[2012] JMSC Civ. 124

IN THE SUPREME COURT OF JUDICATURE OF JAMAICA

IN THE CIVIL DIVISION

CLAIM NO. 2007 HCV 02597

BETWEEN	JERETA BOWNIAFAIR	CLAIMANT
AND	JAMES MONROE	DEFENDANT

Messrs Andre Earle and Kelly Greenaway instructed by
Rattray, Patterson, Rattray for Claimant
Messrs David Batts and Miguel Williams instructed by
Livingston, Alexander & Levy for Defendant

Doctor engages to do emergency special surgery – Fails to do so – Whether Negligent - Damages

Heard: 24th and 25th November, 2011and 17th September, 2012

Coram: D.O. McIntosh, J.

Facts

[1] The Claimant was a patient of Dr. Mathew Beaubrun she was referred to the Defendant for the treatment of an intussusception and intestinal polyp.

[2] The Defendant requested an x-ray to confirm the diagnosis and to ascertain the exact location of the abdominal obstruction.

[3] The x-ray report confirmed the diagnosis that the other tests barium meal and ultra sound had revealed and surgery was regarded as a matter of urgent necessity. This was scheduled for the same day i.e. 12th July 2006.

[4] At this emergency surgery the Defendant did none of the things he had scheduled surgery to do. He did not treat the Claimant's intussusception or remove her intestinal polyp instead he removed her appendix but never told Claimant what he had actually done. There was a recurrence of the symptoms which had affected the Claimant. She sought medical advice and assistance elsewhere.

[5] On the 7th August 2006 Claimant was again admitted to surgery. Dr. Lucien Tomlinson corrected her intussusception and removed her intestinal polyp. That surgery brought relief to the Claimant.

[6] On the 27th June, 2007 Claimant filed claim to recover damages for negligence of the Defendant in his treatment of her as well as interest and costs.

CLAIMANT'S SUBMISSIONS

Injury to the Claimant

7. The Claimant asserts that she has suffered the following physical injuries:
    a. Severe abdominal pain and distension of the abdomen;
    b. Tenderness of the abdomen;
    c. Nausea. Vomiting and diarrhea;
    d. 4-inch scar over right lower abdomen;
    e. Tenderness in the left loin;
    f. Chills and rigors, eructations;
    g. Unnecessary appendectomy;
    h. Increased urinary frequency;
    i. Cramping and epigastric pains;

8. After the Claimant's surgery on July 12, 2006 she continued to experience items a, b, c, e, f, h and i until after her surgery on August 7, 2006. This is a twenty-six (26) day period. Items (d) and (g) are permanent injuries.

9. The Claimant also asserts that she suffered the following mental and emotional injuries:

    a. Shame about her two surgical scars;
    b. Terrifying memories, nightmares and flashbacks;
    c. Difficulty falling asleep;
    d. Period of depression and social withdrawal;
    e. Upsetting emotions, frightening memories and a sense of mistrust of doctors; and
    f. Distressing images and thoughts about the experience.

Expert Medical Evidence

10. Dr. Derrick I.G. Mitchell appeared as the Expert Witness appointed by the Claimant and Doctors Trevor McCartney and Patrick Bhoorasingh appeared as the Expert Witnesses appointed by the Defendant.

Standard of Care in the Treatment of an Intussusception

11. It is submitted that Dr. Mitchell and Dr. McCartney agree on the standard of care and the surgical procedures for the appropriate management of the diagnosis of intussusception. This submission is made in light of the statement of Dr. McCartney at paragraph 6 of his Expert Report. The statement of Dr. Mitchell's which Dr. McCartney was referring to is in the Witness Statement filed on June, 2010.

12. This standard of surgical procedures, as set out in Dr. Mitchell's Expert Report, may be summarized as follows:

    a. the patient should be referred for emergency surgery;
    b. where the patient is an adult and has been diagnosed with an intussusception surgery is mandatory as:
        i. usually there is a bowel tumor as the inciting agent (lead point) which may be cancerous; and

ii. leaving the lead point predisposes the patient to recurrent attacks of intussusception which may lead to other complications such as perforation or gangrene. As such, even where it appears that there was a spontaneous resolution of the intussusception at the time of surgery the standard of care is to search for and remove the lead point.

c. the surgery performed would be a laparotomy;

d. it is standard to perform a full laparotomy in adults to explore the abdomen in cases of acute intussusception;

e. it is not acceptable in adults to use a right lower quadrant incision;

f. it is also the standard to remove the lead point even if the intussusception has resolved spontaneously;

g. the necessary access to the abdomen would usually be gained by making a midline incision. Alternatively, an incision may be made to extend across the midline, which is known as a transverse laparotomy.

13. At paragraph 11 of his report Dr. McCartney says that he assumes that a thorough inspection of the small intestine was done and no masses palpated. Dr Mitchell disagrees with Dr. McCartney on this point as he states that it is not acceptable to use a right lower quadrant incision in an adult to explore the abdomen in cases of acute intussusception. The reason he deems this unacceptable is that such an incision would be insufficient to permit the adequate exploration of the abdominal cavity. In particular it ought to be borne in mind that the Defendant used a muscle splitting approach. It is interesting to note that the three (3) experts agree in evidence that they would have done a midline incision not a right lower quadrant muscle splitting approach (see XXN of Dr. McCartney on p. 52 lines 4-14 of Notes of Evidence 24th November, 2011 at 2.00 p.m. and XXN of Dr. Bhoorasingh p. 15 lines 4-24 of Notes of Evidence dated 25th November, 2011).

14. The Court is humbly asked to take particular note of the following sections of the Expert Report of Dr. Patrick Bhoorasingh:

a. Page 3, paragraph 1(a): **"… there was barium in the appendix which also suggested that the appendix was not inflamed."**

b. Page 4, paragraph 2(b): **"In my practice, armed with the diagnosis of an (sic) ileo colic intussusception I would choose midline incisions."**

c. Page 4, paragraph 2(c): **"I personally would find it difficult to explore the abdomen thoroughly through the incision used by Dr. Monroe. Furthermore, to treat the intussusception by resecting the bowel, which is the recommended therapy, would be a challenge for me with that approach."**

d. Page 4, paragraph 3(a): **"… it was necessary to search for the lead point of the intussusception, even if it had reduced spontaneously."**

e. Page 5, paragraph 4(c): **"Certainly the patient should be informed of the failure to identify the lead point and that likelihood of recurrence of the condition posteoperatively."**

f. Page 5, paragraph 4(d): **"Follow up office appointments should be arranged and also follow up investigations to identify the lead point of the intussusception."**

<u>Spontaneous Resolution of the Intususception</u>

15. It is our respectful submission that the evidence which has adduced in this matter does establish that there was in fact no spontaneous resolution of the Claimant's intussusception.

