COMMONWEALTH OF THE BAHAMAS

IN THE SUPREME COURT

Common Law and Equity Division

2011/CLE/gen/01304

BETWEEN

VALDERINE HENFIELD

Plaintiff

AND

DR ANTHONY W. D. CAREY

Defendant

Before: The Honourable Justice Ian Winder

Appearances: Rionda Godet with Keith Major Jr and Nerissa Knowles for the Plaintiff

Dywan Rodgers for the Defendant

14 and 15 December 2016, 26 April 2017, 22 June 2017, 23 May 2018 and 25 July 2018

JUDGMENT

WINDER J,

This is a claim in medical negligence.

[1.] The background to this matter may be seen from the following chronology of events:

12 Sep 2001	Valderine Henfield (Henfield), then 29 years old, consults for the first time with Dr Anthony Carey as a result of menstrual pain. Subsequent ultrasound reveals small fibroids.
12 Aug 2003	Henfield admitted for pelvic pain. Diagnostic laparoscopy [a surgical procedure in which a fiber-optic instrument is inserted through the abdominal wall to view the organs in the abdomen or to permit a surgical procedure], a mini laparotomy [a surgical incision into the abdominal cavity, for diagnosis or in preparation for surgery] and myomectomy [removal of fibroids (noncancerous tumors) from the wall of the uterus] performed on Henfield by Carey resulting in the removal of 12 fibroids.
<7 Sep 2010	Henfield consults with Carey as a result of chronic pelvic pains and dysmenorrhea. Carey advises Henfield to undergo a hysteroscopy [visual examination of the cervix and interior of the uterus with an endoscope] and polypectomy and open laparoscopy. Henfield advised by Carey that she would be hospitalized for 2-3 days.
7 Sep 2010	Carey assisted by Dr Pamela Carrol performs a hysteroscopy and polypectomy and open laparoscopy on Henfield. Careys says that the open laparoscopy of the pelvis revealed that she had extensive adhesive disease (very hostile environment) with an inability to properly assess the pelvis and this led to the decision to convert the surgery to a laparotomy. Carey also says that once the operative field was accessible a major myomectomy was done removing 19 fibroids with uterine reconstruction. During the procedure injury to densely adherent bowel was noted and repaired.

8 Sep 2010	Post-Operative Day 1 - Carey attends at patient's room twice, in the morning and evening. Henfield develops post-operative tachycardia. CT scan ordered by Dr Carrol and cancelled by Carey. Blood cells given to Henfield.
9 Sep 2010	Post-Operative Day 2 - Carey attends at Henfield's room twice, once in the morning and another in the evening.
10 Sep 2010	Post-Operative Day 3 - Carey attend at Henfield at 8:00 and orders CT scan. Henfield not taken for scan until 11:45. When Henfield returns from Scan Dr McCartney orders Henfield admitted to patient to ICU. Dr Duane Sands intervenes, at the insistence of Henfield's sister, Nurse Carimenda Ferguson. Henfield is immediately diagnosed with perforated small bowel, fecal peritonitis and septic shock. Sands contacts Carey by telephone at 3:15 and advises of his fears that Henfield was becoming septic Emergency surgery performed which confirms diagnosis. Small bowel found to have had multiple perforations with edematous and hemorrhagic mucosa wall. Leaking bowel resected, soiled peritoneum irrigated. Dr Sands says that during the procedure he removed 2 feet of bowel and large amounts of fecal matter from the Henfield's abdomen. Henfield returned to ICU for management of the respiratory failure and septic shock.
>13 Oct 2010	Henfield returns to operating theatre on multiple occasions to irrigate and debride the abdomen, then restore bowel continuity and reconstruct abdominal wall.
13 Oct 2010	Henfield discharged from hospital.
5 Oct 2012	Henfield lodges complaint to the Bahamas Medical Council.
30 Nov 2012	Carey writes to the Bahamas Medical Council explaining involvement in the matter.
11 Feb 2013	Letter from the Medical Board exonerating the Carey's conduct.

[2.] The Statement of Claim alleged negligence, at paragraphs 5-6 as follows:

5. In the premise in treating the Plaintiff, the Defendant owed the Plaintiff a duty of care to exercise reasonable care and skill to perform his duty at the standard of care of an Obstetrician and Gynecologist performing surgical procedures in women's health management;

6. During the course of the laparoscopy/laparotomy the Plaintiff suffered pain and injury and sustained loss and damage.

PARTICULARS OF INJURY

(i) Perforated bowel, multiple sections
(ii) Fecal Peritonitis;
(iii) Intra-abdominal sepsis
(iv) Septicaemia;
(v) Multiple laparotomies;
(vi) Respiratory Failure;
(vii) Pleural Effusion;
(viii) Septic Shock;
(ix) Critically ill to the point of resuscitation and near death;
(x) Extensive, multiple, corrective, reconstructive and curative surgical procedures;
(xi) Unable to dialogue and fully engage in conversation;
(xii) Post traumatic Stress Syndrome and Depression;
(xiii) Hallucinations;
(xiv) Extensive medical care and management by 9 other physicians;
(xv) Intensive care treatment and management;
(xvi) Life support;
(xvii) Resected bowel;
(xviii) Reconstruction of abdominal wall
(xix) Extended medical and hospital care in excess of 5 weeks;
(xx) Physical, mental, social and psychological ill health;

The injury, loss and damage were caused by the negligence and or breach of the Defendant.

PARTICULARS OF NEGLIGENCE

The Defendant was negligent and/or in breach of his duty in:

(a) Failing to carry out his duty of care during surgery and post operatively, in a manner appropriate for a medical specialist;
(b) Failing to take reasonable standard of care during laparoscopy/laparotomy, thereby perforating the bowel of the Plaintiff;
(c) Failing to appreciate the anatomy of the reproductive organs thereby causing small bowels perforation in at least 3 areas and at least 3 serosal tears;
(d) Failing to recognize the perforated bowel and if recognized failing to carry out proper suturing of multiple bowel perforation thus causing fecal peritonitis and septic shock;
(e) Failing to examine the peritoneum properly during the surgical procedures;
(f) Failing to recognize the bowel perforation;

(g) Failing to assess the Plaintiff's condition methodically and systematically, causing the Plaintiff to become critically ill from fecal peritonitis and septic shock amongst other things;
(h) Failing to provide reasonable care and assessment of a doctor holding out to be a specialist in obstetrics and gynecology and women's health;
(i) Failing to take reasonable care necessary to be cognizant of the Plaintiff's condition especially the first 3 days post-operatively, thereby by act or omission, misdiagnosed the Plaintiff's condition, not aware that the Plaintiff was suffering from perforated bowel, caused her to be critically ill to the point of death; caused her to have multiple surgical procedures; caused her to have to be managed by 9 other doctors; caused her to suffer from post traumatic stress syndrome; caused her to have an extensive hospital care and cost;
(j) Failing to adhere to basic operative and post-operative management, causing the Plaintiff tachycardia, fever, hypotension;
(k) Failing to diagnose and order necessary investigations in a reasonable and timely manner consistent with the Plaintiff's signs and symptoms;

The Plaintiff continues to suffer loss and damage. The Defendant mismanaged and misdiagnosed, the Plaintiff's condition, falling below the standard of a professional medical man, who holds himself out to be a specialist in women's health and is liable.

Further particulars of the Plaintiff's injuries are set out in the medical reports and records.

[3.] The Defence was little more than a denial. It provided at paragraphs 3-4 as follows:

3. The Defendant admits paragraph 5 of the Statement of Claim, and says that he at all material times upheld the relevant duty of care owed to the Plaintiff.
4. The Defendant denies paragraph 6 of the Statement of Claim and puts the Plaintiff to strict proof thereof. Further, the Defendant says that at the conclusion of the surgery there was no visible or obvious damage as alleged or otherwise.

