COMMONWEALTH OF THE BAHAMAS

IN THE SUPREME COURT

COMMON LAW AND EQUITY DIVISION

2012//CLE/gen/01679

BETWEEN

MARSHA STUART

Plaintiff

-and-

DR. RALEIGH BUTLER

Defendant

Before: The Honourable Madam Senior Justice Indra H. Charles

Appearances: Mrs. Yolanda Butler of Kingdom Advocates & Associates for the Plaintiff
Mrs. Gail Lockhart-Charles KC with Ms. Tracey Wells of Gail Lockhart-Charles & Co. for the Defendant

Hearing Dates: 16 May 2017, 17 May 2017, 18 May 2017, 28 August 2017, 24 April 2018, 14 December 2022, 4 January 2023

Negligence - Professional Negligence – Whether medical doctor was negligent - Duty of care owed to patient - Whether the Defendant met the standard of a reasonable doctor in the circumstances –Damages

The Defendant is a Gynaecologic Oncologist registered to practise his profession in this country. The Plaintiff, having been referred by another doctor to the Defendant, engaged his service for investigation of left abdominal pain. The Plaintiff asserts that she and the Defendant discussed an operative plan to remove her left ovary with a view to alleviating her pain. On 24 March 2010, the Plaintiff underwent an operative laparoscopy and the Defendant's contemporaneous notes/post-operative records reflected *"specimens removed (pathological diagnosis) (1) left tube and ovary (2) peritoneal washings"*. In fact, the Defendant removed the Plaintiff's right ovary and tube; not the left ovary and tube. He admitted that he made an error in the notes and stated that the notes written on 29 March 2010 are accurate. He also opined that there were compelling factors which caused him to remove the Plaintiff's right ovary. The surgical pathology report indicated that the right ovary was normal.

The Plaintiff brought an action in negligence against the Defendant alleging professional negligence and/or breach of duty of care and/or contributory negligence. The Plaintiff averred that

in both her pre-surgery care and operative laparoscopy, the Defendant's treatment and management of her fell below the standard of a reasonable doctor in the circumstances. As a result, she claimed special damages, general damages, interest and costs.

The Defendant denied negligence but admitted to the removal of the Plaintiff's right ovary. He admitted owing a duty of care to the Plaintiff but denied breaching that duty. He contended that, at all material times, his care of the Plaintiff met the standard of a reasonable doctor in the circumstances.

HELD: Finding that the Defendant's care, treatment and management of the Plaintiff fell below the standard of a reasonable doctor in the circumstances and, as such, he breached the duty of care which he owed to her, the Plaintiff is entitled to damages to be assessed by the Registrar and reasonable costs to be taxed if not agreed.

1. A doctor is not guilty of negligence if he acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. Putting it the other way round, a doctor is not negligent if he is acting in accordance with such a practice, merely because there is a body of opinion that holds a contrary view: **Bolam v Friern Hospital Committee** [1957] 2 All ER 118 applied.

2. A patient alleging negligence against a medical practitioner has to prove (1) that his mishap results from an error and (2) that the error is one that a reasonably skilled and careful practitioner would not have made. It is therefore crucial to establish how the mishap occurred and that he/she should have expert evidence that any error made was a negligent error: **Lashonda Poitier v The Medi Centre and another** [2019] 1 BHS J No 58, para. 98 and **Lendeisha Culmer-Hanna v Dr. Leslie W. Culmer & Anor.** Action No. 2013/CLE/gen/01365 (unreported) applied.

3. The Court does not have to accept even the unchallenged evidence and opinions of an expert if it does not align with the other expert evidence and opinions and the facts of the case. Whose evidence to accept or whose evidence to reject is entirely within the discretion of the trial judge: **Browne v Dunn** [1893] 6 R 67 H.L. distinguished. **Henfield v Dr. Anthony W.D. Carey** 2011/CLE/gen/01304, paras 20 to 22 relied upon.

4. The test for medical negligence is not whether there was a mistake in diagnosis. Whether it amounts to negligence is a question of whether the doctor acted as a reasonable and competent medical practitioner in the circumstances: **Whitehouse v Jordan** [1981] 1 All ER 287 applied.

JUDGMENT

Charles, Snr. J:

[1] The Plaintiff ("Ms. Stuart") was experiencing pain in the left side of her body. She was referred to the Defendant ("Dr. Butler") by another doctor after her pelvic scan revealed "*evidence of a well-defined left adnexal heterogeneously enhancing lesion measuring approx. 6x3x2.5 cm….It is probably ovarian in origin*. *There is also mild enhancing soft tissue fullness in the right iliac fossa adjacent to the bladder….*" Dr. Butler also recommended a scan with a high resolution endovaginal ultrasound of the pelvis. The results of the second scan were normal. However, the blood works came back showing values that were elevated. Ms. Stuart continued to complain of pelvic pain in her left side. Thereafter, she attended a consultation with Dr. Butler who advised her that she would be required to undergo surgery to remove her left ovary (disputed by Dr. Butler).

[2] On 24 March 2010, Dr. Butler performed an Operative Laparoscopy at Doctors Hospital. He removed Ms. Stuart's right ovary and tube. The surgical pathology report indicated that the right ovary was normal. After the surgery, Ms. Stuart continued to experience severe pain. Dr. Butler caused her to do another scan which revealed that her left ovary was intact and the right one had been removed. Although Dr. Butler's contemporaneous notes after the surgery recorded "*specimens (removed for pathological diagnosis) (1) Left tube and ovary (2) Peritoneal Washings",* he asserted that he made those notes late in the evening on the night of the surgery and, in error, wrote "*left*" instead of "*right*". He maintained that he was not negligent and asserted that there were compelling factors for him to remove Ms. Stuart's right ovary. Ms. Stuart alleged that the first time she knew that her right ovary was removed was on 17 March 2011 when she did a third scan.

[3] As a result, she instituted the present action against Dr. Butler claiming damages for professional negligence and/or breach of duty of care and/or contributory

negligence for what she alleged was the unauthorised removal of her right ovary which, according to her, was healthy and did not have to be removed.

[4] The matter took many years to get off the ground because of the absence of Ms. Stuart's medical reports from the United States. The trial then commenced in 2017 but was adjourned many times principally because of Ms. Stuart's ill health. It was only after the Court invited the parties for a status hearing in November 2022 that the trial resumed. By this time, Ms. Stuart had suffered many more medical complications including loss of sight in both her eyes. The matter came to an end on 4 January 2023. I reserved judgment.

[5] For reasons which will become clearer in the judgment, I found that Dr. Butler was negligent and he breached the duty of care which he owed to Ms. Stuart. His care, treatment and management of her fell below the standard of a reasonable doctor. Accordingly, Ms. Stuart is entitled to damages to be assessed by the Registrar. She is also entitled to reasonable costs to be taxed if not agreed.

Background facts

[6] Most of the background facts are agreed between the parties. To the extent that there is any departure from the agreed facts, then what is expressed must be taken as positive findings of facts made by me.

[7] At all material times, Dr. Butler is and was a Gynaecologic Oncologist with offices at Thompson Boulevard, Nassau, Bahamas. At all material times, Ms. Stuart became of a patient of Dr. Butler after being referred to him by Dr. Delton Farquharson ("Dr. Farquharson") in or about 2009.

[8] At all material times, Dr. Butler owed a duty of care to Ms. Stuart to provide sound medical advice and treatment to her and to exercise reasonable care and skill in the administration of such treatment.