16. At paragraph 10 of his report Dr. McCartney states that it:

… is reasonable to conclude from the operative findings that the intussusception had resolved spontaneously and the inflamed

appendix was due to the invagination of the appendix into intussusception.

17. Dr. McCartney's conclusion that there was a spontaneous resolution of the Claimant's intussusception is based solely on his acceptance of the Defendant's Operation notes and the assumptions he has made in light thereof.

18. Dr. Mitchell's opinion on the likelihood of the spontaneous resolution of the Claimant's intussusception is diametrically opposed to that of Dr. McCartney. It is submitted that Dr. Mitchell's opinion ought to be preferred as it is based, not only on the Defendant's Operation notes but also by his independent physical assessment of the Claimant her treatment, the histology report produced in regard to her appendix and the other documents referred to in paragraphs 2 and 3 of Dr. Mitchell's first report which was filed on October 12, 2010. Of the three (3) experts, Dr. Mitchell is the only one who examined the Claimant's abdomen and also measured her right lower quadrant scar.

19. Dr. Mitchell states that the fact that the Claimant was prescribed two powerful pain killers (Fentanyl and Pethadine) before the operation contradicts any assertion that the Claimant's pain subsided prior to her surgery on July 12, 2006 but rather points to the continued presence of the intussusception.

20. Dr. Mitchell states further that the report of the Pathologist included at page 32 of the Judge's Bundle of Agreed Documents, reveals that the condition of the Claimant's appendix , on histological examination, revealed findings often seen in intussusceptions.

21. While Bhoorasingh does acknowledge that spontaneous resolution of intussusceptions does occur he does not make any finding as to the likelihood of such an occurrence in this case. At page 5 paragraph 3(c) of his report he notes that spontaneous resolution is "often seen" especially where a barium enema is done preoperatively. However, it is to be noted that he has merely assumed that such an enema was done. In fact, at no material time was the Claimant administered an enema. The evidence is that the Claimant took a barium meal test. Such a test is administered orally.

Breach of the Standard of Care in the Operation done by the Defendant

22. Dr. Mitchell and Dr. McCartney disagree as to the sufficiency of the surgery performed by the Defendant. Dr. Mitchell states that the one hundred millimeter (four inch) incision made by the Defendant was **inadequate** to explore the Claimant's abdomen and perform the necessary palpation of the Claimant's intestines.

23. Dr. McCartney however seemed willing to "assume" that this incision was sufficient for the Defendant to perform a thorough inspection of the small bowel and that this inspection, having been performed, revealed no masses.

24. It is interesting to note that at two points in the Defendant's Witness Statement he admits that the intussusception was present at the time he performed the surgery. In particular, he admits that he made an incision over the ileo-caecal intussusception region" and that he examined and palpated this intussusception. These statements clearly contradict the Defendant's assertion that the intussusception spontaneously reduced.

25. Dr. Bhoorasingh while having no “strong opposition” to the type of incision used by the Defendant stated that he would not have used that incision in the instant case and he personally would find it difficult to thoroughly explore the abdomen through the incision used by the Defendant.

Causation

26. It is beyond dispute that the Defendant did not cause the Claimant’s intussusception. It is also beyond dispute that he did not cure it. It is therefore our humble submission that this omission of the Defendant’s is the direct and only cause of the Claimant’s continued suffering between the date on which she was operated on by the Defendant and the date on which Dr. Tomlinson operated on the Claimant. This is approximately a 26 day period.

27. None of the three (3) experts who has given evidence herein have faulted the treatment of Dr. Tomlinson in any regard. In fact, Dr. Mitchell states explicitly at paragraph 11 of his Supplemental Report which was filed on February 18, 2011 that there “were no errors of omission or commission noted under the circumstances of care provided” by Dr. Tomlinson.

THE LAW – LIABILITY

The Required Standard of Care

28. Lord Brown-Wilkinson stated in his judgment in the case of, ***Bolitho (deceased) v City and Hackney HA,*** a decision of the House of Lords, that the locus classicus of the test for the standard of care required of a doctor is that a doctor:

… 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 .. . 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.

29. This statement of law was quoted from the speech of McNair,J in the case of ***Bolam v Friern Hospital Management Committee*** and is commonly called the ***"Bolam*** test".

30. What other practitioners would have done, had they been in the position of the Defendant, is a material consideration. However, the fact that there exists a body of medical opinion supporting the conduct of the Defendant does not bar a judge from making a finding that the Defendant was negligent in his conduct. This is so as a judge is not bound to accept the evidence of an expert witness unless satisfied that the body of opinion being relied on is both reasonable and responsible. Although it will be a rare case in which a judge can properly reach the conclusion that the genuine opinion of a competent medical expert is unreasonable this does not alter the fact that professional opinion must be capable of withstanding logical analysis.

31. Another issue arises is the size of the body of medical opinion presented to the court. In the case of ***Defreitas v O'Brien*** the court found that:

… **it is not necessary to show that that body of medical opinion was substantial. It is open to the court to find that a small number of specialists could constitute a reputable body of medical opinion.**

In the case of ***Defrietas*** it was found that two highly specialized practitioners, who were of the same opinion, constituted a reputable body of medical opinion.

Causation

32.] Where a breach of duty of care is either proved or admitted the onus remains on the claimant to prove that this breach resulted in the injury or injuries complained of. As stated by Lord Brown-Wilkinson:

… in cases where the breach of duty consists of an omission to do an act which ought to be done … The question is what would have happened if an event which by definition did not occur had occurred.