[4.] At the trial Henfield gave evidence and called her sister Nurse Carimenda Ferguson, Dr Duane Sands and Dr. Earle Pescatore as witnesses in her case. Carey gave evidence and called Dr Baldwin Carey and Raleigh Butler as witnesses in his case.

[5.] Henfield's evidence is found in her witness statement and supplemental witness statement which provided in part as follows:

Witness Statement of Valderine Henfield

4. I attended Dr. Carey as a patient because he carried on a practice as a Certified Medical Practitioner, specializing in Obstetrics and Gynaecology and held himself out to be experienced, skilled and competent in women's health;
5. On or about the 7th September, 2010, I attended Doctor's Hospital, Collins Avenue and Shirley Street, Nassau, Bahamas at about 9:a.m., on the advice of Dr. Carey for a laparoscopy for pelvic pain dysmenorrhoea. At the time I was ambulant, coherent and in satisfactory mental and physical health when Dr. Carey accepted me as a patient to perform the laparoscopy. My sister Carimenda Ferguson a Registered Nurse at the rank of Nursing Officer I, accompanied me to the hospital and remained a constant and vigilant visitor.
6. Dr. Carey informed me that the proposed procedure would be uneventful as he had done it many times before. I was informed that I should be in hospital for about 2 to 3 days, I was discharged 5 weeks later. The procedure lasted for several hours and I subsequently learnt that I also had a laparotomy. I was very ill after the procedure and realized that due to my extreme ill health and symptoms, that Dr. Carey did not fulfill his duty of care. He did not exercising reasonable care and skill in performing his duty at the standard of care I expected of him an Obstetrician and Gynaecologist performing this surgical procedure. I learnt later from Dr. Duane Sands, who had to perform surgery on me during my illness and from my medical notes that during the course of the laparoscopy/laparotomy, my small bowel was perforated resulting in me experiencing severe pain, injury, loss and damage. Due to this misdiagnosis of the perforation, I developed fecal peritonitis, shock, depression, injury to other organs and continuous ill health. My bowel was perforated in multiple sections during the surgery, causing fecal peritonitis, intra-abdominal sepsis, septicaemia, respiratory failure; and septic shock amongst other things.

...

10. Due to my illness, I needed extensive medical care and management by 9 other physicians and had to go to the Intensive Care Unit for critical care treatment and management, where I was placed on life support.
11. I remained in hospital where I received extended medical care in excess of 5 weeks.

...

13. I have an unsightly abdominal scar from the multiple surgical procedures which will require plastic surgery. I am still suffering physically, mentally, socially and psychologically due to my misdiagnosis and mismanagement by Dr. Carey.

...

15. Having to undergo many weeks of ventilator support, I sustained vocal cord and tracheal damage which resulted in occasional weakness, loss of voice and hoarseness. My normal daily routine at work has been impacted as a result. The procedure which was only to last about an hour

and half, was in excess of 5 hours and my near-death experience, I was discharged on Wednesday the 13th October, 2010. I was still unable to bathe myself, and had problems digesting foods. I have digestive problems as a result of the surgery, the misdiagnosis and mismanagement. The 'facts speak for themselves,' which is that Dr. Carey was negligent and the cause of my injuries, loss and damage. My obstetrician gynaecologist, Dr. Ronald Patterson has advised me that due to my surgery, I will be unable to conceive naturally.

Supplemental Witness Statement of Valderine Henfield

1. In view of the outcome of the surgery undertaken on September 2010 and complications arising therefrom, I am reminded that in 2003, the Defendant had rendered surgery on me, which involved a diagnostic laparoscopy, mini laparotomy and myomectomy with uterine reconstruction. Within hours of that procedure, I was rushed into emergency theatre for internal bleeding and complications arising from that surgery. I never understood what had caused the internal bleeding, but in the days and years following, I continued to see Dr. Anthony Carey as my primary care physician.

...

3. I understood that it was likely that I would have some adhesions arising from the 2003 myomectomy, and I did 'prepare my bowels' as instructed for the September 2010 procedure by fasting and drinking only clear liquids. I expected that during this procedure, that Dr. Carey would have removed any fibroids that he saw. I was informed by Dr. Carey that he would attempt a laparoscopy and if unsuccessful, he would give the same procedure that I had in 2003, (which also included a laparotomy and myomectomy).

4. I was assured by Dr. Carey that I would be ok, and not to worry because he had done several surgeries like this before on women my age who had gone on to successfully bear children. He knew that I wanted to have a child, but he never spoke to me about the possible challenges that might arise if he had to resort to a further procedure (myomectomy) more particularly, a second one, as in my case. I know that I had documented consent for a laparoscopy to remove the adhesive tissue, which I expected would be there, but with respect to a second myomectomy, I was never informed that a botched myomectomy could result in an emergency hysterectomy, that even if I were to conceive, I would more than likely require a caesarian section; I would be at risk of abnormal placement of the placenta inside my uterus and the growth of my unborn child could be restricted. I was never advised that because of my age, there was also a high risk of chromosomal abnormality, gestational diabetes, pre-eclampsia and pre-term labour. Knowing what I do know now, I was not properly consulted concerning this surgery, nor did I give informed or documented consent for it.

...

9. Looking back on it and having regard to all the matter arising, I cannot help hold my surgeon, Dr. Carey singularly responsible for the damage effected to me. I thought I was dead, and in fact, I most certainly would have died, had it not been for Dr. Duane Sands who correctly assessed the situation, intervened and saved my life. The pain that I suffered and the losses and discomfort that remain with me today truly cannot be compensated with dollars and cents, but according to medical assessments, I will always require surgical intervention for the rest of my life.

[6.] Carey's evidence was contained in his witness statement and supplemental witness statement which provided in part as follows:

...

11. On January 20th, 2010, Ms. Henfield presented for a consultation stating that she believed new growth of the fibroids had become symptomatic and her periods were heavy and painful. She was consulted with options for medical management, including injectable hormone preparation or to try a mirena intrauterine device as a way of controlling her cycles and avoiding surgery. She opted to use mesigyna on a monthly basis so as to avoid surgery and manage her bleeding medically.

...

13. Because of her advancing age, now at 38 years old, she was concerned about her reproductive potential with the reoccurrence of these fibroids and I suggested that she do a hysterosalpingogram ("HSG"), which is an imagining process, to check for tubal patency.

14. The hysterosalpingogram was done on May 3rd, 2010, which showed free spillage of contrast. In other words, her fallopian tubes were clear. However, she wanted to correct the anatomy, ie. remove the fibroids, and restore/reconstruct her uterus to normal with a thought that she would consider starting a family in the near future. Ms. Henfield restarted her Depo-lupron with the intention of again doing a myomectomy and uterine reconstruction.

15. Ms. Henfield completed two depo-lupron injections and came for a pre-op evaluation on September 2nd, 2010. Generally, after myomectomy surgery such patients are at risk for adhesive disease. To better explain, cutting into muscle leaves scar tissue and not new muscle. This is understood and accepted within the profession. After performing an operation removing fibroids such a surgery leaves scar tissue which creates a hostile/adhesive environment where bowels could get stuck to tubes due to the scar tissue.

16. I agreed to admit her for pelvic pain, suspected adhesions and endometriosis and to do a laparoscopy and lysis of adhesions. Once a patient has had open abdominal surgery with myomectomy, the risk for

adhesive diseases is always very high and care is always taken to properly consult them about this fact and to ensure that a proper bowel preparation is completed prior to the surgery. This was again carefully done and explained.

17. I went into great detail when I consulted with Ms. Henfield especially as she had to do a bowel preparation. Ms. Henfield had to prepare the night before and clear out her bowels both in the night and in the morning. This is a preventative measure/method when you anticipate having to manipulate the bowel and free adhesions. This is something you expect but you do not know how severe the environment will be until you actually go in. When I performed the open laparoscopy I learned that Ms. Henfield had a very hostile environment.

...

