**IN THE SUPREME COURT OF JUDICATURE OF JAMAICA**

**CLAIM NO. 2008 HCV 02484**

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| **BETWEEN** | **MELISSA SMITH** | **CLAIMANT** |
| **AND** | **PATRICIA DUNWELL** | **DEFENDANT** |

Mr. Dale Staple instructed by Kinghorn & Kinghorn for the Claimant.

Mr. John Graham and Peta-Gaye Manderson instructed by John G. Graham & Company for the Defendant.

**Heard: May 3, 4 and 25 and December 20, 2011.**

**EDWARDS, J**

> ***Negligence-medical specialist-controversial treatment-whether departure from acceptable medical practice-duty to inform of risk-whether failure to warn-consent to treatment-standard of disclosure required-whether objective or subjective test is to be applied-whether defendant liable.***

## INTRODUCTION

[1] The claimant is no different from any other young female. She wants perfect skin. It is the ideal. But perfect skin tone has eluded her from childhood. So, like any other young lady with the resources to do so, as soon as she reached adulthood she sought help for her perceived problem.

[2] The claimant was plagued with a common childhood problem in people of colour; a skin problem known as hyper-pigmentation. In layman's terms, it is the presence of dark spots on the skin. In the case of Miss Smith, it was on her lower limbs. But so conscious was she of their presence that she missed out on the childhood delights of physical education, and that delectable freedom felt in the wearing of skirts and shorts.

[3] She is now 26 years old and happily married but she continues to be haunted by her childhood nemesis, that wretched hyper-pigmentation. In her quest for freedom she began visiting doctors, dermatologists, those who claim to be experts in such matters. The first began treating her with bleaching creams. This offered temporary relief only; for as soon as the use of the creams was suspended, those pesky spots would return.

[4] She was referred to the defendant in this case and was offered a course of treatment, specifically chemical peeling, which gave her some hope of a final resolution to her dilemma. But alas, it was not to be. The end results led to disappointment, damage to the skin and ultimately this claim.

[5] The defendant, on the other hand, has been a dermatologist since 1990 and had been performing chemical peels on black skin for over fifteen years. She also claimed that she had performed over a thousand chemical peels in non-face areas of people of dark skin. In addition to her practice, the defendant also teaches the chemical peel procedure to doctors both locally and internationally. She denied that the damage to the claimant's skin resulted from the chemical peel or any negligence on her part.

**THE CLAIM**

[6] The claimant is suing to recover damages for negligence as a result of the medical treatment administered by the defendant to treat what she described as a minor skin discolouration. The claimant avers that the medical process known as chemical peel which was applied to her skin by the defendant has resulted in her skin being irreparably damaged.

[7] The claimant contended that, due to the defendant's negligence in administering the chemical peels, her skin was damaged and left in a far worse condition than when she first consulted her. As such, the claimant claimed damages for negligence in that the defendant did not act in accordance with

acceptable medical practice. She also claimed that she had not given her informed consent to the treatment.

[8] The claimant further contended that the defendant failed to properly advise her on the risks involved in and the implications of the treatment and had failed to take reasonable care to ensure that the treatment would have the desired result and not worsen the appearance of her skin. In her particulars of claim the claimant alleged that she suffered the following injuries as a result of the defendant's negligence in administering the chemical peel:-

(1) Development of a large ulcer on the posterior aspect of the right thigh;
(2) Large scar on the right thigh and smaller scars and bleached areas on both legs;
(3) Distinct bleached areas at the injection sites and a depressed area at the sites;
(4) Outburst of stretch marks on the thighs;
(5) Large atrophic scar with mottled pigmentation on the right posterior thigh;
(6) Thinned skin on both inner thighs with marked red striae (stretch marks) on the inner areas extending from the inner knees to the upper thigh areas;
(7) Depressed scars with bleaching on the right lateral thighs;
(8) Chemical trauma to the legs, thighs resulting in scarring and bleaching.

[9] The defendant denied the claimant's allegation of negligence and asserted that the claimant's injuries were caused by or contributed to by the claimant's own negligence. The defendant admitted to recommending chemical peeling to treat the claimant's condition as there was no other treatment that she would have recommended to get the results she wanted to see in the claimant's skin.

[10] The defendant claimed that she acted in accordance with accepted practice of a reasonable body of medical practitioners skilled in the practice of

dermatology. She denied that the claimant was not told of what was involved in the process. She insisted that the claimant was properly advised, both verbally and in writing and was told of and recognized that such problems that may arise with her skin was treatable. The defendant averred that the claimant agreed that she would give her the opportunity to treat those problems in accordance with accepted practice and the signed agreement between them.

[11] The defendant averred that the claimant's injuries was caused or contributed to by her aggressive use of the priming agents, in particular Retina A; and also by her failure to attend on the defendant for the continued management and treatment after the chemical peels, as agreed.