33. The ***Bolam*** test is not relevant in determining the answer to this question.

Liability for Damages for continuing pain

34. In the case of ***Knight v West Kent HA*** the Court of Appeal held that the claimant was entitled to damages for an extra two hours of painful labour which she endured. The relevant circumstances of the case were that the claimant's labour was not progressing at a normal pace. Accordingly, the defendant decided to move the claimant to the operating theatre and assist the delivery of the baby by forceps. Eventually the claimant delivered a healthy baby. However, she sued the defendant claiming that he had employed the wrong procedure in assisting her delivery and had thus allowed her to remain in labour for too long.

35. The court held that the claimant was entitled to recover damages for the extra two hours of painful labour which she endured.

APPLICATION TO THE FACTS

The required Standard of Care

36. It is also not in dispute that the Claimant was pre-operatively diagnosed as having an intussusception. The Defendant, by his own admission, was aware of the abdominal ultrasound performed by Dr.Melvin Ritch and of the pre-operative diagnosis of intussusception. The Defendant asserts

that prior to commencing surgery he examined the Claimant's abdomen and found no abnormality.

37. Even if the Court accepts that the Defendant examined the Claimant prior to surgery and found no abnormality two facts remain beyond dispute:

    a. The ultrasound revealed the presence of an intussusception and intestinal polyp; and

    b. The Claimant was in excruciating pain immediately prior to being admitted into surgery. This fact is corroborated by the fact that the Claimant was administered strong opioid analgesics prior to surgery. The Curt is respectfully asked to refer to page 11 of Bundle number 3 (Judge's Bundle of Agreed Documents filed on October 15, 2010). At that page the Court will note that the Claimant was administered Fentanyl and Pethidine prior to surgery. At paragraph 7 of the Expert Witness Report of Dr. Derek Mitchell the Expert notes that the administration of these drugs is evidence that the pain did not resolve prior to surgery.

38. The Defence has sought to make heavy wether of the fact that the notes provided by Nuttall Memorial Hospital do not reflect that the Claimant made any complaints about being in painful distress. However, those notes are prepared without the oversight or approval of the Claimant. The Claimant has no control over their content. Further, the Court is asked to bear in mind that although these are agreed documents, and certainly of use in determining the issues at hand, they are not prepared by a person whose testimony the Court has not had the benefit of. It is thus respectfully submitted that where there is such a dispute in evidence, the evidence given under oath ought to be preferred to documentary evidence not given under oath.

39. It is submitted that even though the Claimant's abdomen may have appeared normal on physical examination, in view of these facts the Defendant had a responsibility to thoroughly check the Claimant's abdomen for the intussusception. Alternatively, if the intussusception had resolved as the Defendant asserts, he ought to have searched the Claimant's abdomen for the lead point of the intussusception and removed it. This, the experts agree, is the required standard of care and, it is submitted, as there was a presumptive diagnosis of intussusception, the Defendant was negligent in that he fell below this standard of care.

40. The Defendant, in his sparsely-worded Witness Statement, seems utterly confused as to what it is that he actually did on July 12, 2006. At one point he asserts that he made an incision over the Claimant's intussusception and immediately thereafter he states that no intussusception was found. Curiously he thereafter asserts that he palpated the intussusception although he then asserts that the intussusception appeared to have corrected itself without surgical intervention.

41. Was there an intussusception at the time the Defendant operated or not? The Defendant does not seem to be certain and, it is submitted, he could not have been as he could not have thoroughly checked the Claimant's abdomen through the small traverse incision which he made (100mm or 4 inches). The Court is asked to bear in mind the type of incision which the Defendant used and the fact that such an incision means that the opening in which the Defendant is able to operate gets smaller the further into the abdomen you go. As such, even though the size cut on the Claimant's abdomen was 100mm the space in which the Defendant was operating, and through which he ought to have palpated the Claimant's intestines to find the lead point of her intussusception would have been remarkably smaller. This is because the Defendant chose a muscle splitting approach

instead of a muscle cutting approach with a midline incision. Hence the opening of the abdomen got smaller the further below the surface the Defendant went – see XXN of Dr. Bhoorasingh p. 16 lines 15-20 of Notes of Evidence dated 25th November, 2011.

42. The Court is asked to find that the intussusception was present at the time of the surgery on July 12, 2006. Further, had the intussusception resolved the Claimant would not have required opioid analgesics immediately prior to the surgery.

Causation

43. It is submitted that it has been established that the Defendant was negligent in his treatment of the Claimant. The question of causation therefore falls to be decided. In particular, whether the Claimant would have been spared the injuries set out at paragraphs 7,8 and 9 hereof if the Defendant had corrected the intussusception and removed the intestinal polyp on July 12, 2006.

44. The strongest evidence of what would have happened had the Defendant performed the surgery he ought to have performed is what in fact happened after Dr. Luchien Tomlinson performed this surgery on August 7, 2006. That is, the Claimant's physical symptoms subsided and her condition quickly improved without any further complications, The Court is asked to take particular note of the fact that the evidence before this Court indicates that the actions of Dr. Tomlinson did not contribute to the pain and suffering of the Claimant.

45. The Claimant has also testified that the ordeal, and in particular the Defendant's treatment of her, has injured her mentally and emotionally in the ways set out at paragraph 9 hereof. In the absence of evidence to the contrary the Court is asked to accept that the Claimant did in fact suffer these injuries. Further, that these injuries were in some cases

exacerbated by and in others caused entirely by the Defendant's negligent treatment of the Claimant.

46. The Court has had the benefit of the professional opinion of seasoned practitioners in the field of surgery. On many points these surgeons appear to agree. However there is one point of divergence which is absolutely critical – did the Defendant's treatment of the Claimant meet the required standard of care? That is was his treatment of the Claimant in keeping with the **"practice accepted as proper by a responsible body of medical men skilled in that particular art"?**

47. Dr. Mitchell has consistently indicated that the answer to that is no. Dr. Mitchell has been credible, consistent and clear in his explanations. He has not contradicted himself and he has been comprehensive and thorough in his explanations.

48. In contrast we have the evidence of Dr. Trevor McCartney. Based on the evidence as it unfolded we have no option but to ask this Court to find that Dr. McCartney was not a witness of truth.