[9] On or around 2005, Ms. Stuart was diagnosed as suffering from fibroids and underwent a hysterectomy. Some years later, Ms. Stuart began to experience pain

in her left side. She attended a consultation with Dr. Farquharson who referred her to Doctors Hospital for a pelvic scan ("the first scan"). The radiological report, dated 29 January 2010, records that "*there is evidence of a well-defined* left *adnexal heterogeneously enhancing lesion measuring approx. 6x3x2.5 cm …It is probably ovarian in origin".*

[10] Ms. Stuart continued to complain of pain to her left side. On or about 3 February 2010, she did a second scan, at the behest of, and after consultation with Dr. Butler.

[11] After the second scan, Dr. Butler saw Ms. Stuart again in February 2010. He examined her abdomen, performed an internal vaginal exam and checked her ovaries, blood work and two scans and advised her that she has to undergo an operative laparoscopy.

[12] Ms. Stuart underwent an operative laparoscopy on 24 March 2010. Dr. Butler's notes/post-operative record on the same day reflected under the sub-head: "*Specimens Removed (for pathological diagnosis):*

(1) Left tube and ovary

(2) Peritoneal washings."

[13] Further, in the same notes/post-operative record, under the sub-head: *Operation in Detail: (Include other significant events/complication(s) that may have occurred during surgery, wound closure and condition of the patient post op)*, "left" is written thrice in Dr. Butler's handwriting. These were the contemporaneous notes of Dr. Butler which he penned about 20-30 minutes after the surgery.

[14] Dr. Butler removed Ms. Stuart's right ovary and tube; not the left ovary and tube as she thought. The surgical pathology report dated 25 March 2010 revealed that sections of the right ovary shows *"**corpus luteum cyst** and multiple cystic follicles. There is no evidence of neoplasia. The fallopian tube shows intact mucosa and wall.*" A *corpus luteum cyst* is a completely normal cyst that forms on the ovary every single month in women of childbearing age.

[15] After the surgery, Ms. Stuart continued to experience pain. Dr. Butler referred her for a third scan which was performed at Fourth Terrace Diagnostic Centre on 17 March 2011. That scan revealed that Ms. Stuart's left ovary was intact and the right one had been removed. This was the first time that Ms. Stuart became aware of this. She was in utter shock, disbelief, pain and disgust.

[16] Dr. Butler has refused to accept liability for the removal of Ms. Stuart s healthy right ovary and tube. He admitted that his contemporaneous notes after the surgery record that he removed the left ovary and tube but he explained that he made those notes late in the evening on the night of the surgery and, in error, he wrote "*left*" instead of "*right*". That error *"left*" can be found at least three times in the notes. Nevertheless, he asserted that there were compelling factors for him to remove the right ovary instead of the left; chief among them, if I understood him well, is the lethality of ovarian cancer which spreads rapidly and can result in death within 3-5 years. It is also difficult to diagnose. Nearly 13 years later, Ms. Stuart is still around as she was in Court in November last year (when I invited the parties for a status report).

[17] Dr. Butler denied any negligence, breach of duty, breach of contract, fault, inadequate treatment, loss or damage to Ms. Stuart who contended that Dr. Butler:

1. removed the right ovary without her consent;
2. removed the right ovary when it was healthy and did not need to be removed;
3. removed the right ovary instead of the left ovary, contrary to all clinical indications that the right ovary did not have to be removed;
4. failed to advise Ms. Stuart of the removal of the right ovary;
5. failed to obtain Ms. Stuart's consent to the removal of her right ovary;
6. failed to advise of other methods/options to treat her left ovarian cysts by non-surgical means in preference to performing an operative laparoscopy;
7. failed to take or exercise reasonable care and skill;
8. did not exercise the standard duty of care and; and
9. failed in his duty towards her which caused her damage, loss and injury.

The issues

[18] The parties identified 29 issues. In my opinion, two broad issues arise for determination namely:

1. Did Dr. Butler breach the duty which he owed to Ms. Stuart? Put differently, was Dr. Butler negligent in the performance of his duties and;

2. Whether the informed consent of Ms. Stuart was necessary for the surgical procedure which Dr. Butler performed?

The evidence

[19] Ms. Stuart gave evidence and called her daughter, Sheria Wemyss. Dr. Nathan Hirsch of Florida, USA gave expert testimony on her behalf. Dr. Butler testified on his own behalf and called Dr. Farquharson and Dr. Samar Nahas as his expert witnesses. As there are many conflicts in the evidence of Ms. Stuart and Dr. Butler as well as the opinions of their respective experts (credibility being at the heart of the dispute), I shall set out the evidence of the main witnesses in some detail.

Marsha Stuart

[20] Ms. Stuart filed a witness statement on 19 September 2016 which stood as her evidence in chief. She is the head chef at the Cove and had been employed with Kerzner International for over 21 years. She stated that sometime around 2005, she developed fibroids and underwent a hysterectomy. That surgery was conducted by Dr. Baldwin Carey. Whilst under the care of Dr. Carey, he referred her to Dr. Farquharson after she began experiencing digestive problems. After consultation with Dr. Farquharson, he diagnosed her as having gall bladder stones and subsequently, she had her gall bladder removed. On or about 2009, Ms. Stuart stated that she began to experience sharp pains in her left side. She went to Dr. Farquharson. He referred her to Doctors Hospital to have a pelvic scan (the first scan). She said that Dr. Farquharson advised her that the scan revealed that she had cysts in her left ovary.

[21] Dr. Farquharson then referred her to Dr. Butler in late 2009 or early 2010. She told Dr. Butler that she was having pain in her left side. He did some physical examinations. He also performed an internal vaginal exam and checked both her ovaries. She stated that, after reviewing the pelvic scan results, Dr. Butler advised her that surgery would be required to remove her left ovary to relieve the symptoms. She was afraid to have surgery but she took his advice. The surgery was scheduled for 24 March 2010. It was performed by Dr. Butler. She remained at Doctors Hospital for about 3 to 5 days. After her discharge, she continued to experience pain in her left side. A week later, she went for a follow-up visit. Dr. Butler removed the bandages which was across her abdomen. She told him that she was in considerable pain. He gave her pain killers.

[22] Ms. Stuart stated that she went to Dr. Butler's office shortly after for a second visit. She told him that she felt like her left ovary was still there. Dr. Butler dismissed her concerns and prescribed stronger pain killer.

[23] She continued to experience pain but was unable to see Dr. Butler because he was ill. Finally, on or about 16 March 2011, she obtained an appointment. She advised him that she still had excruciating pain in her left side and, despite the surgery, the pain has persisted. She claimed that Dr. Butler asked her "*didn't we remove the left ovary*?"

[24] Ms. Stuart said that Dr. Butler requested her to do another scan which was done the following day at Fourth Terrace Diagnostic Centre. The laboratory personnel advised her that her left ovary was still intact and the right ovary was not there. She immediately contacted Dr. Butler's office and advised the receptionist of the laboratory's findings. She stated that, upon further inquiries, Dr. Butler stated that her right ovary had been removed since it was in a worse condition than the left one. She said that she was not informed of this at the hospital or on any subsequent visits. Ms. Stuart stated that she was in utter shock, disbelief, pain and disgust and, at all material times, it was always discussed, known and agreed that the left not the right ovary would be removed. Ms. Stuart stated that the pain

continues up to today and, in her opinion, Dr. Butler made a terrible error and has been negligent in the performance of his duties towards her.