**THE ISSUES**

1. Whether the claimant was properly advised by the defendant of the risks inherent in and implications of the treatment administered;
2. Whether the claimant gave informed consent to the treatment which was administered;
3. Whether the defendant was negligent in administering the treatment to the claimant.

**FACTS**

[12] The defendant is a dermatologist with sterling qualifications. She was consulted by the claimant in December 2006 regarding her face and lower limbs. The defendant diagnosed the claimant as having post inflammatory hyper-pigmentation of lower limbs and buttocks, small scattered multiple scars to lower limbs, stretch marks to buttocks and inner thighs, keratosis pilaris to the thighs and acne vulgaris to the face. The face was successfully treated and there is no complaint in that regard. For the hyper-pigmentation the defendant recommended a course of treatment involving chemical peeling. The claimant consented to undergo this course of treatment.

[13] Before the administration of the chemicals the defendant provided the claimant with priming agents to be applied to the skin in preparation for the peels. These were Retin A, Beta Hydroxy and Glycolic lotion. She was also given sun blocking lotions. Before commencing the procedure, the claimant signed a document termed “Informed Consent for Chemical Peeling”. The plan was to perform three chemical peels to the lower limb. The first peel was administered on the 25 January 2007 and the second on March 24, 2007. A third peel was never done. The first peel was carried out by applying Glycolic acid (70%) (superficial peeling all over the legs) and Trichloracetic acid (35%) (medium peeling to the spots and scars).

[14] Before the second peel was administered, the defendant noted that the claimant’s legs were irritated in certain areas. She had multiple areas of irritation with cracks in the skin especially on the inner thighs and posterior thighs. Despite this, the second peel was administered to the lower limbs. The irritated areas were protected with petrolatum and avoided. Because of the skin irritation the processing time for the second peel was abridged but still the claimant suffered severe discomfort. The peeling time was shortened from thirty minutes to eight minutes.

[15] On both occasions the claimant was sent home with post peel moisturizers and instructions. She was also given antibiotics to apply to the irritated areas. The prescribing of antibiotics was disputed as no record of it appears in the doctor’s notes. But I accept as most likely than not that the doctor would have prescribed treatment to the broken skin and even more likely that the claimant would have requested such treatment.

[16] By April 2007 the irritated areas had crusted and were in the healing stages. The peeled areas had normal response with uniform fine exfoliation. The irritated areas on the posterior thighs healed with hyper-pigmentation and a small scar. She was prescribed Dermovate. She was also given an injection in May 2007 for

a deeply imbedded hyper-pigmented old scar. The claimant missed her follow-up appointment on June 6, 2007. Her wedding took place on the 9th June 2007. She returned to the defendant in July and August for further treatment.

[17] By August most of the superficial and deep pigmentation were gone but thereafter, the claimant visited the defendant and complained of the scarring to her posterior right leg and stretch marks to her inner thighs. She claimed that these scars and stretch marks were not present prior to the peel. She became dissatisfied with the results of her treatment and discontinued the services of the defendant.

[18] As noted earlier, the claimant has had this stubborn skin problem (as she described it) to her legs since childhood. Her first visit to a dermatologist with regard to the problem was sometime in 2006. At that time she had been terribly self-conscious about her legs and had been so since high school.

[19] She was in the care of that first dermatologist for less than a year. He prescribed a course of treatment to the legs. Her evidence was that she possibly made more than 5 visits to that dermatologist. Her objective was to have the spots removed from her legs. Her evidence was that the dermatologist did not seem to be sure he could cure her problems. Or at least that was her impression. Her evidence was that he gave her no guarantees.

[20] He prescribed creams and did micro-dermabrasion. The cream was to be applied to the area for 2 weeks. These prescriptions were to be repeated. The cream was to be applied before and after the micro-dermabrasion. She was unable to say for how long and over what period she did this treatment. She admitted however, that the creams she was given to use and did use were bleaching creams.

[21] She was later recommended to the defendant. By this time, as she admitted, she wanted to be talking to a doctor who could give her a 100% guarantee of a cure. According to her claim form she first saw the defendant in December 2006.

However, in her evidence she could not recall this. The defendant's evidence is that she first saw the claimant on December 21, 2006. This I accept. At that time she was told that the claimant had already received treatment from another dermatologist. She testified that the claimant complained of stretch marks from that first visit. She was also aware that the claimant had been using bleaching creams on her lower limbs prior to seeing her and it was her evidence that bleaching creams could cause stretch marks.

[22] The defendant recommended a process called chemical peeling as the one which would provide the best result for improvement in the claimant's skin. The claimant's evidence was that like the situation with the previous dermatologist, the defendant was not able to give her a 100% guarantee of a cure.