49. As previously stated Dr. McCartney unabashedly adopted the standard of care advanced by Dr. Mitchell. However, under cross-examination Dr. McCartney sought to qualify his confirmation of the standard described by Dr. Mitchell. Dr. McCartney does so by indicating that while a mid-line incision is the norm, and it is what he would have expected and opted for, the transverse right lower quadrant incision with a muscle splitting approach may be of some use at the **diagnostic** stage. He concedes however that to treat the intussusception it would be necessary either to extend that incision across the lower abdomen and adopt a muscle cutting approach or to close the lower quadrant incision and use a mid-line incision.

50. Dr. McCartney, under cross examination, went on to say that based on the documents he has seen he is not satisfied that the Claimant had an intussusception at the time she presented for surgery. This despite the fact that the radiologist found clear evidence of one and the fact that Dr. Tomlinson removed an intussusception from the abdomen of the Claimant about a month later. Also removed from the Claimant's abdomen was a large intestinal polyp measuring 4.3.5x2.5cm.

51. So what is Dr. McCartney saying? That despite all objective and scientific evidence to the contrary he is convinced there was no intussusception or polyp when the Claimant presented for surgery on July 12, 2006? And the basis for this is that the Defendant told him so? Incredulous!.

52. Dr. Mcartney has himself indicated that only a portion of the abdomen could be accessed by a right lower quadrant muscle splitting approach. He has also admitted that the position of an intussusception in the abdomen can change with time. So who then is he so sure the Defendant thoroughly examined the Claimant's intestines via the tiny incision he made? We submit he has no credible evidence on which to base this opinion.

53. It is respectfully submitted that Dr. McCartney bobbed and weaved throughout his entire testimony in his best efforts, perhaps well intentioned, to help a colleague. But in doing so he had misled this Court!.

54. It is submitted that Dr. McCartney's true feelings on this case were expressed in his letters of November 13, 2009 (suggesting that the **Defendant "settle the claim as soon as possible"**) and August 3, 2010 – see Bundle 8. Letters the Doctor wrote to the Defendant's Attorney-at-law at a time he was certain they would never see the light of day.

THE LAW – DAMAGES

55. It is submitted that the cases referred to below, provide a useful guideline in determining quantum.

56. In ***Pauline Douglas v Damion Dixon and Nicholas Williams*** the claimant was hit down b a motor bike and sustained pain in the lower abdomen, tenderness in the suprapubic region and microscopic haematuria in the urine. She was admitted to the hospital for observation but as her condition worsened she underwent an exploratory laparotomy wherein it was discovered that there was a 1.5cm contused area of distal jejunum that appeared to be compromised and as such same was excised and a primary anastomosis done. Her post-operative period was uncomplicated and she was discharged six (6) days after her operation with left inguinal hernia repair being recommended.

57. Damages were assed in February 2000 and the claimant was awarded the sum of $650,000.00 for pain and suffering. Updated to today's value (as at June 2012, CPI = 183.8) that is an award of $2,255,853.47.

58. In the case of ***Mary Hibbert v Reginald Parchment***, a 22 year old claimant sustained a gun shot wound to the abdomen for which she was admitted to hospital and underwent emergency surgery which involved repair of small bowel and a loop colostomy. Her post operation period was uneventful and she was discharged about a week later to another hospital where her colostomy was closed. Following closure, the claimant developed faecal fistula and was transferred back to the previous hospital where closure was repeated. When examined a few months later, the claimant was found to be in fairly good health. Also, she had three visible scars to her abdomen resulting from the surgical incisions and the gun shot would. The claimant testified that she wore the colostomy for five (5)

months during which she experienced pain, discomfort and embarrassment.

59. Damages were assessed in May 1999 and the claimant was awarded the sum of $900,000.00 for pain and suffering and loss of amenities. Updated to today's value that is an award of $3,339,119.90.

60. The similarity between the injuries sustained by the claimant in the case of ***Pauline Douglas*** and the Claimant in the instant is the feelings of pains and the surgical procedure known as a laparotomy which both ladies underwent. However, it must also be remembered that the Claimant in the instant case underwent 2 laparatomies and had her appendix unnecessarily removed. The Claimant in the instant case also had diarrhea, vomiting, tenderness in the loin, chills and rigors, cramping and epigastric pains, eructations, and was admitted to the hospital on more than one occasion and was subjected to numerous tests (such as: CT scans, examination by an internist and kidney specialist, HIV tests). Additionally the Claimant complains of mental and emotional trauma. The Claimant also suffered serious mental distress in particular a feeling of hopelessness and the feeling that she was going to die, which according to Dr. Bhoorasingh would have happened if the intussusception had not been removed – see p. 27 line 3 – p 30 line 6 of Notes of Evidence dated 25th November, 2011.

61. As such, it is humbly submitted that Ms. Bowniafair's injuries were more extensive and perhaps even more severe and thus are worthy of a significantly higher award.

62. In the case of ***Mary Hibbert*** the duration of time for wearing the colostomy, the resulting scars, pain, discomfort and embarrassment suffered by the claimant is greater than the period of suffering of the

Claimant in the instant case. It is submitted however that as there is evidence that the Claimant, four years later, is still suffering with the mental scars she obtained at the hands of the Defendant that any downward adjustment of this award should be very slight.

63. In the circumstances it is respectfully submitted that the Claimant ought to receive an award of $3,000,000.00 for General Damages for her pain and suffering.

64. The Claimant also seeks **$461,518.45** (being the sum of **$186,000.00** for medical expenses and **$275,518.45** for hospital expenses) in special damages which amount **is undisputed and has not been challenged** on the evidence (see receipts/bills in **Bundle 3 pp. 33 – 45**).

CONCLUSION

65. It is respectfully submitted that the resolution of this case requires answers to the following questions:
    a. Was a credible diagnosis of intussusceptions made prior to the Defendant commencing surgery of the Claimant?
    b. If yes to (a) did the Defendant have notice of that diagnosis?
    c. Did the Defendant approach the relevant surgery with a view to taking a reasonable and thorough approach of the treatment of the diagnosis of which he was aware?
    d. What is the standard of care in the treatment of an intussusceptions in an adult.
    e. Did the Defendant's treatment of the Claimant meet that standard of care?
    f. Would a reasonable body, of honest men, deem the approach of the Defendant accepted practice?
    g. Did the Defendant's treatment of the Claimant cause her to suffer, be injured and experience pain?