22. While inside Ms. Henfield we identified that she had a small serosal tear and we repaired the tear uneventfully. In other words, as is the norm we took our time and carefully examined inside Ms. Henfield and upon identifying the tear, because it was not a complicated tear, there was no need to utilize a surgical consult to perform the repair of the tear.

23. Once the operative field was accessible, a major myomectomy was done removing 19 fibroids with uterine reconstruction in a general fashion. See the operative report.

...

25. Again, this type of adhesiolysis was done very carefully. During the procedure I was assisted by Dr. Pamela Carroll who worked with me at Health Centre for Women. Because of Ms. Henfield's hostile environment, we both took our time and very carefully/cautiously examined inside Ms. Henfield to ensure that nothing was wrong. Nothing out of the ordinary was noted or suspected. I am a stickler for attention to detail.

...

27. On post-operative Day 1 the patient looked clinically as expected. Commonly from these types of surgeries patients develop ileus and low-grade temperatures. By post-operative Day 2 Ms. Henfield did not show any tremendous improvement but also did not show any deterioration. However, as she was not steering the course that I would normally expect, a CT scan was ordered on post-operative Day 3.

...

29. The CT scan machine at Doctors Hospital Health System was not working and the patient was sent to Fourth Terrace by Ambulance to undertake the study. The CT scan report was generated at 2pm and showed free fluid in the abdomen and the pouch of douglas, suggestive of perforation and abscess formation and perforation. As I was in office and Ms. Henfield's sister is a nurse and Dr. Duane Sands happened to be at Princess Margaret Hospital, her sister asked Dr. Sands to look at the CT scan.

30. Dr. Sands called me and advised that upon review of the CT scan he felt Ms. Henfield was becoming septic and would require a re-exploration.

This was the purpose of me ordering the CT scan, so that I could ensure Ms. Henfield's proper recovery.

...

34. It should be noted and emphasized that in addition to Ms. Henfield commencing these Supreme Court proceedings, she also lodged a complaint against me with the Bahamas Medical Council. See her letter dated October 5th, 2012. Consequently, Dr. Franklin Walkine wrote a letter dated October 24th, 2012, addressed to me calling for my explanation.

35. By letter dated November 12th, 2012, my Attorney, Dywan Rodgers, wrote to the Medical Council informing them of this Supreme Court Action and informed them that the Supreme Court Action is in the process of determining whether there was in fact any negligence on my part.

...

37. Nevertheless, I was still summoned by the Bahamas Medical Council and made to answer the complaint lodged by Ms. Henfield. At the conclusion of my explanation which was also tendered in writing to the Council by letter dated November 30th, 2012, the Board Certified highly competent Doctors (MY PEERS) who presided over the proceedings exonerated me and found that I was not negligent in my handling, treatment and care of Ms. Henfield.

Supplemental Witness Statement of Dr. Anthony Carey:

...

11. Post operative day one, day two and day three I was present along with my junior Dr. Pamela Carroll. We would meet examine the Plaintiff and I would instruct what should be done. In examining the doctor's progress notes you can see my attendance and my signature is on same. Thereafter, Intensive Care Unit doctors and surgeons (Dr. Duane Sands) took charge of the Plaintiff so my attendance was not as necessary. However, I still attended the Plaintiff and although not charged with her care or treatment I followed up with the Doctors that were charged with same.

[7.] Under cross-examination, Carey stated:

(1) The Pathologist collect the tissue that is removed and analyze it under microscope and can tell because of their training what types of injuries we are dealing with that could have caused the problem. In his final diagnosis the pathologist says that there is a segment of small intestine that has hemorrhagic infraction. Hemorrhagic infraction is a result of ischemia or lack of blood supply coming to the portion of the bowel that is being nurtured.

(2) T*he CT Scan ordered by Dr. Pamela Carroll, under his direction.*

(3) That part of the bowel that was removed was very carefully inspected and the only injury that was observed was the tear in the serosal. That's what had to be repaired. And before you leave and close a surgical site, we are very careful to apply copious amounts of fluid, look for bleeding, look and see if there's any of the fluid contents that could come through where you were working and none

of that had occurred. It would be unconscionable to have a bowel injury and close ... knowing that she is going to have complications ... that is unacceptable".

(4) He gave the instructions to hold the CT Scan on the 8th as the patient was showing some clinical improvement. Henfield was having a normal postoperative change after a big open surgery.

(5) Before the surgery is undertaken, Henfield would have had to undergone a very extensive bowel preparation, her diet is changed to liquids. If evacuate the bowel, Henfield being unable to eat for the first two days and there was no faeces no food or anything inside of it, there isn't anything in her gastrointestinal system.

[8.] Evidence of an expert nature were given by Dr Duane Sands, Dr. Earle Pescatore, Dr Baldwin Carey and Dr. Raleigh Butler. All witnesses were deemed experts without objection.

[9.] The evidence-in-chief of Dr Duane Sands, cardiovascular surgeon, was that:

(1) Henfield had undergone a difficult gynaecologic procedure, laparoscopy /laparotomy which was performed by Dr. Anthony Carey and Dr. Pamela Carroll at Doctors Hospital on the 7 September, 2010. During the procedure (myomectomy), injury to the densely adherent bowel was noted and repaired.

(2) Post-operatively, she developed worsening tachycardia and respiratory failure resulting in her ultimate transfer to the intensive care unit. It was not immediately recognized that her deterioration was due to faecal contamination of the peritoneum. She became progressively more ill and was ultimately transferred to the Intensive Care Unit in septic shock.

(3) When initially seen by [him] on 10 September, 2010, she was critically ill and systemically toxic. She was tachycardic and hypotensive. She was obtunded due to her sepsis and unable to fully engage in a conversation. She had evidence of peritonitis. This diagnosis was supported by a CT scan that showed intra-loop collections and generalized ascites.

(4) After aggressive resuscitation with fluids and antibiotics, Ms. Henfield was taken to the Operating theatre on the [10] September, 2010, where the pre-operative diagnosis of faecal peritonitis from the injured small bowel was confirmed. The small bowel had multiple perforations with oedematous and haemorrhagic mucosa wall.

(5) He adopted a "damage control" strategy. At the initial procedure the leaking bowel was resected (stapled) the soiled peritoneum was irrigated and she was returned to the ICU for management of the respiratory failure and septic shock. Her abdominal fascia was kept open and domain was restored with the use of a plastic "Bogota bag." Bilateral chest tubes were placed and she was invasively monitored. Over the ensuing weeks, she was returned to the

operating room on multiple occasions to irrigate and debride the abdomen, then restore bowel continuity and then ultimately to reconstruct her abdominal wall. A vena-caval filter was placed.

(6) Appropriate consultations from nephrology specialists (renal failure,) critical care, internal medicine, infectious disease, plastic surgery and psychiatry were obtained.

[10.] Under cross examination Dr Sands stated that:

(1) The standard of care provided to the patient in the postoperative stage was unacceptable and consistent with malpractice. All of the signs were there from the first post-operative day and they were missed.

(2) The finding both at surgery and at pathology demonstrate that the bowel was dead at those points and that this could only happen with an old injury".

(3) The possibility of bowel perforation occurring in postoperative period may possible, but is so remote, the more reasonable explanation for the perforations he found on operating on Henfield is that of a missed injury.

[11.] The evidence-in-chief of Dr. Earle Pescatore Jr., DO provided that:

(1) He is a board certified in obstetrics and gynaecology by the American Board of Obstetrics and Gynaecology. He has practiced for over 20 years as an OBGYN in the US and is licenced in Florida, Texas and California.

(2) Bowel injuries are a known complication of laparoscopy and laparotomy. The incidence has been estimated at 0.54%. [Henfield] was at increased risk of injury due to the distorted anatomy from prior surgery. The occurrence of the bowel injury is not outside the standard of care. The surgeon described in detail the significance of the adhesions but failed to recognize the subsequent bowel injury. Failure to recognize and appropriately manage the injury at the time of the initial surgery does not meet the standard of care. If the bowel had been carefully examined or "run" it is more likely the injuries would have been detected and appropriately managed.