[23] The claimant had never done the procedure before and was neither concerned nor apprehensive before her first chemical peel on January 25, 2007. She signed a consent form to the procedure and asked no questions.

[24] Now, I must indicate that around the time the claimant saw the defendant she was planning her pending nuptials. The date of her nuptials was discussed with the defendant. It would appear that the claimant wanted to see some improvement, if not a total cure, by her wedding day and certainly in time for her honeymoon. She expressed this hope and desire to the doctor. It was her evidence that the defendant assured her that she could help the situation by the wedding date. As noted previously her wedding date was set for June 9, 2007.

[25] There was evidence from the claimant, which I accept as true, that the defendant told her that there was a process to be followed with this type of treatment. She was told she would have to do more than one chemical peel to get the results she desired. She was also told that she would be given priming agents to rub on her legs to prepare them for the peel after which she would be assessed. She was given a prescription, along with a preparation purchased

from the defendant's office for the priming. She asked the defendant no questions as she had confidence in what she was being told.

[26] The priming agents were creams. Her evidence is that she asked no questions regarding them or what effect they would have on the skin. She said she was told it was in preparation for the chemical peel and as she was not expecting to see anything abnormal she asked no questions.

[27] Incidentally, she had also seen the dermatologist for problems to her face but no complaint was raised regarding treatment to that area. She recalled being given instructions regarding her face but could not recall any instructions regarding her legs (that is, for the application of the cream to her legs). She said however, that on the prescription for her leg it instructed her to apply it sparingly, but from the defendant herself she claimed to have gotten no instructions. She also did not see it necessary to ask for any. In her witness statement she said she would go for creams periodically from a nurse in the office and apply them as directed by the nurse.

[28] I find it unlikely that she would have been instructed as regards her face but not her legs. I accept that she was informed by the defendant as to the purpose and use of the primers and was in fact given instructions as regard the application of the primers to her legs by the defendant's nurse. There is no allegation that the nurse was not competent to give such instructions on behalf of the defendant.

[29] There was a patient advice form which was tendered into evidence. The claimant told the court that she saw and read this form prior to her first chemical peel. However, she could not recall if she had asked the doctor any questions regarding it. She asked no questions about the patient consent form (which had also been tendered into evidence) because according to her it was clear cut. Her understanding was that if something went wrong the doctor could control it or fix it.

[30] It was her evidence that although she was told the treatment was a process, she had not been told the length of the process and she did not ask. She however, was working with her wedding date for an end result, which was a time that she said the defendant had not objected to. She agreed that there was nothing on the form which indicated that the process would not go beyond 6 months. She was also aware that it was possible for the treatment to go over the time. She pointed out that she had signed a consent form and based on that she did envisage that the process could go beyond June. She was also aware that something could go wrong with the treatment, but that whatever went wrong would be treatable.

[31] She saw the defendant over 6 times and kept all her appointments except for the one on 6th June 2007. This was close to her wedding day and with visitors coming in and being out of Kingston it was not convenient for her to keep this appointment. That appointment was after her second peel. She went back to the defendant's office on the 5th July 2007, one month later.

[32] To the best of her memory (admittedly now poor since the birth of her first child) she did two chemical peels although her particulars of claim indicated she did three peels. I accept from the evidence that she in fact did only two peels.

[33] She said that when she got the scar to her posterior leg she was not apprehensive because of what was stated in the consent form. She was prepared to work with the doctor. She said however, than when her legs began getting worse the defendant told her she could not guarantee it would get any better or any worse. The defendant then advised a continuing course of the chemical peel treatment and proposed a new treatment with laser, at which time she decided to get a second opinion.

[34] She went to Dr. Clare-Lyn Shue, a dermatologist, for a second opinion. She also went to a health spa for advice. Dr. Clare-Lyn Shue was a witness for the claimant in this case. I will come to her evidence in due course. After getting a

second opinion she went back to the defendant to discuss it with her. She had gone to see her without an appointment but the doctor agreed to see her. It is her evidence that at this visit she found the defendant's attitude to be dismissive and disrespectful. I make no finding as to that.

[35] Following her last visit to the defendant she went to see a plastic surgeon to get his advice. She said she had made up her mind to discontinue treatment with the defendant after Dr. Clare-Lyn Shue advised her not to continue. She however, did not treat her neither did she suggest any alternate treatment for her. The claimant advised the court that she has decided to live with her scars because of the fear that any further treatment will make them worse. She admitted that in her reference to scars she also meant stretch marks.

[36] She admitted that the defendant had told her that as part of the process there would be damage to the skin which could be fixed. She gave evidence of being aware that the peel would cause some damage to the skin. She was aware that there would be a chemical application which would result in initial trauma. She agreed she stopped attending before allowing her to fix the problem. Her evidence was that based on discussions with Dr. Clare-Lyn Shue, she now believes that the chemical peel was not the best option for her skin type.