66. It is humbly submitted that it has been proved, on a balance of probabilities, that the Defendant was negligent in his treatment of the Claimant and that as a result the Claimant has suffered pain, suffering and injury and is entitled to damages. There should therefore be judgment for the Claimant with damages, interest and costs to be taxed if not agreed.

DEFENDANT'S SUBMISSIONS

1. This action is brought in Negligence. The Claimant must therefore establish a duty, that there was a breach of that duty and that breach of duty caused injury to the Claimant.

IS THERE A DUTY OF CARE

2. There is no doubt that the Defendant owed a duty of care to the Claimant. The Defendant had a contractual duty to the Claimant. There is no claim in relation to the contract. This case is based entirely on the tort of negligence. Insofar therefore as it was reasonable foreseeable that neglect in her treatment would cause loss then the Defendant can be said to owe a duty of care to the Claimant.

HAS THERE BEEN A BREACH OF THE DUTY OF CARE

3. It is well established that a breach of duty does not occur merely because a Claimant has been injured. In cases of alleged professional negligence a breach is not proved because there is a body of opinion which says the Defendant was wrong in what he did. That is not sufficient to establish a breach of the duty of care. In order to establish a breach of professional duty of care it must be proved that the Defendant adopted a procedure or method of treatment which no reasonable professional in his position, or holding out the skills he professed to possess, would have adopted.

4. In **Maynard v West Midlands Regional Health Authority** [1985] 1 All. E.R. 635 the House of Lords examined the burden of proof on the

Claimant and took into account the fact that different opinions existed, Lord Scarman at page 638 opined as follows:

> **"A case which is based on an allegation that a fully considered decision of two consultants in the field of their special skill was negligent clearly presents certain difficulties of proof. It is not enough to show that there is a body of competent professionalopinion which considers that theirs was a wrong decision, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances.**
>
> **<u>It is not enough to show that subsequent events show that the operation need never have been performed, if at the time the decision to operate was taken it was reasonable in the sense that a responsible body of medical opinion would have accepted it as proper.</u> I do not think that the words of the Lord President (Clyde) in Hunter v Hanley 1955 SLT 213 at 217 can be bettered:**
>
> > **"In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men … The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care …"**
>
> **I would only add that a doctor who professes to exercise a special skill must exercise the ordinary skill of his speciality. <u>Differences of opinion and practice exist, and will always exist, in the medical as in other professions. There is seldom any</u>**

> **one answer exclusive of all others to problems of professional judgment. A court may prefer one body of opinion to the other, but that is no basis for a conclusion of negligence.**
> **(emphasis added)"**

5. In the *Maynard* case (above), it was noted that a judge ought not to simply "prefer" one body of distinguished medical opinion over another. Lord Scarman stated at page 639 that:

> **"I have to say that a judge's 'preference' for one body of distinguished professional opinion to another also professionally distinguished is not sufficient to establish negligence in a practitioner whose actions have received the seal of approval of those whose opinions, truthfully expressed, honestly held, were not preferred.** If this was the real reason for the judge's finding he erred in law even though elsewhere in his judgment he stated the law correctly. **For in the realm of diagnosis and treatment negligence is not established by preferring one respectable body of professional opinion to another. Failure to exercise the ordinary skill of a doctor (in the appropriate speciality, if he be a specialist) is necessary.**
> (emphasis added)".

6. In another decision of the House of Lords, *Whitehouse v Jordan and another [1981] 1 All ER 267* it was decided that even in a case where a doctor made an error of judgment the Claimant had failed to show that the Defendant surgeon failed to measure up to the standard of the ordinary skilled surgeon exercising and professional to have the special skill of a surgeon.

7. Applying these principles to the facts of this case, it is clear that there has been no breach of the duty of care. Both doctors Bhoorasingh and McCartney opine that:

(i) the transverse (split) cut was sufficient and could be used to properly examine the intestine and hence confirm the diagnosis of intussusception **[Witness Statement Dr. Trevor McCartney para. 18 Exhibit 2 page 38; Letter dated 10 December 2007 T. McCartney to R. Braham Exhibit 2(d) page 6; Letter dated 22 July, 2012 McCartney to R. Braham Exhibit 2(d) page 12; Letter dated 3 August, 2010 McCartney to R. Braham Exhibit 2(d) page 14; Expert Report of Dr. Patrick Bhoorasingh para. 2(d) Exhibit 2 and Notes of Evidence 25 November 2011 @ 10.00 a.m. page 3] and [page 19 lines 1-10] and page 20 line 1-10; Notes of Evidence 2011 @ 10.00 a.m. page 44 lines 5-8**]. The Medical Council of Jamaica saw nothing wrong with it either **[letter dated 3 November, 2008 Medical Council of Jamaica to Dr. James Munroe, Exhibit 2(a) Judge's Bundle of Agreed Documents page 2].**

(ii) the intussusception having spontaneously resolved it is manifest that there was no need to treat it and hence no need for an extended transverse cut or for a midline cut.

(iii) that having made the cut it was consistent with standard medical practice for Dr. Munroe to remove the appendix. Dr. Mitchell also agreed with this latter point, **[see page 14 (line 8-12) and page 15 (line 1-4) Notes of Evidence for 24 November, 2011 @ 2.00 p.m.].**

8. The Claimant's expert, Dr. Mitchell, asserts that a transverse muscle splitting cut as done by the Defendant was inappropriate for the purpose of locating and treating an intussusception and polyp. He admits that the location of the intussusceptions and polyp had been identified pre-operatively as being in the right lower abdomen. This x-ray was done on

the same day of the surgery 12 July, 2006**. [Exhibit 2(a) Judge's Bundle of Agreed Documents page 26].** Dr. Mitchell also admits that the incision made by Dr. Munroe was to the right lower abdomen. He admits that the spontaneous resolution of intussusceptions is fairly common and that if that did occur before or during surgery then the appendix might appear red and inflamed to the surgeon. The doctor also admitted that the intestine would in such circumstances be swollen and would have made identification of a small polyp by palpation difficult. He agreed that it is appropriate to remove the appendix after a transverse cut so as not to cause confusion in the future and where it appears red and inflamed. **[Notes of Evidence 2.00 p.m. 24 November, 2011 pages 10,11,13,14,15,17,28,24**]. Dr. Mitchell also agreed that the intestine in the ileocecal area could be examined via a transverse incision **[page 24 line 7-11 Notes of Evidence @ 2.00 p.m. on 24 November 2011].**