[25] Under cross-examination, Ms. Stuart maintained her account. She repeated on multiple occasions during cross-examination that the agreement was for Dr. Butler to remove her left ovary and there was no discussion about her right ovary. She said that she was not sure whether Dr. Farquharson assisted in the surgery. She was unaware that Dr. Butler discussed with Dr. Farquharson that it would be best to remove her right ovary and they both agreed.

[26] She acknowledged that she signed the consent form but stated that she consented to the removal of her left ovary. It was suggested to her that Dr. Butler acted in her best interest when he removed her right ovary. Ms. Stuart stated that it was not discussed with her and said: "*It was a matter of life and death?*" (Transcript of Proceedings dated 16 May 2017 at page 14 line 14). She also stated that Dr. Butler never discussed ovarian cancer with her.

[27] During further cross-examination, Counsel for Mr. Butler, Mrs. Lockhart-Charles KC questioned Ms. Stuart about the error made in her documents by Dr. Butler: (see page 20 lines 17- 27 of the Transcript of Proceedings dated 16 May 2017):

> Q: So, Ms. Stuart, I put it to you that you have not suffered the damage that you alleged in your statement of claim. <u>That the only error that Dr. Butler made was to incorrectly note left ovary in one of your documents when in fact the right ovary was removed</u>?
>
> A: Say that again.
>
> Q: <u>The only error that Dr. Butler made was to incorrectly note left ovary in one of your documents when in fact the right ovary that was taken out</u>?

A: No ma'am, <u>the only error he made was taking how the (sic) my right ovary</u>."

[28] It was further suggested that the most compelling clinical indication was Dr. Butler and Dr. Farquharson's observations in the surgery. Ms. Stuart retorted "*That could be, but I never had pain on my right side.*"

Dr. Raleigh Butler

[29] Dr. Butler signed a witness statement on 25 January 2017 which was filed the following day. It stood as his evidence in chief.

[30] He is a Gynaecologic Oncologist. He acknowledged that Dr. Farquharson referred Ms. Stuart to him in or around February 2010. He requested that Ms. Stuart undergo blood work and a further pelvic scan. He was aware of the findings of the first pelvic scan which was done in 2009. He said that the results of the second scan were normal. However, Ms. Stuart's blood tests came back showing values that were elevated and she continued to complain of persistent pain. Further investigation was therefore required.

[31] Dr. Butler asserted that, on 10 February 2010, he discussed Ms. Stuart's results in detail and advised her that because the pain continued to persist, the fact that the scans did not confirm the obvious cause of the persistent pain and she had a borderline elevation of her tumor marker for the possibility of ovarian cancer or tubo ovarian abscess, that she should consider undergoing a laparoscopy as this procedure may give the answer as to why the pain continues to persist. He stated that, during the course of the discussion, he took time to illustrate the procedure and generally informed her. He also wrote to Dr. Farquharson on 5 March 2010 and advised him that he would organise a laparoscopy because Ms. Stuart continues to experience pelvic pain.

[32] Dr. Butler said that the laparoscopic procedure that he performed was intended to investigate and determine the cause of Ms. Stuart's persistent pain and to determine what treatment ought to be pursued to resolve the problem.

[33] He further stated that, prior to the surgery, he again discussed with Ms. Stuart the findings and possible causes of her symptoms of persistent pain and the purpose of the intended surgery.

[34] Dr. Butler asserted that the consent form which was signed by Ms. Stuart confirmed the nature of the surgery and also she consented to such other procedures which he may deem necessary in the exercise of his professional judgment based on conditions observed during the course of the surgery. He said that due to Ms. Stuart's complex history, he requested that Dr. Farquharson, who is a general and vascular surgeon, assist him in the surgery.

[35] Dr. Butler said that during the surgery he conducted a comprehensive examination of the left ovary and determined that it was grossly normal and no intervention was called for. The right ovary, however, was tethered by dense adhesions and had a firm calcified mass. He discussed the appearance of the right ovary with Dr. Farquharson who also observed that there was evidence of pathology on the right ovary. After the discussion, they both agreed that it would be best to remove Ms. Stuart's right ovary. He listed a plethora of reasons which, according to him, supported his decision namely:

a. Ms. Stuart had a history of a prior CT scan suggestive of abnormality on the right side;
b. She had a history of persistent pain and elevated blood results;
c. Intra-operatively, the right ovary appeared suspicious and unhealthy;
d. Intra-operative findings revealed the right ovary to have a dense mass;
e. Removal of the suspicious right ovary could save the patient from possible ovarian cancer, which is a condition that it almost 100% lethal;
f. Ovarian cancer usually results in death within 3-5 years and it is difficult to diagnose;
g. Removal of the right ovary permits definitive and absolute determination of the presence or absence of malignancy and;
h. Removal of one ovary has negligible impact on a female with two ovaries intact, this negligible impact when weighed against the benefit of ruling out

and possibly eliminating ovarian cancer made removal of the right ovary, in the circumstances, the reasonable and prudent course to pursue.

[36] He acknowledged that the right ovary was sent to pathology for analysis. The final diagnosis was that there was a corpus luteum cyst.

[37] Dr. Butler maintained that although his notes in Ms. Stuart's medical records on the night of the laparoscopic procedure state "*specimens (removed for pathological diagnosis) (1) left tube and ovary (2) peritoneal washings",* that was an error because he made the notes late in the evening. According to him, the specimens that were removed were in fact correctly identified in his communications with the Doctors Hospital Department of Pathology as being the right ovary and tube.

[38] Dr. Butler stated that, following the laparoscopic surgery, Ms. Stuart attended follow-up visits at his clinic and, in March 2011, he recommended that she should have another pelvic scan since she was still complaining of pelvic pain.

[39] He stated that the third scan was consistent with the explanation that he gave to her on the night of the surgery and it was also consistent with the surgical pathology report dated 29 March 2010 which states that the specimens submitted post-surgery were identified as the right tube and ovary. According to him, it is therefore to be expected that the third scan would reflect that the left ovary remained intact.

[40] Under cross-examination, Dr. Butler accepted that when Ms. Stuart presented herself, she had pain in her left side and she placed her trust in him. He also accepted that, as his patient, he owed her a duty of care.

[41] Dr. Butler disagreed that Ms. Stuart was never informed of the results of the scan which he ordered her to do on 2 March 2010.

[42] It was suggested to Dr. Butler that the discussions he had with Ms. Stuart, even on the day of the surgery, was in regard to the left ovary. He stated that the major discussion was with respect to the left ovary but that was not the only discussion.

[43] Dr. Butler was taken to his handwritten notes which he penned about 20-30 minutes after the surgery. He wrote:

> Under **Pre-operative Diagnosis & Indications:**
>
> "1. Complex **left** adnexal mass and;
> 2. An elevated CA-125 (which is a tumour marking for potential ovarian malignancy;
>
> Under **Procedure:**
> 1. EAU (Examination under anaesthesia). Operative laparoscopy and;
> 2. Retroperitoneal … and excavation of a retroperitoneum mass.
>
> Under **Postoperative Diagnosis**
> 1. Complex adnexal mass 9-10 cm;
> 2. **Left** retroperitoneal mass.
>
> Estimated blood loss was 200 mls.
>
> Under **Specimens removed: (for pathological diagnosis)**
> 1. **Left** tube and ovary
> 2. Peritoneal Washings
>
> Under **Operation in detail: (include other significant events/complication (s) that may have occurred during surgery, wound closure and condition of the patient post op:**
> EUA and operative laparoscopy;
> **Left** tube and ovary, Washings"

[44] Dr. Butler was shown the consent form. He stated that Ms. Stuart consented for a laparoscopy. He was asked whether, after he saw the calcified mass, he could have perform a biopsy, terminate the surgery, further consult with Ms. Stuart and have another surgery once the results showed that the right ovary was cancerous. He said that there is always a possibility and another laparoscopy could have been scheduled that same night if you wish. He however added that the pathology report would be crucial and, on average, from Doctors Hospital, it could take 3 to 4 weeks.