(3) Another option would have been to call for a general surgery consultation to help manage the extensive bowel adhesions. Had these injuries been treated appropriately at the time of the initial surgery there would have been limited impact beyond the initial healing.

(4) The patient had declining clinical picture following surgery, however, the patient did not meet typical criteria for sepsis until postoperative day #3. In the first 12-24 hours aggressive fluid therapy was a reasonable clinical plan. Blood loss may have been underestimated and sequestration of fluid (third spacing) in a highly manipulated bowel may have been contributing to the decreased urine output and tachycardia. However, when the patient's tachycardia and decreased urine output failed to respond to intravenous fluid further investigation was indicated. The initial thought to assess for pulmonary embolus was reasonable and it is unclear why the CT of the chest was cancelled.

(5) The operating surgeon likely suspected infection because antibiotics were continued beyond what would be considered prophylaxis (>24 hours). The indication for the continued antibiotics were not documented within the records. If sepsis was considered cultures should have been performed including blood, urine and sputum cultures prior to continuing antibiotics. A chest x-ray should have been obtained to assess for a pulmonary source (i.e. pneumonia). If the antibiotics were for treatment of sepsis rather than prophylaxis another choice should have been made.

(6) The persistent tachycardia in an otherwise healthy female should have led to earlier investigation on postoperative day #2. Earlier consultation with cardiology and imaging of the chest and abdomen would have led to the diagnosis of sepsis in a more timely fashion. Once the cardiac issue was investigated it became clear that there was another source (sepsis) for the tachycardia and tachypnoea.

(7) The delay in the diagnosis of sepsis led to the progression of illness resulting in ARDS, need for intubation, chest tubes and the prolonged ICU care. If Dr. Anthony Carey would have been more aggressive in his postoperative care and addressed the issues on postoperative day #2 septic shock with cardiovascular collapse would have been avoided.

(8) Due to the short window (12-24 hours) when the symptoms presented following the initial surgery the bowel injury is most consistent with a direct injury at the time of the surgery by Dr. Carey. Alternative explanations such as altered blood supply, infection and necrosis usually present at a later timeframe (typically 5-7 days).

(9) His specific opinion was identified as follows:

It is my considered opinion, based on a detailed review of the medical records that Dr. Anthony Carey failed to meet the standard of care with regard to multiple issues in this case. The issues include inadequate consent, failure to diagnose bowel injury, and delay in diagnosis of sepsis leading to additional procedures and morbidity.

Following the inadequate consent process, the resulting subsequent unconsented elective procedure (myomectomy) clearly exceeded the intended planned diagnostic procedures. During the unconsented elective surgery (myomectomy) a bowel injury occurred that was not recognized due to inadequate observation and evaluation of the bowel at the time of the surgery (failure to "run" the bowel). Finally, there was delay in diagnosis of the sepsis as the result of the intraoperative bowel injury that was unrecognized. The early signs were attributed to other issues until the patient had fulminant septic shock. This series of errors led to additional surgery, ICU care and subsequent hospitalizations.

(10) Having regard to the hospital records presented, one observes that from Day 1 and Day 2 of post operative care, the Plaintiff suffered tachycardia, hypotension and decreased urine output, (in spite of having received aggressive fluid resuscitations by way of IV drips and replacement of electrolytes) and significant amount of blood products. In view of such intervention, by Post operative day 2, the Patient should have been

stabilizing, (if not altogether improving), but instead, her clinical picture is clearly deteriorating. This factor alone should have presented a red flag, therefore, Dr. Anthony Carey could not suggest that while the Plaintiff was not "getting any better, she was not getting any worse", because she was most certainly getting worse.

(11) By post operative Day 3, she suffered even worse tachycardia and was given a beta blocker to presumably decrease her heart rate (treat the tachycardia). On top of this, in order to facilitate a bowel movement, she was given her a suppository to aid in a bowel movement. This is not reflective of good care because the patient had extensive lysis of adhesions per Dr. Carey's report along with some degree of bowel repair at the index procedure. Allowing the bowel to return to activity without intervention is the usual course of care.

(12) The serosal tears discovered in the emergency procedure undertaken by Dr. Sands on Post Operative Day 3 came about during the surgical intervention of Dr. Carey, and not by way of some infection, which in general presents five to seven days after the fact. It is my professional judgement that in the post operative care, Dr. Anthony Carey was curiously missing, and that Dr. Pamela Carroll, his Assistant, was more involved in the care of this patient, despite this being a situation fraught with issues.

(13) What seems to be missing here, however, is not just the poor quality of post-operative care rendered upon the Plaintiff, but also the pre-operative care. Again, referring to hospital notes, the patient was admitted on 9/7/2010 for a planned hysteroscopy with removal of polyp and laparoscopy to rule out endometriosis – both of which, according to medical reports, there were no polyps, nor was there evidence of endometriosis. More particularly, there is no statement of samples being taken to confirm the fact of endometriosis or the absence of it.

[12.] Under cross examination Dr. Pescatore stated:

(1) He is unfamiliar with medical facilities and hospitals in The Bahamas.

(2) His reading of the operative report indicates there was no suggestion that Carey ran the bowel. "If he did run the bowel he missed it, if he didn't he should have. Either way he is at fault."

(3) A laparoscopy can proceed to a laparotomy. It happens in the US 6% of the time. It could occur because of laparoscopic complexity, body mass or encountering things that weren't anticipated and surgeon inexperience. He couldn't speak to what occurs in The Bahamas.

(4) Henfield complained of chest pain. CT scan ordered and cancelled but it wasn't clear why the scan was cancelled.

(5) A figure eight is a hemostatic stitch and shouldn't have been used unless it was controlling hemorrhage. The correct way would have been interrupted sutures.

(6) It's possible that the bowel could perforate because of ischemic or infectious ideology, but that typically presents in five to seven days not day two to three.

You have evidence to a single serosa tear, two days later, we note that a two foot portion of the bowel had to be removed because of extensive damage.

(7) A CT scan was a good idea, absolutely. However, on post-op day number two, in spite of aggressive fluid resuscitation, in spite of three units of packed cells, in spite of continuing antibiotics which weren't explained, they did nothing. And the patient had worsening symptomology at day two, not improving symptomology.

(8) Day one was well managed. Day two is where he begins to have concerns. Antibiotics were continued beyond the point that they would be considered prophylactic, and there was no suggestion why that was done. There was increasing use of fluids and also packed blood cells to a total of three units. In spite of that care, the patient continued to deteriorate significantly with a tachycardia now up above 120 beats per minute.

(9) The patient did not meet the typical criteria for sepsis, but this is where clinical decision making becomes important. This is where subtleties need to be addressed and they were not, they were missed. The next day, the patient was on the verge of cardiovascular collapse. It's easy to see there's a problem there.

(10) They probably should have ordered the CT scan 24 hours earlier. It was clear that the patient was getting sicker and more aggressive investigation was necessary.

(11) In his expert opinion, he would not have given the patient a suppository. It would have her bowel highly manipulated as your client has described. He describes it as a mistake.

(12) From the time Dr. Sands assumed care, the patient was well managed and she appeared to be very sick, requiring intensive care.

(13) Carey would not have known ahead of time that this was going to be as bad as it was, so he does not necessarily fault him for doing a laparoscopy from that standpoint. If he thought he was going to take out nineteen fibroids with a laparoscope, that was completely unreasonable. There is no way he could have accomplished that. There's no way anyone could have accomplished that with a laparoscope. So if he knew he was taking out multiple fibroids, he probably should have approached it with a laparotomy to begin with.