9. Doctors McCartney and Bhoorasingh are both eminent and experienced surgeons. They are of the opinion that it was possible to examine the entire small intestine via a transverse muscle splitting operation [see references at para. 6 above]. This is because the examination of the intestine is done outside the body and 6-8 feet of the intestine comes out once the incision is made. Furthermore, where as in this case the location of the suspected intussusception was identified preoperatively, the choice of incision could not be said to be unreasonable. Both doctors would themselves have done a midline incision but both agreed that the cut that was done was adequate for the purpose of inspecting the intestine to confirm the clinical diagnosis prior to treatment. Should treatment be required, then the incision could be extended or it could be closed and a midline done instead **[page 47 line 1 to 18 and page 48 lines 9-11, Notes of Evidence @ 2.0 p.m. for 24 November, 2011].**

10. It is perhaps appropriate to quote from the experts' opinion:

Per, Dr. Bhoorasingh (Bundle 13 Exhibit 2(f) para. 2):

"(a) The choice of incision was used to treat the patient by Dr. James Munroe was a muscle splitting transverse incision.

(b) In my practice, armed with the diagnosis of an ileocolic intussusceptions I would choose midline incisions.

(c) I personally would find it difficult to explore the abdomen thoroughly through the incision used by Dr. James Monroe. Furthermore, to treat the intussusceptions by resecting the bowel which is the recommended therapy, would be a challenge for me with that approach.

(d) <u>However, the muscle splitting transverse incision that Dr. James Monroe uses is not unusual among general surgeons as well as other non midline incisions.</u>

(e) I have strong opposition to the use of the transverse incision by any surgeon, if in their practice they are experienced in using that approach. I have used this incision infrequently for surgery in this area of the abdomen.

(f) In conclusion the transverse incision may also be safely employed for this patient and for this procedure.

Per Dr. T. McCartney letter dated 3 August, 2010 [Bundle 10]:

"The bowel exploration should be done through a laparatomy incision. Whilst a lower transverse incision is not the ideal method of abdominal exploration it is frequently used for this purpose and I believe that adequate examination of the small bowel and ascending colon can be achieved by this method."

11. Dr. Munroe stated that he palpated preoperatively and felt no mass. He therefore did the muscle split to confirm the diagnosis. His words when being cross examined are worthy of note:

> **"Q: What I am suggesting to you that the incision that you made was done specifically for you to perform appendectomy?**
>
> **A: The answer is no. I told you I palpated her abdomen before the operation, we could not feel it therefore the diagnosis of intussusception was in doubt. To confirm I made a small intussusception [incision] over area, had no ……..**
>
> **Q: I am suggesting to you …….**
>
> **A: In fact we weren't expecting to see any intussusceptions."**

This evidence is combined by his operating **notes [Exhibit 2(a) Judge's Bundle of Agreed Documents p.3]** and his report **[Exhibit 2(d) Judge's Bundle of Agreed Documents page 1-2].**

12. Both Doctors McCartney and Bhoorasingh also stated that the transverse cut could have been extended across the midline if the intussusception had not spontaneously resolve and needed to be removed. Alternatively, it could be closed and a midline done to remove the intussusception. In the event this was unnecessary as the intussusception resolved spontaneously and there was no need for further surgery at the time.

13. It is submitted that given the clear medical opinions there is no evidence on which this court can find that Dr. James Monroe adopted a procedure which no ordinary surgeon with his skill would have performed. Dr. Monroe therefore did not breach a duty of care to his patient by using a transverse incision to search for and confirm diagnosis of the

intussusceptions. The intussusception having resolved spontaneously there was no need for further surgery.

14. In this regard we know that the intussusceptions in the right lower abdomen resolved spontaneously prior to or at the time of surgery because:

(a) The Claimant reported no pain post surgery, see nurse's notes **[Exhibit 2(a) Judge's Bundle of Agreed Documents pages 19-23**]. We urge the court to reject the Claimant's evidence which is unsupported by anydocumentation. The nurses were very careful and even noted the patient's complaint about a lizard **[page 21**]. On a balance of probabilities had the complainant experienced acute pain postoperatively the nurses would have made notations.

(b) All medical experts who gave evidence admit that the spontaneous resolution of the intussusceptions is not an unusual occurrence. This is due largely to the nature of the bowel which is flexible.

(c) The Defendant searched for but did not fine the intussusceptions or the polyp see his notes **[Exhibit 2(a) page – Judge's Bundle of Agreed Documents]** and his report [**Exhibit 2(d), Judge's Supplemental Bundle of Agreed Documents page 1]** and his evidence **[Exhibit 2 Judge's Bundle of Witness Statements and Expert Reports page 35 para. 7-10 Notes of Evidence 25 November 2011 @ 10.00 a.m. page 58 lines 1-7], [Notes of Evidence 25 November 2011 page 73 lines 1-7]:**

(d) It is incredible to believe that the Claimant would have had acute post operative pain consistent with a recurring intussusception and that Dr. Monroe would not have acted immediately especially since the possibility of recurrence is well known.

(e) The Claimant admits that Dr. Monroe told her that if she had any continuing problem she should call him **[page 24 lines 13-22, page 24 line 25, page line 10 Notes of Evidence @ 10.00 a.m. 24**

November 2011]. Is it probable that the doctor having given her that warning would have treated with less than alacrity a report of continuing post-operative acute pain? Dr. Monroe's own words in that regard:

"Q: You didn't say to her come back and see me on July 24 if your symptoms don't subside.

A: No I did not. I told her say, over the weekend if you have problems on the weekend call me up and let me know about it and come and see me on the Monday July 24, she did not appear, she went to another hospital."

[Notes of Evidence 25 November 2011 @ 10.00 a.m. page 91 line 6-12].

15. The intussusceptions having resolved spontaneously prior to or at the time of surgery a larger muscle cutting operation was not required. An 18 mm polyp would be hard to locate in an intestine which was swollen due to a spontaneously resolved intussusception **[See evidence Dr. Mitchell Notes of Evidence 24 November 2011 @ 2.00 p.m. page 1 lines 5-11; Dr. McCartney Notes of Evidence 24 November 2011 @ 2.00 p.m. page 47 line 19 to page l48 line 11; Expert Report Dr. Patrick Bhoorasing para. 3(b)**]. Therefore, the failure to locate the polyp was not due to the transverse nature of the incision or to the fact it was a muscle splitting incision but rather due to the inflamed condition of the intestine after the spontaneous resolution of the intussusceptions.