He agreed that, by April, he would have been able to say to Ms. Stuart that the right ovary is cancerous and remove it.

[45] It was suggested to Dr. Butler that his assertion about the lethality of ovarian cancer which usually results in death within 3-5 years would not have surfaced since the surgery could have been done in 30 days. He explained that there is another part of this equation: if you delay and miss an ovarian cancer and it goes beyond 3 to 4 weeks, the prognosis can go from stage 1 to a stage 3 and 4 which equals death.

[46] It was suggested that he was reckless in removing a healthy ovary and he answered negatively.

[47] Under re-examination, he was asked why did he not remove the left ovary and Dr. Butler said that "*it looked grossly normal*." He insisted that it was not a mistake to remove Ms. Stuart's right ovary.

Expert medical evidence

Dr. Nathan Bruce Hirsch

[48] Both parties called their own expert witness. In fact, Dr. Butler called two expert witnesses, Dr. Farquharson who stated that he was in the operating room and Dr. Nahas who swore a witness statement and presented what appeared to be an expert report. Her evidence was stipulated.

[49] Ms. Stuart called Dr. Hirsch, a medical doctor specializing in Obstetrics and Gynaecology with a degree from Jefferson Medical College, Philadelphia. He has been an obstetrician gynaecologist for close to 49 years in Florida. He is the Senior Partner in an eight person obstetrical and gynaecological group that does gynaecology. He was deemed an expert in obstetrics and gynaecology. He relied on his witness statement which was filed on 25 January 2017.

[50] In paragraph 11 of his witness statement, he stated that he reviewed the documents pertaining to Ms. Stuart and the second scan (ultrasound) which was

performed on her at Doctors Hospital which revealed that "*both ovaries are well seen and normal in size. There is a 2 cms follicular cyst in the right ovary, smaller follicles are seen otherwise. Normal color Doppler flow is seen in the ovaries. No obvious adnexal mass noted on abdominal or transvaginal approach. The previous described CT finding of left adnexal cystic lesion could be a follicular cyst or a post op seroma. Minimal free fluid is seen in the pelvis. And the impression: no significant ovarian or adnexal pathology detected in the present USG study clinical and lab correlation is recommended*."

[51] Dr. Hirsch stated that the second scan did not show any abnormal findings and no description of this left adnexal mass previously described in the first scan. As a physician, this could mean that the mass "*left adnexal heterogeneous enhancing lesion measuring 6x3x2x.5 cm"* has resolved on its own which many ovarian cysts sometimes do or it was missed on the ultrasound. According to him, if Ms. Stuart continued to complain of pain then despite the normal findings of the second scan (ultrasound)(surgery)(exploratory) could still be considered. According to him, although all you may find is some adhesive disease and scarring which is secondary to having had surgery before (the hysterectomy).

[52] Dr. Hirsch explained that, at this point before surgery, proper counselling is necessary to explain the imaging findings. A physician would explain the possibility that there may be no mass and both ovaries might appear normal. At this point proper consent would explain the limits of what the surgeon is prepared to do exploratory/operative laparotomy, removal of left adnexal mass possible cystectomy/possible oophorectomy. The operating physician would also explain the risks of the surgery which may include damage to bowel and bladder and any surrounding organs which may deem it necessary to have another surgeon present and a bowel repair or even colostomy performed. Blood loss more than expected could mean the need for a lifesaving transfusion. Or even damage to the opposite ovary or its blood supply deeming it necessary to remove one or both ovaries.

[53] He emphasised that a proper consent form describes the risk and benefits and, to the best of his knowledge, information and belief, Dr. Butler failed to advise Ms. Stuart of the risk of impending surgery.

[54] Dr. Hirsch insisted that Dr. Butler failed to adhere to a number of medical protocol procedures. Firstly, either the surgical pathology report gave a different ovary and tube or the operative report of Dr. Butler was inaccurate in describing which ovary or tube was removed. Dr. Butler also failed to give more detailed operative reports of Ms. Stuart's surgery. He said that, as a result of Dr. Butler's negligence in failing to remove the specified left ovary, Ms. Stuart continued to experience extreme pain on her left side.

[55] Dr. Hirsch opined that Dr. Butler was negligent in the execution of his duties.

[56] Under cross-examination, Dr. Hirsch stated that he practices basic oncology and they treat patients with cervical cancer and early ovarian cancer. They do it laparoscopically and robotically. They also treat ovarian cyst and ovarian pathology on a weekly basis. However, he is not trained as a gynaecological oncologist.

[57] Dr. Hirsch was asked the hypothetical question that if you have a patient during a laparoscopy and you suspect ovarian cancer how do you diagnose whether there is ovarian cancer or not, how do you rule that out, or how do you obtain a definitive diagnosis? Dr. Hirsch stated that "*If you suspect ovarian cancer, and you observe something in the abdomen that looks like cancer you do not biopsy, you excise it*."

Dr. Delton Farquharson

[58] Dr. Butler called Dr. Farquharson as one of his expert witnesses. Dr. Farquharson filed a witness statement on 8 February 2017 and a supplemental witness statement (as ordered by the Court) on 14 December 2022. They stood as his evidence in chief. He is a consultant general and vascular surgeon at Bahamas Surgical Associates Centre. He is well qualified and has many years of experience. He was deemed an expert.

[59] Dr. Farquharson previously treated Ms. Stuart in 2009 for gall bladder disease and complaints of pelvic pain. To determine the cause of her pain, he ordered a computerized tomography scan (the first scan) of her abdomen and pelvis. The scan revealed a complex left adnexal mass. Following the results of the scan, he referred Ms. Stuart to Dr. Butler, a Gynaecologic Oncologist, for further investigation and treatment for pelvic pain, as necessary.

[60] Dr. Farquharson asserted that, in March 2010, he received a request from Dr. Butler to assist with the surgical management of Ms. Stuart during a laparoscopic surgical procedure to investigate her pelvic pain. He further asserted that, at the time of the procedure, he observed that there was no pathology noted on the left adnexal. However, a cystic mass was on the right ovary.

[61] He corroborated Dr. Butler's evidence that, in the surgery room, they held discussions and decided that it was in the best interest to remove Ms. Stuart's right ovary since there was evidence of pathology there. As a result of this decision, a right salpingo-oophorectomy was completed on 24 March 2010. A histopathology confirmed a benign disease.

[62] In his supplemental witness statement, he spoke to the frozen procedure that Dr. Hirsch referred to when he was being further cross-examined by Mrs. Lockhart-Charles. It is a procedure whereby a pathologist processes a specimen while the patient is still under anaesthesia. It requires the pathologist to be readily available to perform the evaluation of the specimen while the patient is still asleep. He stated that such a procedure was not readily available at Doctors Hospital in 2010.