[13.] The evidence-in-chief of Dr Baldwin Carey provided that:

(1) [He] reviewed in detail the post operative and pathology reports generated in respect of Ms. Valderine Henfield and [he] have considered the description of events proffered by Dr. Anthony Carey and Dr. Duane Sands, in the reports and in their respective Witness Statements. It is clear from same that Dr. Carey is adamant that he met all reasonable standard of care and it is also

clear that Dr. Sands did not make a finding as to whether Dr. Carey was within the standard of care and was not negligent. ...

(2) It is no deficiency in skill that a patient may have bowel tears or perforations after dissection and lysis of adhesions, especially in an environment described as "*extensive adhesive disease (very hostile environment)*".

(3) What is important is that after the lysis of adhesions has been performed the doctor in question, Dr. Carey, would (what we call) "RUN" the bowel. In other words, he carefully inspected/examined the bowel noting whether there were any tears or perforations or anything else that should be attended to.

(4) The process of inspecting and examining the bowel or the process of running the bowel involves using your eyes (a visual process) and slowly and meticulously looking over every part of the bowel holding same in your hands. No matter how meticulous you may be in running the bowel, there is no guarantee that you will see a leak or a tear at that particular time. However, the standard of care required is the fact that Dr. Carey did in fact address his mind to running the bowel, which he describes in his statements, and upon finding a serosal tear he felt competent enough to repair same and to follow with a thorough examination of the bowel to ensure that there was no further cause for concern.

(5) [H]e can say with all certainty that this has been the process and procedure that [he] have adopted and followed as well as [he] can say that this is the usual and common practice in the United States of America and within The Bahamas (which is the jurisdiction that we are concerned with). There have been occasions when upon running the bowel [he] found tears or perforations and [he] repaired same and there have been times that [he] deferred to a General Surgeon for consultation; it is a judgment call but the fact that Dr. Carey elected to repair the serosal tear himself in no way connotes a departure from the correct standard of care and should not be relied on to suggest negligence.

(6) His professional opinion based on his Forty (40) plus years of experience that while the timeframe of "*5-7 days*" may be typical as suggested by Pescatore, Jr., DO, it is not conclusive/definitive and does not mitigate diminish or take away from the fact that the alternative explanations proffered by Dr. Raleigh are possible. Nothing in medicine is that precise.

[14.] Under cross examination Dr Baldwin Carey stated that:

(1) Major injury to the bowel can lead to an inflammatory response in two to three days, that it would most likely take a major injury for there to be death to the bowel in three days, that it is not easy to miss a major injury to a bowel and that a physician exercising reasonable care should identify and address a major bowel injury before closing the patient's abdomen.

(2) "After a running of the bowel a physician a surgeon will detect any obvious injury to the bowel ... you see it ... it is possible to miss it. I did not say it is easy, it is possible to miss it"... "You are looking for any damage to the bowel ... any damage to the bowel that can be identified visibly on inspection".

(3) In the post-operative period "*you are watching your patient, you are observing your patient and you see and you determine if there is a problem. But you are not necessarily looking for a bowel problem, you are looking for any difficulty or problem*". ...

(4) There was no delay as he can see in the postoperative treatment of Henfield: Carey continued to treat his patient, reviewed her charts to see what is happening.

[15.] The evidence-in-chief of Dr. Butler provided that:

(1) He reviewed in detail the post operative and pathology reports generated in respect of Ms. Valderine Henfield and have considered the description of events proffered by Dr. Anthony Carey and Dr. Duane Sands, in the reports and in their respective Witness Statements. He is very familiar with the treatment provided and procedure performed by Dr. Carey and Dr. Sands.

(2) He is confident in saying that if Dr. Carey noted a small serosal tear and repaired same, it is clear that he exercised a sufficient degree of care in examining the patient to ensure that her bowel and organs were free from obvious tears, perforations, punctures etc. <u>It is highly unlikely</u> that Dr. Carey or any doctor would note and not correct a small serosal tear and thereafter neglect to check for any other visible tear injury that may have been caused by the surgery. Further, it is highly unlikely that Dr. Carey or other doctor after addressing a small serosal tear would thereafter fail or neglect to carry out further exploration. Lastly, and I emphasize the point, it is highly unlikely that Dr. Carey or other doctor would identify further visible tears or injuries and fail to correct same before closing.

(3) Dr. Carey in his statement comments "... *I do not do "Cowboy" surgeries and I am very quick to have intra operative consults by my specialist colleagues when there is any suspicion of damage out of the ordinary*". I can attest to this because I have been consulted by Dr. Carey on various occasions over the years of practice. He would routinely as ask for my advice or the advice of fellow physicians if he felt that there was a case outside the norm.

(4) Dr. Carey did everything consistent with the proper care and treatment of Ms. Henfield. The CT scan was order and carried out within a timely fashion and until the scan results were completed and analyzed a course of treatment cannot be embarked upon. In this instance, once the scans were analyzed a course of treatment was agreed between Dr. Sands and Dr. Carey with Dr. Sands attending to operate on Ms. Henfield. This was also done in a very timely fashion without delay.

(5) According to Dr. Sands' statement "*The small bowel had multiple perforations with edematous and hemorrhagic mucosa wall*". It is very important to note, that use of the word "perforation" does not necessarily mean a scalpel perforation or perforation directly caused by Dr. Carey. A perforation or tear

could result from any number of reasons that have nothing to do with or that does not stem from any form of negligence on the part of Dr. Carey. In other words, a perforation does not necessarily stem from an injury directly caused or inflicted by Dr. Carey.

(6) Serratia peritonitis as described by Dr. Sands could have come from a hospital acquired infection from a line or contaminated instrument beyond the control of Dr. Carey which then setup this patient for an infection of her entire peritoneal cavity. This hostile environment with a difficult case as this was could account for the perforations, without Dr. Carey actually inflicting or directly causing such perforations and this would have occurred after closing.

(7) Further, I honestly and respectfully believe that it is unlikely that a doctor and in this case Dr. Carey, who I have assisted in the past, would end a case and close a patient knowing that there were perforations and/or tears.

(8) The notes of Dr. Carey demonstrate the meticulous manner and fashion in which he closed Ms. Henfield. He looked, he found and repaired the small serosal tear and thereafter, he closed.

[16.] Under cross examination Butler stated that the perforations could have been caused by infection and not caused by any negligence on the part of Carey. The possibility of a scar tissue, the blood supply to the scar tissue being compromised leading to infraction or necrosis which in turn will lead to perforation.

Issues

[17.] The issues for determination in this dispute is whether or not Carey breached his duty of care owed to Henfield before, during and/or after the operative/surgical procedure performed on Henfield.

The Law

[18.] The usual starting point with respect to any discussion in claim of medical negligence is the oft cited dicta of ***McNair J*** in the English High Court decision of ***Bolam v Friern Hospital Management Committee [1957]1 WLR 582, 587***. According to ***McNair J:***

> I myself would prefer to put it this way, that he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. I do not think there is much difference in sense. It is just a different way of expressing the same thought. Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view. At the same time, that does not mean that a medical man can obstinately and pig-headedly carry on with

some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion. Otherwise you might get men today saying:

> "I do not believe in anaesthetics. I do not believe in antiseptics. I am going to continue to do my surgery in the way it was done in the eighteenth century."

That clearly would be wrong.

[19.] McNair's statement has become known as the Bolam test and is the baseline treatment for determining medical negligence. The test has been refined over the years in cases such as ***Bolitho v City and Hackney Health Authority 1998 AC 232***. In ***Bolitho***, a 2-year-old child suffered catastrophic brain damage as a result of cardiac arrest induced by respiratory failure. ***Lord Brown Wilkinson*** identified two questions relative to liability for medical negligence, namely: (1) whether there is proof of negligence where the act complained of is an omission; and whether the ***Bolam*** test has been satisfied. In discussing the ***Bolam*** test, ***Lord Brown Wilkinson*** stated:

> My Lords, I agree with these submissions to the extent that, in my view, 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 W.L.R. 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 recognised as proper by a competent *reasonable* body of opinion." Again, in the passage which I have cited from *Maynard's case* [1984] 1 W.L.R. 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.