16. It is respectfully submitted therefore that the body of medical opinion in this matter id divided. Dr. Mitchell suggest that only a midline cut was appropriate. Even he however admits that a cut to the right lower abdomen could locate an intussusception in that area. The other two medical professionals who gave evidence say that a muscle split in the right lower abdomen is adequate to inspect and confirm the diagnosis. All

professionals agree that the intestine is swollen after an intussusceptions resolves spontaneously and that it is difficult to feel a small polyp in such an intestine. It is submitted therefore that on this evidence it cannot be said that when deciding to do a muscle split incision to the right lower abdomen the Defendant adopted a procedure which no reasonable professional in his position would have adopted. Similarly, it cannot be said that his inability to locate the polyp was negligent as the polyp was 18 mm or smaller and the intestine was swollen.

17. The Claimant has sought to demonstrate that the polyp was much larger than 18 mm and hence ought to have been discovered. We ask your Lordship to reject that suggestion because:

(a) The only other measurement of the polyp occurred on the 21st August 2006 **[see Exhibit 2(a) Judge's Bundle of Agreed Documents page 24];**

(b) The evidence is that by that time there had been hemorrhaging in the poly **[Notes of Evidence 24 November 2011 page 56 lines 19 to page 57 line** 12**], [Notes of Evidence 25 November 2011 page 41 lines 4-13].** This caused it to increase in size.

(c) The pre-operation x-ray of 12th July on the same Dr. Monroe did the surgery, showed an 18 mm **[Exhibit 2(a) Judge's Bundle of Agreed Documents page 26].**

(d) Drs. Bhoorasingh, McCartney and the Defendant all agree that the polyp became enlarged after the 12 July 2006.

18. Given the size of the polyp in July it is manifest that palpation of the inflamed intestine might not have led to its discovery regardless of the size or type of incision. It is the agreed medical position that if the intussusception resolved spontaneously, the polyp could not be removed surgically unless it was found. Since therefore it was not found because of the inflamed condition of the intestine, it cannot be said that the nature of the incision affected the end result.

19. There has been some suggestion that Dr. Monroe breached his duty post operatively. Al experts agreed that an intussusception which resolved spontaneously and for which the polyp had not been located, was likely to recur. There was some detailed evidence about the post-operative care required in such circumstances. However, the **experts (Dr. Mitchell Notes of Evidence 24 November 2011 @ 2.00 p.m. page 32 lines 12-17; Dr. McCartney Notes of Evidence 24 November 2011 page 86 lines 9-16),** agreed that such care could not commence until the patient had healed after the surgery on the 12th July 2006. Dr. McCartney explained that a couple of weeks were required. This period had not elapsed before the Claimant attended the Andrews Memorial Hospital. This period had not elapsed before the Claimant elected not to attend Dr. Monroe for the appointment on the 24th July or to even let him know she has having further pains and had been admitted to Andrews Memorial Hospital. The Claimant disobeyed the doctor's advice to advise him of further problems and to return to see him on the 24th July, 2006.

20. As regards the removal of the appendix, it is manifest that having made a transverse incision in that location its removal was in accordance with standard medical practice **[Dr. Mitchell Notes of Evidence 24 November 2011 @ 2.00 p.m. page 24 line 21 – page 24 line 3; Dr. McCartney Judge's Bundle of Witness Statements and Expert Reports Exhibit 2 page 40 para. 10; Dr. Bhoorasingh Expert Report para. 1(a) to (h) Notes of Evidence 25 November 2011 page 8 Notes of Evidence 25 November 2011 page 46 lines 11-22]**

21 Furthermore, Drs. McCartney and Bhoorasingh agree that the appearance of the appendix to the surgeon can justify its removal and Dr. Mitchell agreed that an appendix can appear inflamed after an intussusceptions has spontaneously resolved **[Notes of Evidence 25 November 2011 @ 10.00 a.m. page 52 lines 15-22; Dr. Bhoorasingh Expert Report para.**

11(i) (d); per Dr. Mitchell Notes of Evidence 24 November 2011 @ 2.00 p.m. page 10 line 22 to page 11 line 11; page 12 lines 17 to page 13 line 6]. The Claimant has therefore not demonstrated that by removing the appendix the Defendant breached any duty to her. The evidence supports the fact that its removal was in accordance with standard medical procedure. No evidence has been led to suggest that an ordinary surgeon in the Defendant's position would never have removed the appendix in those circumstances.

22. Further, Dr. Bhoorasings opined that the appendix had no known utility. **Exhibit 2 para. 1©, Notes of Evidence 25 November 2011 @ 10.00 a.m. page 6 line 19-25 and page 7 line 1-9].** Dr. Mitchell was not entirely definitive about the value of the appendix. We submit that the Claimant has not proved she suffered any loss by its removal.

23. The Defendant therefore breached no duty to the Claimant either pre or postoperatively as he told her to inform him of any further problems and to return to see him on the 24th July, 2006.

CAUSATION

24. This then leads to a discussion of the final element of the tort causation. The or any act of negligence must be shown to have caused injury, loss or damage to the Claimant. The Claimant we submit has failed to prove that the or any alleged negligence by Dr. Munroe caused her loss.

25. It cannot be said that the nature of the incision caused the injury to the Claimant. The injury to the Claimant was caused by the recurrence of the intussusception. Recurrence is highly probable where after spontaneous resolution the polyp remains in the intestine. It is after all the presence of the polyp which causes the intussusceptions. If therefore as is conceded by the Claimant's expert a small polyp is difficult to palpate and may

therefore not be found in an inflamed intestine, and if, an intestine is normally inflamed after spontaneous resolution of an intussusception, it cannot be said that the Defendant caused the recurrence of the intussusception.