[63] Under cross-examination, Dr. Farquharson stated that he had never seen the second scan which Dr. Butler ordered about a month before the surgery. He understood that scan to say that, from the radiologist's impression, there was no ovarian pathology based on this study. Specifically, the radiologist spoke of the first scan (which he ordered) of the left adnexal cystic legion which could be a follicular cyst or post-op seroma.

[64] He said that his involvement in the surgery was to assist Dr. Butler in taking out an ovarian cyst. As far as he knew, based on the first scan, it was on the complex left side. His presence with Dr. Butler was to ensure that there was no bowel injury and there was no bleeding (being a vascular surgeon).

[65] Dr. Farquharson stated that, based on what he saw, he could not put it in the category of life and death. What he saw could have been postponed but, as he said, like all good clinicians when you make a judgment call you have a cyst that you cannot distinguish whether it is benign or malignant, you have no knowledge and since Ms. Stuart had an elevated CA125 which is a tumour marker and an elevated tumour marker in the presence of a cyst, is cancer until proven otherwise. Very seldom you get a second chance to do a definitive procedure but he agreed it was not life and death.

[66] With respect to paragraph 6 of the consent form, Dr. Farquharson interpreted it in this manner (see page 24, lines 10-22 of the Transcript of Proceedings dated 18 May 2017):

> "Q: I suggest to you that when Marsha Stuart gives this consent she's not giving you consent for something to be done that could be postponed, she's given (sic) it for life and death.
>
> A: I would not agree with you because in the case of surgical procedures, the definitive test that she would have gotten would have been histology and so, that is not life or death, but that could determine how long her mortality, how long she lives.
>
> Q: But it still could have been postponed?
>
> A: Yeah, it have (sic) been delayed, but she gave us permission to do and as a part of that is a diagnostic test."

[67] Dr. Farquharson stated that, after the surgery, they saw Ms. Stuart but he did not tell her that her right ovary was removed. He was surprised that the contemporaneous notes penned by Dr. Butler on 24 March 2010, recorded that Ms. Stuart's left tube and ovary were removed. He said that when he left the surgery he knew that Ms. Stuart's right ovary was removed.

[68] Under further cross-examination, Dr. Farquharson stated that frozen section requires arrangement.

Dr. Samar Nahas

[69] Dr. Nahas filed a witness statement on 8 February 2017 which stood as her evidence in chief. She was the second expert witness for Dr. Butler. As the doctor lives and practises in California, USA, there were some impractical logistics for her to attend, even by zoom, at the court's convenience. At the end of the day, Mrs. Rolle determined that she would not cross-examine her.

[70] Dr. Nahas is a Gynaecologic Oncologist certified by the American College of Obstetrics and Gynaecology, the Royal College of Physician and Surgeons, Canada, the Society of Gynaecologic Oncology and the American Associations of Gynaecologic Laparoscopists. Like the other experts, she is highly qualified and an expert in her field.

[71] Dr. Nahas exhibited to her witness statement, the reasons why, in her opinion, Dr. Butler acted within the standard of care. I shall highlight them when I deal with this issue later on in the Judgment.

[72] Much was said of the fact that Dr. Nahas' evidence was unchallenged and therefore, the Court must accept it. Mrs. Lockhart-Charles argued that, in accordance with the rule in **Browne v Dunn** [1893] 6 R 67 H.L., having elected not to cross-examine Dr. Nahas, Ms. Stuart is barred from seeking to contradict anything that is contained in Dr. Nahas' witness statement and exhibit and the Court should accept her evidence in its entirety.

[73] The rule in **Browne v Dunn** is a very old rule. It is one of the most important rule of evidence when it comes to cross-examination. The rule establishes that when a witness is giving evidence and you intend to call evidence that contradicts what that witness says, you must put the substance of that contradictory evidence to the witness during cross-examination and give him/her an opportunity to comment on it.

[74] The rule is however not applicable here as Dr. Nahas, in giving expert testimony, is entitled to give opinions. As I understand the law, if an expert's evidence and opinions are not challenged, the court is still not bound to accept it as true and accurate. The Court has a discretion to determine what expert evidence and opinion(s) it chooses to accept or reject even if it is unchallenged.

[75] In general, the Court will consider various factors when assessing the reliability of expert evidence including the qualifications and experience of the expert, the methodology used, the evidence upon which the expert has relied and any limitations of uncertainties associated with the expert's opinion.

[76] In **Henfield v Dr. Anthony W.D. Carey** (2011/CLE/gen/01334), Winder J, at paras 20 to 22 gave guidance on expert evidence and the manner in which courts treat the evidence of those witnesses which I gratefully adopt.

Factual findings

[77] This is a civil case wherein the burden of proof is on a balance of probabilities. It is not in dispute that Ms. Stuart's evidence as to which took place before and after the laparoscopic procedure is diametrically opposed to that of Dr. Butler. Undeniably, the issue of credibility of these two witnesses is of focal importance together with an analysis of the expert evidence including their creditability. Having had the opportunity of seeing, hearing and observing the demeanour of the witnesses who testified before me. I found the evidence adduced by Ms. Stuart to be more plausible and persuasive than the evidence of Dr. Butler.

[78] Ms. Stuart struck me as a sincere witness. I accepted her account of what was related to her by Dr. Butler before going into surgery. According to her, she was under the distinct belief that the pain which she was experiencing in her left side was related to her left, not right, ovary. She underwent surgery thinking that her left ovary would have been removed. It came as a shock when she discovered, after a third scan and after still experiencing pain, that her left ovary was intact and the right ovary (by all account, normal) was removed.

[79] There is no doubt in my mind that Dr. Butler is an outstanding Gynaecologic Oncologist but, unfortunately, he removed the wrong ovary. This was not an error of judgment but was of such a nature that no reasonably well-informed and competent gynaecologic oncologist could have made. I find that the notes/post-operative record dated 24 March 2010 which was penned in Dr. Butler's handwriting about 20-30 minutes after the surgery accurately captured what he did on the day in question namely the removal of Ms. Stuart left ovary and tube.

[80] Then, when he caught himself, he prepared another report a few days after which stated that the specimens submitted post-surgery were identified as the right tube and ovary.

[81] Now to the evidence and opinions of the experts. The English House of Lords decided in **Whitehouse v Jordan** [1981] 1 WLR 246 that an error of judgment will amount to medical negligence only if such error would not have been made by a reasonably competent medical practitioner with the standard and the type of skill concerned, acting with ordinary care.

[82] In this case, the expert witnesses did not come to the same conclusion on whether Dr. Butler's actions met the acceptable standards. In this regard, I am guided by the dicta of Bingham LJ in **Eckersley v Binnie** [1988] 18 Con LR 1. See also **Deonarine v Ramlal** [2007] T & T CA, per Mendoca JA at paras 30-41. Bingham LJ in **Eckersley** at p. 77 said:

> **"<u>In resolving conflicts of expert evidence, the judge remains the judge; he is not obliged to accept evidence simply because it comes</u>**

> **<u>from an illustrious source: he can take account of demonstrated partisanship and lack of objectivity</u>. But, save where an expert is guilty of deliberate attempt to mislead (as happened only very rarely), a coherent reasoned opinion expressed by a suitable qualified expert should be the subject of a coherent reasoned rebuttal, unless it can be discounted for other good reason."**[Emphasis added]

[83] While Dr. Farquharson is a highly qualified doctor, he had never seen the second scan which Dr. Butler ordered about a month before the surgery. The result of that scan might have provided vital background information to Dr. Farquharson because it was a more recent scan. In addition, his involvement in the surgery was to assist Dr. Butler in taking out an ovarian cyst. As far as he knew based on the first scan which he ordered, it was on the complex left side. His presence with Dr. Butler was to ensure that there was no bowel injury and there was no bleeding.