Expert Evidence

[20.] As with every medical evidence case, much depends on the treatment of the expert witnesses and each party implores the court to accept the evidence of their expert witness and reject the evidence of their opposer's. This case is certainly no different.

[21.] In **National Justice Compania Navierasa S.A v Prudential Insurance Company (Ikarian Reefer) (1993) 2 LLR 68,** Justice Creswell examined the duties and responsibilities of the expert. He stated:

> (i) Expert evidence presented to the court should be, and should be seen to be, the independent product of the expert uninfluencedas to form or content by the exigencies of litigation;
> (ii)An expert witness should provide independent assistance to the court by way of objective unbiased opinion in relation to matters within its expertises.....An expert witness in the High Court should never assume the role of advocate
> (iii) An expert witness should state the facts or assumptions upon which his opinion is based. He should not omit to consider material facts which could detract from his concluded opinion;
> (iv) An expert witness should make it clear when a particular question or issue falls outside his expertise;
> (v) If an expert's opinion is not properly researched because he considers that insufficient data is available, then this must be stated with an indication that the opinion is no more a provisional one. In cases when expert witnesses who has prepared a report could not assert that the report contain the truth, the whole truth and nothing but the truth without some qualification, that qualification should be stated in the report;
> (vi) If after the exchange of reports, an expert witness changes his view on a material matter having read the otherside's expert report or for any other reasons, such change of view should be communicated (through legal representatives) to the otherside without delay and when appropriate to the court.

[22.] Ordinary witnesses of fact are not allowed to give opinion evidence. They can only say what they saw and what they heard. Expert witnesses however, are able to give opinion evidence. They are nonetheless witnesses and in the same way that I must assess the evidence of every witness, I assess the evidence of these professional witnesses, including their expert testimony. The caution here is that

before throwing out or discarding the evidence of an expert witness I must think carefully before doing so. But because an expert expresses an opinion, it doesn't mean that I have to accept it. Here however, where competing opinions are lined up on the two sides of this dispute, it's really a matter of assessing and attributing weight to the various opinions.

[23.] Henfield attacks the witnesses for the defendant as to their independence and suggests that they are no more than character witnesses for Carey. There is some merit in this complaint as whilst Dr Butler and Dr Baldwin Carey are clearly competent physicians they also clearly have an affinity to Carey and consistently refer to what they know of his skills. This is not helpful for expert witnesses as I am not convinced that they are not giving him the benefit of the doubt in the circumstances of this cases. Examples of this are evident in the evidence of Dr Butler:

> *"Further, I honestly and respectfully believe that it is unlikely that a doctor and in this case Dr. Carey, who I have assisted in the past, would end a case and close a patient knowing that there were perforations and/or tears.*
>
> *I can attest to this because I have been consulted by Dr. Carey on various occasions over the years of practice. He would routinely as ask for my advice or the advice of fellow physicians if he felt that there was a case outside the norm.*
>
> *I am confident in saying that if Dr. Carey noted a small serosal tear and repaired same, it is clear that he exercised a sufficient degree of care in examining the patient to ensure that her bowel and organs were free from obvious tears, perforations, punctures etc.*
>
> *The notes of Dr. Carey demonstrate the meticulous manner and fashion in which he closed Ms. Henfield. He looked, he found and repaired the small serosal tear and thereafter, he closed."*

[24.] Carey says, in relation to Dr Pescatore, that he is not familiar with The Bahamas and has never practiced as a medical practitioner within The Bahamas. Carey says that this makes a significant difference because there are many nuances unique to The Bahamas that he would not be familiar with, such as costs generally, costs

of various scans, availability of machinery, availability of technicians to operate the machinery, accessibility to consultants/specialist, availability of consultants/specialist.

[25.] In relation to Dr Sands, the complaint of Carey is that his evidence is untrustworthy. Carey says that Dr. Sands' Witness Statement was issued January 27, 2014, and was very neutral in tone but once he took the stand, almost three (3) years later, despite having time to change or amend his Witness Statement, he attempts to deliver a very hostile report and the question is – why? They also say that Dr. Sands "mixed up this case with another, it is not unreasonable given the lapse in time and given his confusing testimony on the stand during trial." Further they say that Dr. Sands' oral testimony was very biased, confused and wrong. It appeared that Dr. Sands either was mistaken in cases or was out to damn the Defendant. Finally. Carey says that given the stark contrast in Dr. Sands oral and written testimony, little to no weight should be attached to his oral testimony. In his report Dr. Sands makes no mention of the Defendant being negligent, however, on the stand he condemns the Defendant and describes the standard of care provided to the patient in the postoperative stage as unacceptable and consistent with malpractice.

[26.] Carey also suggests that Dr Sands was mistaken on his findings because in his oral testimony he referred to removing quarts of foul smelling stool around the perineal cavity of Henfield. They suggest that such an occurrence was unlikely as:

(1) Henfield's bowels would have clear as a result of the preparation for surgery and her gastrointestinal system would have been clear as she was only given fluids; and
(2) Sands never said in his any of this in his witness statement.

I did not accept this complaint as valid as:

(1) Carey accepted that some fecal matter was removed from the Henfield if not stool; and

(2) The allegation as to being mistaken on this issue was not put to Dr Sands by Carey. I accept that this evidence, as with the other opinions as to Carey's mismanagement of Henfield was made in Sands' oral testimony, however the Court specifically granted permission to Carey to recall Sands for the purpose for continuing the cross-examination on this issue which Carey says took him by surprise. Sands was notified that he could expect to be recalled. Carey specifically chose not to recall Dr Sands in the result that any mistake as to his evidence was not put to Dr. Sands.

[27.] It is perhaps appropriate here to deal with the determination of the Medical Council. Carey says that this clearance by the Council is determinative of the claim as it is a determination by "his peers" that he acted within the standard accepted by the profession. I am unable to accept this submission, not only because I am required to come to my own findings, but because there is absolutely no information as to what the Council considered. If evidence was taken, Henfield claims that she was unaware as she was not contacted in the process, notwithstanding she made the complaint. Additionally, it is unclear whether they considered the evidence of Dr. Sands or Dr Pescatore.

Preoperative Care

[28.] Henfield contends that Carey breached his duty to secure her informed consent prior to engaging in the procedure.

[29.] Henfield did not specifically plead this issue but says that it falls to be considered under the general breach of duty. The Court, in an interlocutory ruling, allowed the issue to be raised as it has been fleshed out in Henfield's witness statement. Carey was given adequate leeway to address the issue. The issue however continued to evolve and morph as the trial proceeded and I now tend to agree with Mr Rodgers' assessment that this issue (in its morphed form) could not be adequately gleaned from the pleadings as they stand. Henfield case ultimately was that the defendant's failure to provide informed consent consisted of:

(1) A physician not advising his patient as to the significant risks extending not only to the intended procedure but as well as to subsequent opportunities given the patient's clearly communicated wishes;
(2) A physician not ascertaining his patient's internal condition/environment pre-operatively when possible to do so without intrusion (i.e. incision),
(3) A physician embarking on procedures extending beyond those covered by his patient's actual consent

[30.] Having heard the witnesses and considered the evidence I am satisfied that the defendant obtained the consent of Henfield and advised her of the risks associated with the procedure, prior to embarking upon the procedure.