26. The role of Dr. Tomlinson needs also to be considered. The Claimant chose to go to Dr. Tomlinson rather than attend on Dr. Monroe for the follow up session scheduled for the 24 July 20. She said that she informed Dr. Tomlinson of her previous management by Dr. Monroe **[page 35 line 22-25 Notes of Evidence 24 November 2011].** Dr. Tomlinson made no contact with Dr. Monroe even though this would have been advisable **(per Dr. Mitchell page 34 lines 4-15 Notes of Evidence @ 2.00 p.m. 24 November 2011].** Dr. Tomlinson spent some time investigating for fall stones and kidney infections **[para. 23 Claimant's Witness Statement]** and took some time to diagnose. Dr. Tomlinson seems to have thought the Claimant had had an appendectomy **[medical report of Dr. Tomlinson Exhibit 2(A) Judge's Bundle of Agreed Documents page 29].** It is submitted that Dr. Tomlinson's delayed diagnosis resulted in the recurred intussuscuption festering and becoming inflamed. The Claimant's failure to return to Dr. Monroe as instructed led to a new doctor who perhaps because he was unfamiliar with her entire history, took an extended time to diagnose her condition. The pain and suffering in the period is therefore not attributable to Dr. Monroe's action. Dr. Tomlinson had her in his care from the 20th July to the 15th August, he performed surgery on her on the 7th August 2006. It is submitted that the Claimant would have had no such extended period of distress had she returned to Dr. Monroe on the 24th July 2010 as instructed or had she reported to Dr. Monroe the acute pain she alleges occurred postoperatively.

27. The Defendant submits further that the post operative care by the Defendant was not proved to have occasioned any loss to the Claimant. The Claimant admits that she was given an appointment to see the Defendant which she did not keep **[p. 25 line 6-10 Notes of Evidence 24 November 2011 @ 2.00 p.m**.]. She instead went to the Andrews Memorial Hospital when pain returned. She was treated by Dr. Tomlinson. She did no notwithstanding the Defendant's advice to call him if pain occurred on the weekend and to come see him in any event on Monday the 24th July 2006.

28. Dr. Tomlinson made several misdiagnosis before finally, and a time when the intsussusception had returned and the polyp had become enlarged, didgnosing the problem. The Claimant was under their management for some three (3) weeks. There is no evidence that Dr. Tomlinson made any effort to contact or consult with the Defendant and the Defendant positively denies any such contact was made, although this would have been prudent **[Notes of Evidence 24 November 2011 @ 2.00 p.m. page 34 lines 4 to 14, Notes of Evidence 25 November 2011 @ 10.00 a.m. page 57 line 15-18].**

29. It is reasonable to presume that had the Claimant returned to see Dr. Monroe or had her new doctor consulted with him, a recurred intussusceptions would have been immediately diagnosed and therefore immediate steps taken to correct it surgically. It was the delay in diagnosis by the doctors at Andrews Memorial Hospital who caused her trauma and not any act or omission by the Defendant.

CONCLUSION

30. The muscle split cut to the right lower abdomen is considered by a considerable group of medical experts to be an acceptable mode of confirming a clinical diagnosis of intusssuception. It is submitted that it cannot be said that the Defendant was negligent in failing to locate the

polyp within an intestine which was inflamed. The Claimant was discharged from Nuttall Memorial Hospital in no apparent discomfort and with instructions to return to see the Defendant on the 24th July 2006 and to contact him if pain returned. When pain returned the Claimant went elsewhere for treatment and no contact was made with the Defendant would have led to speedy diagnosis of a recurred intussusception.

31. In the premise we submit that the Defendant was not negligent and that judgment should be rendered accordingly.

COURT

[7] There can be no doubt that the Defendant was regarded as one of Jamaica's pre-eminent surgeon. His qualifications are impeccable.

[8] His defence to this action is based on his finding no mass or evidence of the presence of an intussusception upon external manual palpation of the Claimant before he made his incision.

[9] Strangely, his experts seem to have followed this reasoning . They should all have been aware that the intussusceptions even when unresolved may move and may not be apparent on manual palpation of the patient.

[10] More significant however is the Polyp. If the polyp is not removed then the intussusception will recur. It would therefore be necessary to remove the polyp in any event.

[11] For the eminent doctor to have concluded there was no intussusceptions would be to doubt the tests that the patient had undergone including the x-ray which he himself ordered.

[12] It is highly probable that the Claimant's intussusceptions was not apparent on palpation or the several diagnosis which were wrong would not have occurred. The latter tests [x-ray] did confirm the reason for the scheduling of emergency surgery.

[13] It is agreed by all the experts that the incision made by Defendant was more suited to perform an appendectomy than a laparotomy -

1. It is apparent that when the Defendant made his incision he intended merely to do an appendectomy and not a laparatomy. This was in complete disregard of the results of the most recent test and confirmation by the x-ray of the intussusceptions and polyp.
2. Any appearance of discolouration of the appendix was due to the barium meal test which the Defendant in all probability was aware of.

[14] The removal of the appendix of the Claimant was obviously unwarranted and unnecessary.

[15] The failure of the doctor to disclose to the patient that he had merely removed her appendix and to warn her about the highly possible recurrence of her symptoms as he had not removed the catalytic poly are clear instances of negligence by the Defendant.

[16] It is his negligence that caused the Claimant to have to undergo a second surgery to have the treatment that the Defendant was expected him to have done. It is frightening to know that the Claimant's sufferings were exacerbated after the Defendant's surgery and the corruption of the intussusceptions which should have been removed by emergency surgery had not taken place.

[17] Any miss diagnosis of the Claimant's illness would have been contributed to by the inexplicity of the actions of the Defendant and perhaps the absence of the intussusceptions on external manual palpation.

[19] Simply put, the Defendant failed to make an adequate incision to properly examine the Claimant's intestines for the intussusuception and or the catalysis polyp.

(a) The Defendant routinely removed the Claimant's appendix based on discolouration on which should have evidently resulted from the barium meal test.

(b) The Defendant did not inform the Claimant that he had merely removed her appendix and had failed to remove her intussusceptions and catalytic polyp.

[20] I am at a loss as to why the Defendant did not take his friend's advice and "settle quickly".

[21] Perhaps this is due to the thinking that there had been a possible resolution of the intussusceptions, which I find was highly probable.

[22] This Court will enter judgment for the Claimant as follows:

Special Damages of $461,518.45 with interest at 3% from the 27/6/07 to the 17/10/12.

General Damages of $2,500,000.00 with interest at 3% from the 5/7/07 to the 17/10/12