[84] He also stated that, based on what he saw, he could not classify her surgery in the category of life and death. What he saw could have been postponed but, as he stated, like all good clinicians when you make a judgment call, you have a cyst that you cannot distinguish whether it is benign or malignant, you have no knowledge and since Ms. Stuart had an elevated CA125 which is a tumour marker and an elevated tumour marker in the presence of a cyst is cancer until proven otherwise. Very seldom you get a second chance to do a definitive procedure but he agreed it was not life and death. I accept Dr. Farquharson's evidence and, if indeed he was present in the surgery room (Ms. Stuart did not recall seeing him), he too made a bad judgment call in concurring with Dr. Butler to remove an ovary which was normal and not life-threatening.

[85] With respect to Dr. Nahas, she stated that *she usually consent her patients for a unilateral Salpingo- oophorectomy without giving the exact location because very often, it is wrong*. In my opinion, this is difficult to digest.

[86] She further stated that "*in view of the difficulty of her surgery and excessive BMI and the amount of adhesions, Dr. Butler elected to remove her right tube and ovary that looked abnormal from all the inflammation and adhesion which makes it very difficult to differentiate between a benign against a malignant pathology and it was*

deemed necessary to remove the right ovary at that point which was a very reasonable judgment as the gynaecologic oncologist in that scenario. *She said that the pathology came back benign which is great news for the patient and she still has a functional left ovary which will give her all the needed hormonal support. The surgery did not have any negative impact on her*. This is also difficult to digest.

[87] Dr. Nahas stated that *mislabeling the specimen has a very minimal or no impact on the patient's outcome or prognosis*. *Only one ovary was removed as per the patient's consent and her outcome is the same*. This is an odd statement coming from a doctor.

[88] Dr. Nahas did not refer at all to the two scans which predated the surgery and she appeared to be speaking generally and not with respect to Ms. Stuart. She stated that one ovary was removed in accordance with Ms. Stuart's consent. In my considered opinion, Dr. Nahas failed to comprehend that Dr. Butler removed a perfectly normal ovary. She also failed to comprehend that Ms. Stuart still has excruciating pain and is afraid to undergo another surgery because the wrong ovary - a healthy ovary - was removed. All in all, I reject Dr. Nahas' evidence and opinions. On a balance of probabilities, I preferred the evidence of Dr. Hirsch to that of Dr. Butler and Dr. Nahas. With respect to Dr. Farquharson, I found his expert testimony to be reliable except for the bad judgment call to remove the right ovary and his interpretation of the consent form which I shall come to momentarily.

[89] In my judgment, Dr. Butler negligently removed the wrong ovary.

The law

[90] In the tort of negligence, liability is based on the conduct of the defendant and has three elements or requirements namely:

1. The existence of a duty of care situation (i.e. one which the law attaches liability to carelessness). There has to be a recognition by law that the careless infliction of the kind of damage complained of on the class of person to which the plaintiff belongs by the class of person to which the

defendant belongs is actionable;

2. *Breach of the duty of care by the defendant, i.e. he failed to measure up to the standard set by law*; and

3. A casual connection between the defendant's careless conduct and the damage.

Existence of a duty of care

[91] In general, a duty of care will be owed wherever in the circumstances it is foreseeable that if the defendant does not exercise due care the plaintiff will be harmed: see **Clerk & Lindsell on Torts (9th Ed)**, at paras. 8:05 et seq. It is the law that a physician "…owes a duty of care to the patient to use diligence, care, knowledge and skill in administering the treatment. No contractual relationship is necessary, nor is it necessary that the service be rendered for reward. The law requires a fair and reasonable standard of care and competence." In **Cephas Marshall v F.H.H. Emergency Medical Associates et al**, Suit No. 1023/2002 [unreported], Cornelius J said:

> **"By the very existence of doctor and patient relationship, a medical doctor has a duty to use reasonable care and skill in examination, diagnosis and treatment of his patient."**

[92] Having extrapolated the applicable legal principles, Mrs. Lockhart-Charles KC acknowledged that Dr. Butler owed a duty of care to Ms. Stuart.

Breach of duty of care/ professional negligence

[93] There is no dispute as to the applicable law. In **Lendeisha Culmer-Hanna v Dr. Leslie W. Culmer and ACL Medical Office Center** 2013/CLE/gen/01365 (Bahamas Judiciary website (2023 Judgments), this Court dealt with this very issue of breach of duty of care/professional negligence. At paras [90] to [92] of the Judgment, I quoted as follows:

> **"[90] Negligence, as defined by Anderson B. is in ordinary or general language but the standard required by law with respect**

to medical doctors, has developed over the century. There is now a myriad of cases which set out the test that the Court must apply in determining whether a medical practitioner breached his duty of care and was negligent. The *locus classicus* is Bolam v Friern Hospital Management Committee [1957] 2 All E.R. 118. At pages 121-122. McNair J laid down the following test:

> **"The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art…. A doctor is not guilty of negligence if he acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. Putting it the other way round, a doctor is not negligent if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view." [Emphasis added]**

[91] The Bolam test was further explained in light of the role of expert opinions in Bolitho v City and Hackney Authority [1997] 3 WLR 1151. Lord Browne-Wilkinson explained that negligence is for the Court to determine. In making that determination, the Court must be satisfied that the medical opinion relied on is sufficiently logical. At page 1159, Lord Browne-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 recognized 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 <u>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.</u>"**[Emphasis added]

[91] In *Lashonda Poitier v The Medi Centre and another* [2019] 1 BHS J No 58, this Court explained what a plaintiff patient is required to prove in order to establish negligence. At para 113, I stated:

> **113 Having accepted that Dr. Basden owed a duty of care to Ms. Poitier, the next part of the negligence equation is the standard of care appropriate or required in the particular situation. At para. 8:50 in Clerk & Lindsell (17th ed), the learned authors put it this way:**
>
> > **"<u>A patient alleging negligence against a medical practitioner has … to prove (1) that his mishap results from error and (2) that the error is one that a reasonably skilled and careful practitioner would not have made. It is therefore crucial to establish how the mishap occurred and that he should have expert evidence that any error made was a negligent error</u>."**

[94] Simply put, it is settled law that a doctor is not guilty of negligence if he acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. Putting it the other way round, a doctor is not negligent if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view.

Discussion, analysis and findings

Issue 1: Did Dr. Butler breach the duty of care which he owed to Ms. Stuart?

