increased pressure, called the intraocular pressure, can damage the optic nerve, which transmits images to the brain. If the damage to the optic nerve from high eye pressure continues, glaucoma will cause loss of vision (http://www.webmd.com/eye-health/glaucoma-eyes).

[26] O.D. is the abbreviation for ***oculus dexter***, a Latin phrase meaning "***right eye***" (http://medical-dictionary.thefreedictionary.com/O.D).

[27] *Laser Trabeculoplasty* is a kind of surgery which uses a very focused beam of light to treat the drainage angle of the eye. This surgery makes it easier for fluid to flow out of the front part of the eye, decreasing pressure in the eye (http://www.med.nyu.edu/healthwise).

[28] According to Peter, after seeing Dr. Tuaño on the 15th of December 1988, he next saw him on the 17th of the same month. Per Exhibit 1-a, the patient's index card, however, after the 15th of December 1988, Peter's next visit was on the 23rd of the same month.

[29] Exhibit "1-a"; records, p. 618-A.

[30] TSN, 11 October 1993, pp. 16-17.

[31] Id. at 18.

[32] Exhibit "C"; records, p. 352.

[33] The slit-lamp evaluation/examination looks at structures that are at the front of the eye using a *slit-lamp*, a low-powered microscope combined with a high-intensity light source that can be focused to shine in a thin beam (http://www.nlm.nih.gov/medlineplus/ency/article/003880.htm).

[34] *Funduscopy* is the examination of the back part of the eye's interior (fundus); also known as ophthalmoscopy.

[35] *Zeiss Gonioscopy* (indirect gonioscopy) is the visualization of the anterior chamber angle of the eyes undertaken using a Zeiss lens. It is essential to determine the mechanism responsible for impeding aqueous flow (http://www.glaucomaworld.net/english/019/e019a01.html).

[36] Peripheral Anterior Synechiae.

[37] *Timolol Maleate* is a generic name of a drug in ophthalmic dosage form used in treatment of elevated intraocular pressure by reducing aqueous humor production or possibly outflow (http://www.umm.edu/altmed/drugs/timolol-125400.htm).

[38] B.I.D. is the abbreviation of the Latin phrase ***bis in di´e***, meaning "***twice a day***" (http://medical-dictionary.thefreedictionary.com/B.I.D).

[39] The generic name of the medication D'epifrin is *dipivefrin ophthalmic*. It is used to treat open-angle glaucoma or ocular hypertension by reducing the amount of fluid in the eye thereby decreasing intraocular pressure (http://www.drugs.com/mtm/dipivefrin-ophthalmic.html).

[40] Carbon Anhydrase Inhibitor.

[41] Exhibit "D"; records, pp. 356-357.

[42] Exhibit "1-a"; id at 618-A.

[43] A test to determine the total area in which objects can be seen in the peripheral vision while the eye is focused on a central point (http://www.healthline.com/ adamcontent/visual-field).

[44] A centrally constricted field of vision that is like what you can see through a tube (http://www.medterms.com/script/main/art.asp?articlekey=24516).

[45] A form of open-angle glaucoma that usually is associated with topical steroid use, but it may develop with inhaled, oral, intravenous, periocular, or intravitreal steroid administration (http://emedicine.medscape.com/article/1205298-print).

[46] As evidenced by a Marriage Contract between Peter and Fatima; records, p. 340.

[47] As evidenced by the child's Certificate of Live Birth; id. at 341.

[48] As evidenced by the child's Certificate of Live Birth; id. at 342.

[49] Amended Complaint, p. 4; id. at 79.

[50] Peter alleged that due to is impaired vision, he was 'forced' to decline several opportunities to cover international and regional sports events, *i.e.*, the 1988 and 1992 Olympics as well as various Asian Games; and he could not cover fast-paced games, *i.e.*, basketball.

[51] Amended Complaint, p. 4; records, p. 79.

[52] Id.

[53] Id.

[54] Id. at 82.

[55] Answer, p. 6; id. at 38.

[56] Id.

[57] Id.

[58] Id.

[59] Answer, p. 13; id. at 45.

[60] Id.

[61] Id. at 722-734.

[62] Id. at 734.

[63] Id.

[64] Id. at 731.
[65] Id.
[66] *Rollo*, p. 68.
[67] Id. at 67
[68] Id. at 66.
[69] Id. at 23.
[70] *Civil Service Commission v. Maala*, G.R. No. 165253, 18 August 2005, 467 SCRA 390, 398.
[71] *Alfaro v. Court of Appeals*, 416 Phil. 310, 317 (2001).
[72] Petition, p. 16; *rollo*, p. 24.
[73] Id.
[74] Id. at 26.
[75] Amended Complaint, p. 6; records, p. 81.
[76] *Garcia-Rueda v. Pascasio, et al.*, 278 SCRA 769, 778 (1997).
[77] Id.
[78] *Snyder v. Pantaleo* (1956), 143 Conn 290, 122 A2d 21.
[79] *Johnson v. Superior Court,* 49 Cal. Rptr. 3d 52 (Cal. App. 3d Dist. 2006).
[80] *Garcia-Rueda v. Pascasio,* supra note 76 at 779.
[81] *Chan Lugay v. St. Luke's Hospital, Inc.*, 10 CA Reports 415 (1966).
[82] *Calimutan v. People of the Philippines*, G.R. No. 152133, 9 February 2006, 482 SCRA 44, 60, citing *Vda. de Bataclan v. Medina*, 102 Phil. 181, 186 (1957).
[83] *Barngrover v. Hins*, 657 S.E.2d 14 (Ga. Ct. App. 2008).
[84] *Dr. Cruz v. Court of Appeals*, 346 Phil. 872, 884-885 (1997).
[85] http://www.druglib.com/druginfo/maxitrol/.
[86] Court of Appeals *Decision*, p. 17; *rollo*, p. 66.
[87] Steroid responders are people whose intraocular pressure (IOP) goes up very high when they use steroids (http://www.willsglaucoma.org/supportgroup/20030827.php).
[88] TSN, 7 February 1997, p. 17; *rollo,* p. 66.
[89] Solis, Pedro P., *Medical Jurisprudence*, 1988, Garcia Publishing, Co., Philippines.
[90] *Domina v. Pratt*, 13 A 2d 198 Vt. 1940.
[91] TSN, 7 February 1997, pp. 18-19.
[92] 61 Am. Jur. 2d. §359, p. 527.
[93] Id.
[94] Newell, Frank W., Ophthalmology, Principles and Concepts, 6th ed., 1986, C.V. Mosby Company, Missouri.
[95] Id.
[96] Id.
[97] Cup to Disc ratio.
[98] *Dr. Cruz v. Court of Appeals*, supra note 84 at 884-885.
[99] *Prudential Guarantee and Assurance Inc. v. Trans-Asia Shipping Lines, Inc.,* G.R. No. 151890, 20 June 2006, 491 SCRA 411, 433.
[100] *Bank of the Philippine Islands v. Royeca,* G.R. No. 176664, 21 July 2008, 559 SCRA 207, 215.
[101] *Jison v. Court of Appeals*, 350 Phil. 138, 173 (1998), citing Vicente J. Francisco, Revised Rules of Court in the Philippines, Evidence (Part II, Rules 131-134).
[102] *Go v. Court of Appeals*, 403 Phil. 883, 890-891 (2001), citing 20 Am. Jur. 1100-1101 as cited in Francisco, Revised Rules of Court.