[31.] The forms completed by Henfield indicated the procedure to be performed and contained the following statement which was signed by her:

DOCTORS HOSPITAL
Health For Life

DOCTORS HOSPITAL
CONSENT TO THE PERFORMANCE OF
SURGICAL AND OTHER PROCEDURES

1. I *Valderine Henfield* (Signed) HEREBY REQUEST AND AUTHORIZE Dr. *CAREY, ANTHONY* ("the Attending Physician") and/or such other physician associate(s) and/or assistants as may be selected by him/her to perform the following operative, invasive, or other procedure(s)

LAPAROSCOPIC / LAPAROTOMY. hysteroscopy

---

on *Valderine Henfield* (Signed)

2. The Attending Physician has discussed with me my/the patient's present condition, the perceived benefits of the procedure or therapy and the likelihood of the success of the procedure or therapy. I acknowledge that I have been given an explanation of and the opportunity to ask questions about my/the patient's condition, the procedures to be used and the risks and hazards involved, the alternative forms of treatment and the risks of non-treatment. I believe that I have sufficient information to give this informed consent *VH* (Signed)

...

4. I understand the proposed care may involve risks of serious and substantial harm and possible complications (including those relating to the recovery period) and that certain complications have been known to follow the procedures to which I am consenting even when the utmost care, judgment and skill are used. I acknowledge that the Attending Physician has explained any alternative methods or treatment to me. VH (Signed)

...

6. I recognize that, during the course of the procedure, unforeseen conditions may necessitate additional or different procedures than those explained, I therefore further authorize and request that the Attending Physician, his/her assistants and any Consultant Physicians whose involvement and/or participation in my/the patient's treatment are deemed necessary by the Attending Physician utilize and perform such procedures as are, in their professional judgment, necessary and desirable for my/the patient's well-being including but not limited to the use of diagnostic tests and therapeutic procedures, including invasive diagnostic procedures and the performance of services including pathology, radiology and cardiac procedures. VH (Signed)

[32.] Henfield acknowledged in evidence that she was advised that the procedure may move for the less invasive laparoscopy to the open procedure of the laparotomy similar to the procedure previously performed on her.

[33.] Carey's oral testimony on this issue, of advising Henfied of the risks associated with the procedure, included the following:

> *There is a standard hospital consent form that when the patient is getting admitted, they have to be made to realize that this is the nature of the surgery. This is what we're going to do. You have to sign the consent to undergo these procedures and then I in turn have to sign them. There is a series of papers that have to be dealt with before the surgery happens*
>
> *She would end up having -- well, you would want to evaluate fibroids. Are they inside the uterus? Can they be outside? If they can be a combination. So we elected to look inside the womb to see if fibroids were there and it's all documented in the photos because I do documentation. And then the decision was made to see if the fibroids can be removed laproscopically or did we have to go and do a laparotomy to remove the fibroids so all of those options were discussed.*

That the nature of having had fibroids surgery there is always a risk that you develop adhesions and adhesive disease that could complicate this kind of surgery. In fact, when we're leading up to getting the surgery to be planned, there was a whole issue that deals with the kinds of preparation, the kinds of bowel preparation you have to do so that you know that when you go and do the surgery, there is a possibility that you will encounter these issues that complicates the kind of surgery you're doing. So all of that is discussed because this process goes over the course of four to six weeks. It is not automatically assumed that they're going to go to the hospital to have surgery. So there's ample opportunity for the discussion. ...

[34.] In all the circumstances, I am satisfied that Henfield was appropriately advised of the risks associated with procedure which was performed.

Operative Care

[35.] Henfield contends that Carey breached his duty of care during the operative procedure, in particular that say that Carey had a duty to:

(1) Run of the bowel upon completion of laparotomy to (i) identify and (ii) repair any injuries to the bowel;
(2) Perform the appropriate stitches in repairing bowel injuries responsibly; and
(3) Consulting with appropriate experts where necessary to assist in performing difficult procedures.

[36.] Carey says in his submissions that:

> "In respect of the operative procedure, Dr. Butler correctly states that (1) the findings described by Dr. Sands are strongly suggestive of the fact that the perforations could have been caused by infection and not caused by any negligence on the part of Dr. Carey. (2) Dr. Carey's careful conservative approach was the correct one as he brought the Plaintiff into the operating room and he examined below through the vagina and he put a laparoscope into the abdomen, he did it by open procedure. (3) Dr. Carey subsequently identified a number of adhesions and scar tissues so he promptly removed his instruments and went on to do the procedure openly. (4) After removing 19 fibroids from a hostile environment, he inspected (ran the bowel) found a serosal tear repaired same and the closed the Plaintiff (sic)."

[37.] As to the allegation of Carey's use of an inappropriate stitch in repairing the damaged bowel, whilst Dr Pescatore makes this complaint there is no evidence as

to the effect of the use of the figure eight rather than the interrupted stitch. In such a case the absence of this causal connection, negligence could not be proven.

[38.] The main complaint centred around the issue of whether Carey ran the bowel. All physicians describe running the bowel as taking it into your hands and examining its full length to ensure that no perforations had been made during the procedure of removing the fibroids and dealing with adhesions. As Dr Pescatore indicated, the fact of perforations on the bowel does not indicate that there was want of care as this is an expected consequence of the procedure. According to Pescatore, it's not identifying the perforation and repairing them where the standard of care would not be met. Henfield's case is that there is no indication aside from Carey's evidence that her entire bowel was ran by Carey upon his completion of the laparotomy. They say that it is not indicated in the operative report and there is no other corroborating, timeous evidence, in support of the Carey's assertion.

[39.] Carey is adamant that he did run the bowel and refutes the allegations otherwise. It is true that other than his assistant Dr Carrol, there were the no witnesses as to whether he did in fact run the bowel. Dr Carrol did not attend to give evidence. Having heard and examined Carey as he gave his evidence, I am satisfied that, on balance, he did examine the bowel but I am not convince that he ran the bowel. The operative notes did not speak to running the bowel but did indicate that the bowel was inspected and it is not disputed that during the inspection a serosa tear of the bowel was located and repaired by him. I accept the evidence of Dr Baldwin Carey and Dr. Butler that it was more likely than not that Dr. Carey or other doctor after addressing a small serosal tear would thereafter fail or neglect to carry out further exploration.

[40.] I am nonetheless satisfied that the injury to the bowel was caused as a result of the procedure and was missed by Carey. I accept the evidence of Dr Sands that the damage he saw was from an old injury and I am prepared to reject the alternative theory of Dr Butler as to infection as the cause. Dr Sands stated:

> *When I got in the operating room, the damage to the bowel was clearly a transmural or full thickness perforation in several places. And the findings both at surgery and at pathology demonstrate that the bowel was dead at those point. And that could only happen with an old injury. ... And the abdominal cavity, the bowel was so damaged that it was impossible to close her belly, we had to leave her bowel in a plastic bag.*

[41.] I am not satisfied, on the evidence, that on a balance of probabilities such inspection as was carried out by Carey was adequate in all the circumstances. The evidence of Dr. Pescatore and Dr. Baldwin Carey are instructive in my coming to this decision:

> Dr Carey: "*after a running of the bowel a physician a surgeon will detect any* ***obvious*** *injury to the bowel ... you see it ...* ***it is possible to miss it. I did not say it is easy****, it is possible to miss it".*
>
> Dr Pescatore: "*There's nothing here to indicate the bowel was run at all... If he did run the bowel he missed it, if he didn't he should have. Either way he is at fault.*"

[42.] Whilst complimentary of the defendant, Dr Baldwin Carey was cautious in the language chosen. He said it was possible, not easy to miss this injury. The converse is that it is hard to miss the injury to the bowel. Having detected an injury to the bowel it was incumbent upon the defendant to be extra vigilant in examining the bowel. Having heard and observed him I am not satisfied that was so vigilant.

[43.] In all the circumstances I am satisfied that there was a breach of his duty of care by Carey in the conduct of the procedure and that this breach caused damage to Henfield.