[95] As Mrs. Lockhart-Charles correctly alluded to, Ms. Stuart bears the burden to prove her allegation that Dr. Butler was negligent in his care and treatment of her. She must present plausible evidence that the treatment or action/inaction of Dr. Butler fell below the standard of care of an ordinary competent gynaecologic oncologist (which he held out to be) in the same circumstances and that his negligence caused her damage. In **Halsbury's Laws of England, 4th edn re-issue,** Vol. 30 para 35, the learned authors stated:

> **"A person who holds himself out … ready to give medical advice or treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Whether or not he is a registered medical practitioner, such a person who is consulted by a patient owes him certain duties, namely a duty of care in deciding what treatment to give, and a duty of care in his administration of that treatment."**

[96] Dr. Butler, having acknowledged that he owed a duty of care to Ms. Stuart, the next part of the negligence equation is the standard of care appropriate or required in the particular situation. At para 8:50 in **Clerk & Lindsell on Torts (17th ed)**, the learned authors stated:

> **"A patient alleging negligence against a medical practitioner has … to prove (1) that his mishap results from error and (2) that the error is one that a reasonably skilled and careful practitioner would not have made. It is therefore crucial to establish how the mishap occurred and that he should have expert evidence that any error made was a negligent error."**

[97] Also, at para 3:130 of the treatise, **Medical Negligence** by Michael Jones, the learned author pointed out that:

> **"Medical evidence is invariably a vital element in an action for medical negligence, but the importance attached to expert opinion should not obscure the underlying basis for a finding that the defendant has been negligent, or not (as the case may be). This is that, in the light of the expert evidence, the defendant has taken an unjustified risk….In other words, expert opinion about the defendant's conduct (whether favourable or unfavourable) should itself be measured against the general principles applied to the question of breach of duty."**

[98] In attempting to discharge this burden, Ms. Stuart testified and brought her expert, Dr. Hirsch. Her case is that she relied solely on the expertise of Dr. Butler to disclose and or explain to her all of the risks, alternatives, real possibilities and/or dangers inherent in the operation which he had proposed and advised her to accept. She also relied on him to perform only the procedure he had in fact discussed with her (which was to remove her left ovary) and to which she ostensibly consented to and nothing more.

[99] Dr. Butler insisted that he did not say to Ms. Stuart that the surgery being performed was for the removal of her left ovary (or any ovary). He maintained that the purpose of the surgery was to investigate the causes of the persistent pain and it was understood that he had the authority to perform such procedures (including ovary removal) as he might deem necessary based on his findings during the course of the surgical investigation.

[100] Dr. Butler stated that, during the surgery, he conducted a comprehensive examination of the left ovary and determined that it was grossly normal and no intervention was called for. The right ovary, however, was tethered by dense adhesions and had a firm calcified mass. He discussed the appearance of the right ovary with Dr. Farquharson who also observed that there was evidence of pathology on the right ovary. After the discussion, they both agreed that it would be best to remove the right ovary. In his oral testimony before this Court, he listed the reasons which, according to him, supported his decision, foremost among them being ovarian cancer which, if not detected early enough, is lethal.

[101] When the right ovary was sent to pathology for analysis, the final diagnosis was that there was a corpus luteum cyst (a common cyst which is completely normal in women of childbearing age).

[102] Upon re-examination, Dr. Hirsch was asked whether he was familiar with Ms. Stuart's case. He answered in the affirmative. He was asked to explain the second

scan. At page 11 line 11 to page 12 line 25 of the Transcript of Proceedings of 28 August 2017, Dr. Hirsch had this to say:

> **“There is a very important statement made here in the description, and it says *both ovaries are well seen and are normal in size*. ‘There is a 2 cm follicular cyst in the right ovary, smaller follicles are seen otherwise.’ The most important statement here it says, ‘*normal color Doppler flow is seen in the ovaries. No obvious adnexal mass noted on abdominal or transvaginal approach.* The previous described CT finding of left adnexal cystic lesion could be a follicular cyst or a post op seroma. Minimal free fluid is seen in the pelvis.’ The impression is, “*no significant ovarian or adnexal pathology detected in the present ultra sound study, clinical and lab correlation is recommended*.” So, to describe it completely we have two very important things here one, that the only thing they saw in the right ovary was a 2 cm follicle (sic) cyst. *A normal woman who is still ovulating, every cycle forms follicle cysts that are as large as 2.5 cms so that is not a cyst of consequence; it is a function of ovulation*, and that was seen. And in the second thing, your Honour, that was seen, was that there was normal color Doppler flow, and that is the most significant advance in ultra sound and present starting around 2004; and that helps you to make a diagnosis of whether the ovary has anything in it that could be pre-cancerous or cancerous. The Doppler flow due to increase vascularity of cancer goes up dramatically if there is cancer in the ovary. So, here we have a report that say (sic), not only are the (sic) both ovaries normal in character, and normal with the follicle that is going to cause the ovulation for Mrs. Stuart in that particular cycle, *but also the doppler flow is normal, and this was ordered by Dr. Butler, and is approximately a month before he did the surgery. So, he knew that the ovaries were normal*.”** [Emphasis added]

[103] Dr. Hirsch further stated that, after receiving a report like this, he would sit down with the patient as there was plenty time to do so and tell her that the most likely cause of her pain in the left lower quadrant is scar tissue or adhesions and since you are still having pain, which Dr. Butler appropriately said, maybe we can find these adhesions or scar tissues and destroy them so that you would not have the pain. And, if necessary, you will remove the left ovary if we see it tied up in adhesions. Dr. Hirsch stated that he would make Ms. Stuart very much aware of the fact that the ovaries had a normal appearance and there was no risk of cancer. He (Dr. Hirsch) would have repeated that multiple times.

[104] Dr. Hirsch did not agree that since Ms. Stuart was complaining of pain in her left side, that something in her right region could be causing the pain in the abdomen as nothing in the report indicated that the right ovary needed to be removed. According to him, there was no need to remove Ms. Stuart's right ovary and, having done so, was a significant deviation of standard of care.

[105] With the leave of the Court, Mrs. Lockhart-Charles asked Dr. Hirsch a few questions arising out of re-examination with respect to the consent form. Dr. Hirsch stated that paragraph 6 means that "a *surgeon has a bunch of information prior to doing his operation, knows where the problem is, and unless there is something away from the problem that is so significantly looking at normal (sic) [abnormal], then what his obligation is, is not to just remove it, his obligation is to stick with the area of concern. If there is an injury to fix it, or have help in fixing it, but if there is a significant finding such as tumor on the liver, he goes in with a laparoscope and he is looking at the ovaries and he is looking at the area where the pain is, he turns around and he says "oh my God, there is something there." He has an obligation to go to the family in the middle of that case and go out and say "I have found this and I think it is appropriate that we remove it*."

[106] He nevertheless reiterated that if you *suspect* ovarian cancer, "*you don't biopsy, you remove it*." According to him, analyzing the two scans, there was nothing to make Dr. Butler suspect that Ms. Stuart had ovarian cancer as both ovaries were normal in character. He also stated that the Doppler flow was normal and that scan was ordered by Dr. Butler approximately a month before he did the surgery so he ought to have known that there could not be any suspicion of cancer. In any event, said Dr. Hirsch, if he was going to remove the right ovary, he should have informed Ms. Stuart since her condition was not life threatening. He could have postponed the surgery until he received her informed consent.

[107] Applying the applicable legal principles to the facts of this case, I find, on a balance of probabilities, that Dr. Butler is guilty of negligence and breached the duty of care which he owed Ms. Stuart when he removed her left ovary. He fell below the

standard of a reasonable doctor in removing the healthy right ovary when he had no prior discussion with her. No reasonably well-informed and competent doctor possessing the expertise and skill that Dr. Butler professed could have removed Ms. Stuart's right ovary without her consent. He said that he had her informed consent. That is the next issue to be considered.

Issue 2: Whether the informed consent of Ms. Stuart was necessary for the removal of her right ovary?

[108] Dr. Butler relied on the consent form which was signed by Ms. Stuart prior to going into the operating room as an unequivocal licence for him to do what he did. In other words, to remove the right ovary instead of the left one.

[109] In this regard, Dr. Butler relied on the fact that Ms. Stuart signed the written consent form. He also relied on the evidence of Dr. Farquharson and Dr. Nahas.

[110] The critical paragraphs of the consent form are set in below:

> **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. *MS*** (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. *MS*** (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.** ***MS*** (Signed) [Emphasis added]

[111] Ms. Stuart has not denied that she signed the consent form. She also initialed it. Nothing on this standardized consent form speaks to ovary. The form simply states that she authorised Dr. Butler to perform a laparoscopy. There is no mention of where in the body this laparoscopy was to be performed. Therefore, it must be inferred that during prior discussions between Dr. Butler and Ms. Stuart, that must have been clarified. Otherwise, Dr. Butler could remove the kidney or lungs and, according to the consent form, once he performs it laparoscopically, he is protected. By no stretch of the imagination, could this be the proper interpretation of the consent form which, for all intent and purpose, is vague. As I prefer Ms. Stuart's evidence to that of Dr. Butler, the laparoscopy was with respect to the removal of Ms. Stuart's left ovary.

[112] Dr. Butler relied on a decision of Winder J (as he then was) in **Henfield** where the learned Judge set out the terms of the consent form which had been signed by the Plaintiff in that case and concluded that, in the circumstances, the consent had been appropriate. At para 31 of the judgment, the learned judge set out the terms of the consent form and the procedure to be performed namely "*laparoscopic/laparotomy, hysteroscopy."* In paras 32-33, the learned judge stated:

> **"[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 Henfield 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 laparoscopically 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 are 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 will go to the hospital for surgery. So there's ample opportunity for the discussion. ...”**

[113] Winder J then determined, on the facts before him, that he was satisfied that the Plaintiff was appropriately advised of the risks associated with the procedure which was performed.

[114] Mrs. Lockhart-Charles urged the Court to find that, in the present case, Ms. Stuart was appropriately advised and consented to the procedure which was performed.

[115] In my judgment, the facts of **Henfield** are distinguishable from the facts of this case. I have already determined that Ms. Stuart understood that she was going into surgery to remove her left ovary since she was experiencing pain in her left side. She never had pain in her right side. She also stated that Dr. Butler never

discussed the right ovary with her and he never said that he was going to look to see what was wrong because, according to her, he already knew what was wrong. He never discussed cancer and tumour. It was suggested to her that because cancer was suspected in the right ovary, that is why Dr. Butler took out the right one because if it is done too late, it becomes lethal. To that, she retorted *"it's never too late 'cause I am still here*."

[116] Mrs. Rolle argued that the removal of the alternate (right) ovary was not of a medical necessity. Neither was it life threatening nor was it done to correct a medical mishap. She forcefully argued that Dr. Butler ought to have afforded Ms. Stuart the opportunity to agree to undergo the removal of her right ovary. In failing to give her this opportunity, Mrs. Rolle argued that Dr. Butler was negligent and breached the duty of care which he owed to Ms. Stuart. She relied on the case of **Samira Kohli v. Prabha Manchanda & Another** [2008] 5 LRC 284. In that case, the Indian Supreme Court held that:

> **"Every person's body is inviolate and performance of a medical operation on a person without his or her consent was unlawful. Consent in the context of a doctor/patient relationship meant the grant of permission by the patient for an act to be carried out by the doctor. Such consent should be real and valid. The patient should have the capacity and competence to consent, the consent should be voluntary and on the basis of adequate information concerning the nature of the treatment procedure. The 'adequate information' to be furnished by the doctor (or a member of his team) who treated the patient should enable the patient to make a balanced judgment as to whether he or she should submit to the particular treatment or not. The doctor should disclose:**
>
> **a. the nature and procedure of the treatment and its purpose, benefits and effect;**
>
> **b. the alternatives, if any, available;**
>
> **c. an outline of the substantial risks and**
>
> **d. the adverse consequences of refusing treatment.**

[117] Though not binding on this Court, the reasoning in **Samira** is instructive. Dr. Hirsch held similar views on the interpretation to be given to paragraph 6 of the consent

form. At page 19 of the Transcript of Proceedings dated 28 August 2017, Dr. Hirsch stated:

> **"…What this paragraph 6 means especially in the case of Marsha Stuart that we didn't know, the doctor, Dr. Butler did not know what he was going to get into. He knew the ovaries were normal, at least with all the evidence that we have including a CA 125 that no one has found and I have not seen but was border line and that is normal. That normal, does not mean cancer. Knowing all of that he knew he was going to get into an area of scar tissue. So, when you sign 6, that means if the doctor gets into the area of scar tissue and trying to make Ms. Stuart better he injures the ureter, injures the colon which could be inherent to the scar tissue. Requiring another surgeon, or Dr. Farquharson who is a general surgeon to do a colostomy, or a vascular procedure, or a urologist to come in and fix a ureter which is in the area of where her pain is, that is what this means. It doesn't mean that you go to some other area of the abdomen and remove something that has nothing to do with the left lower quadrant pain."**[Emphasis added]

[118] In my judgment, paragraph 6 cannot mean that the attending physician is at liberty to do anything he pleases. The fact that the additional surgery was beneficial to Ms. Stuart or that it could save considerable time and expense to her or would relieve her from pain and suffering in the future (which in this case it did not) were not grounds of defence in an action in tort for negligence. The only exception to that rule, as was correctly pointed out by Mrs. Rolle, is where the additional procedure although unauthorized was necessary in order to save the life or preserve the health of Ms. Stuart and it would be unreasonable to delay such additional surgery for a while until she was given the required consultation and made a decision.

[119] In this case, all experts including Dr. Butler acknowledged that there was no life threatening medical emergency preventing him from ceasing the operation and discussing what he saw with Ms. Stuart so she could have made an informed decision and given her express consent.

[120] I find as a fact that the consent which Ms. Stuart gave was specific to the removal of her left ovary and, irrespective of what Dr. Butler discovered during surgery, the onus was on him to cease the operation and consult further with Ms. Stuart about

his findings. In my considered opinion, Dr. Butler made a colossal error, not a judgment error, in removing Ms. Stuart's right ovary. In medical law, it is well recognized that a catch-all clause in the consent form giving the surgeon permission to do anything necessary does not grant authority to remove whatever he fancies ***but is intended for life threatening medical emergencies.***

[121] The submission advanced by Counsel for Dr. Butler that there was no requirement on Dr. Butler to remove the left ovary instead of the right ovary, nor was there any negligence in his removal of the right ovary once he had ascertained in the course of his investigation that the right ovary and not the left one ought to be removed, is untenable and must fail.

Other issues raised by Ms. Stuart

[122] Given my findings, there is no need to dwell on the other issues raised by Ms. Stuart.

Conclusion

[123] It is not disputed that the test for determining the standard of care owed by medical professionals to their patients is that the professional will not be in breach of their duty of care if they acted in a manner which was in accordance with practices accepted as proper by a responsible body of other medical professionals with expertise in that area. If this is established, it does not matter that there are others with expertise who would disagree with the practice.

[124] Applying the legal principles to the facts of this case, I find that Ms. Stuart has adduced persuasive evidence to demonstrate that Dr. Butler's action or inactions fell below the standard accepted by a body of medical professionals with expertise in his field. He breached the duty of care which he owed to Ms. Stuart. She has suffered loss and injury and is therefore entitled to damages.

[125] I will order that damages be assessed by the Registrar. Ms. Stuart will also be entitled to reasonable costs to be taxed if not agreed.

Dated this 28th day of February 2023

Indra H. Charles
Senior Justice