Post-operative Care

[44.] Henfield contends that Carey breached his duty to properly manage her care following the operative procedure. Henfield says that Carey's care of her fell below the standard in the following manner:

(1) A physician ignoring or not having proper regard for the symptoms of a condition in his patient thereby, not ascertaining and correctly diagnosing his patient's sepsis.
(2) A physician not advocating strenuously for necessary imaging for his critically-ill patient.
(3) A physician not taking all reasonable steps to rule out all possible conditions by cancelling imaging that is an appropriate investigative tool.
(4) A physician responding inappropriately and not in a timely fashion as regards the ordering of investigative imaging, application of excessive antibiotics without justification, application of procedures inappropriate for critical care.
(5) A physician not consulting with the appropriate experts given his patient's extreme condition and the need to render necessary care.
(6) A physician not increasing his visitation to patients in accordance with the severity of their condition, thereby being in-attendant to critically ill patients given the severity of their situation.

[45.] In respect to the allegation that Carey ought to be have been more aggressive and should have ordered the CT Scan sooner, Carey says in his written submissions that he *"was/is by no means clairvoyant. It is all well and good to look back and say that the Defendant should have done so and so and done things differently and be more aggressive, but we all know that "hindsight is 20/20". The main point is that the Defendant did attend to the Plaintiff and he took steps to treat the Plaintiff and according to Dr. Carey and Dr. Butler the postoperative steps and treatment taken met the standard of care."*

[46.] In ***Reilly v Thompson [2004] BHS J. No. 352*** the Supreme Court considered complaints that a physician's (Dr. Thompson's) inadequate care either was the direct cause of an infection, or facilitated it, and it was the care that the patient [Reilly] did not receive which caused the infection to fester and deteriorate significant portions of her breast tissue. ***Davis J*** relied on the case of ***Rex v Bateman 94 L.J.,K.B. 791*** in dealing with the duty of care that a medical person owes to a patient he undertakes to treat. Per ***Lord Hewart, C.J.***, at page 794:

> "The law as laid down in these cases may be summarised thus: If a person holds himself out as possessing special skill and knowledge and he is consulted, as possessing such skill and knowledge, by or on behalf of a patient, he owes a duty to the patient to use due caution in undertaking

> the treatment. If he accepts the responsibility and undertakes the treatment and the patient submits to his direction and treatment accordingly, he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment. It is for the judge to direct the jury what standard to apply and for the jury to say whether that standard has been reached. The jury should not exact the highest, or a very high, standard, nor should they be content with a very low standard. The law requires a fair and reasonable standard of care and competence."

[47.] The dicta of ***Davis J*** at paragraph 104 of the decision is apropos to the present circumstances. He stated:

> **104** However, it is with much regret that I find negligence on the part of Dr. Thompson in his post-operative care of the plaintiff, inasmuch as he has failed in his duty of care towards her in not trying hard enough to search for and to deal with the offending infection in a manner that was appropriate to deal with a situation which demanded urgent and aggressive treatment. I am not satisfied that he attained that fair and reasonable standard of care and competence stipulated by Lord Hewart in the Bateman case.

[48.] Having received the evidence advanced at trial, heard and observed the witnesses as they gave their testimony and given the matter careful consideration, I am satisfied that the management of Henfield's care fell below the standard expected in the circumstances. The urgent and aggressive treatment required of the physician in ***Reilly*** was no less demanded in this case but was conspicuously absent. I have no hesitation in indicating that I prefer the evidence of Drs Sands and Pescatore who were unwavering in their opinion that Carey ought to have acted earlier in ordering the CT scan which ultimately determined the severity of Henfield's injury. I find that Drs Butler and Carey were coloured by their personal knowledge of Carey and their respect for his medical skills. Whilst I accept that Carey is a good physician, on balance, I must find that his management of this patient on this occasion was less than the acceptable standard.

[49.] It would appear that Carey did not appreciate the severity of Henfield's condition and did not act reasonably and timelessly in resolving the obvious distress which she faced. I am persuaded in my decision by the following bits of evidence:

(1) Dr Sands' description of his first encounter with Henfield in post-operative day 3 is extremely telling:

"My first encounter with the patient was one of a patient in extremis [point of death], so ill that it was my opinion that she was at a risk of death, imminent death. So sick that her lungs, her kidneys, her liver, her neurological status had deteriorated to a point of near shutdown. And it was inconceivable to me that she could have been managed by a physician who did not recognize this as clear cut evidence of overwhelming sepsis."

Unlike, Dr Pescatore, Dr Baldwin Carey or Dr Butler, Drs Sands actually examined Henfield at the relevant time and had a real and true appreciation of her condition.

(2) Despite recognising that the patient's condition "*was not what he expected to be seeing*" on the morning of post-operative day 3 causing him to order the CT scan at 8 am, Carey makes no inquiry of the patient or her status, at all, up to 3:15 pm. The timeline during that period is as follows:

(i) the CT scan is ordered at 8 am

(ii) Henfield was taken for CT scan at 11:45 a.m., despite the 8 a.m. ordering of the CT scan,

(iii) Henfield was ordered to be admitted to the ICU at 12:45 p.m. by Dr. McCartney, upon her return from the scan,

(iv) at 3:15 p.m. Dr. Sands is attending to Henfield, diagnosis the septis and contacts Carey as Henfield is prepared for emergency surgery.

Henfield was obviously gravely ill (described as near death by Dr Sands) however the response of Carey was business as usual, he was content to maintain his routine of visiting her in the morning and the evening. The situation clearly begged for close attention and immediate action.

(3) Another physician, Dr McCartney, apparently determining the seriousness of Henfield's condition admits her to the ICU on her return from taking the CT scan. But for the concern of Henfield's sister, in causing Dr Sands to intervene, it is unlikely, in my view, based upon the evidence of Dr Sands, Henfield would

have survived. So absent was Dr Carey on post-operative day 3, he is contacted by Dr Sands who actually makes the diagnosis of septis. Thus, not only did Carey not diagnose Henfield's post-operative condition on post-operative day 1 or 2, he did not diagnose this condition at all.

(4) According to Dr. Sands, "*All of the signs were there from the first post-operative day and they were missed*"... "*the administration of Lopressor, Lasix, blood transfusion et cetera, were all inconsistent with the standard of care for critical care and inappropriate when applied by somebody who is not trained to manage such an ill patient*".

(5) The standard of care required by Carey with respect to his post-operative duty was to respond appropriately and in a timely manner. According to Dr Pescatore this required the defendant to have ordered the CT scan a whole "*24 hours earlier*" or simply not cancel the CT scan ordered on day one. Not cancelling the CT scan on post-operative day 1, when Henfield complained of chest pain and was experiencing the tachycardia, would have made it possible for an earlier diagnosis of sepsis on the part of Carey and thereby the avoidance of septic shock with cardiovascular collapse on the part of Henfield. I am also not satisfied that Carey provided an adequate explanation for why the CT scan was ordered on post-operative day 1 and then cancelled.

(6) Dr. Sands expressed similar but stronger criticism of the defendant's post-operative treatment of Henfield when he stated:

> *And so given all of these findings, it was clear to me that this was a missed bowel perforation that was not considered in the postoperative period* ***despite obvious clinical signs****. That there were diagnosis considered that were inconsistent with the findings. That appropriate consultation was not sought by experts who might have been able to assist both intraoperatively and postoperatively. And overall this resulted in catastrophic injury to Ms. Henfield. ...Hence my opinion that this constitutes malpractice.*

As Dr Sands noted, Carey ought to have been alive to the need to adequately consult with appropriate experts. On the evidence, this was a resource which was not appropriately utilized.

(7) Whilst Dr Pescatore stated that the patient did not meet typical criteria for sepsis until postoperative day # 3 he nonetheless was adamant that the CT Scan should have been ordered sooner as Henfield condition was clearly getting worse.

[50.] In all the circumstances I am satisfied that there was a breach of his duty of care by Carey in the management of the post-operative care of Henfield and that this breach caused damage to Henfield.

Conclusion

[51.] As this was a split trial, having found negligence, I order that the Registrar engage in an assessment of the damages sustained by Henfield as a result of the defendant's negligence. Henfield shall have her reasonable costs to be taxed if not agreed.

Dated this 2nd day of April 2019

Ian Winder
Justice