[37] She admitted knowing that the creams received from the previous dermatologist were bleaching creams. She could not recall if one was called Kligmans. She could not recall how long she used those creams for. She said she got some results from it. It bleached the area as it said it would. She was happy with the results at first because the spots were lightened but they soon returned.

[38] She said that although because of the spots, she was more comfortable wearing pants, during the peeling process and for about a week after she wore skirts, on the instructions of the defendant. She claimed that after that the defendant had no problem with her wearing pants, as long as they were not close

fitting. After the peel she was still applying chemicals to the skin and although she began wearing pants they did not irritate or rub against her skin. She said she had no irritation to the skin at back of the knees before the peel. She insisted she complied with instructions not to wear tight fitting or coarse clothes. In the result, she ended up with a scar to the posterior (back) of her mid thigh about 3 inches above the knee.

[39] It was the defendant's assertion that chemicals were not applied to the back of the claimant's knees and peeling was not generally done in that area. The claimant had not made any definitive claim that the scar to the posterior right leg was caused by the chemical peel it self. I find on a balance of probability that based on the evidence it was caused by irritation either from the preparatory application of chemicals pre-peel or constant rubbing in that area post peel.

[40] It was the claimant's evidence that she had no stretch marks before the peel. She claimed that it was after the peel that she ended up with stretch marks and scars. I have to say that her medical records show that she attended on the defendant with stretch marks and small pigmented scars already present on her legs. To her mind the presence of the stretch marks and scars after the peel meant something had gone wrong. She wanted a guarantee from the defendant that continued peeling and laser would fix it. She got none.

[41] In cross-examination she was asked to describe her understanding of the process. Her understanding was that having done the peel there were possible side effects that would be treatable; the peeling would involve application of chemical to the skin, which would stay on for awhile and there would be a slight discomfort after which it would be wiped off. She stated that whilst the first dermatologist made her no promises, the defendant did promise that she could fix the problem.

[42] She declared that she was told by Dr. Clare-Lyn Shue that the scars she got from the peel were life long scars (again she admitted that by scarring she also

meant the stretch marks). She claimed she was told that peeling would not solve it, neither would laser treatment help. Under much distress and trauma punctuated with incessant crying, the claimant showed to the court the condition of her legs. I must confess to have been pleasantly surprised, as based on the evidence, I truly expected much worse than what was seen on inspection.

[43] There was a noticeable small scar to the back of the right leg just above the knee. It appeared to be a healed lesion. There were stretch marks down the front of the right leg. The inner thighs had stretch marks which were fading with very slight discolouration. Stretch marks were below the right knee. The left leg had noticeable stretch marks on the inner thigh. I saw no noticeable hyper-pigmentation (spots) on the skin. This would suggest that the peel did in fact work in that regard. In fact I accept the defendant's evidence that when she saw the claimant in August 2007, most of the superficial and deep pigmentation were gone, leaving only stretch marks and keratosis pilaris to the skin.

**CLAIMANT'S SUBMISSIONS**

[44] Counsel for the claimant contended that the defendant did not properly advise her of the risks inherent in the treatment administered to her. The gravamen of his contention was that she ought to have been told that post inflammatory hyper-pigmentation was virtually untreatable in black patients.

[45] His argument was that the claimant's request was for the removal of the discolouration and therefore she ought to have been told that there was medical opinion to the effect that this was not possible in her skin type. This, he claimed, was information the patient should have been given so that it would be taken into account when deciding whether or not to have the treatment.

[46] Counsel suggested that some guidance might be found in the reasoning of the court in the case of **Rogers v Whitaker** 175 CLR 479, relating to what a doctor is required to do in giving advice to patients before they undergo any course of medical treatment. He further argued that the defendant had a duty to

advise the claimant that the option of chemical peeling was not likely to have much success. The court was asked to accept that the defendant did not take the time to advise the claimant of the range of options available or what the process of chemical peeling which she suggested, involved. He suggested that his position was supported by the English authority of the House of Lords decision in **Chester v Afshar** [2005] 1 A.C. 134.

[47] The court was further asked to accept that the claimant did not give informed consent to the procedure used as she was not fully and properly advised by the defendant as to the risks involved in the procedure and the likelihood of success in treating her condition. This, it was submitted, was to be judged on the objective standard laid down in the case of **Reibl v Hughes** (1980) 114 DLR (3d) 1; based on that standard the defendant was negligent in the advice given to the claimant.

[48] It was also submitted that the defendant guaranteed or purported to guarantee a full and successful resolution of any and all problems which might have arisen from the chemical peel itself, when it was manifestly clear from available medical knowledge that this was unlikely.

[49] Counsel further submitted that as the defendant was a member of the American Association of Dermatologists she ought to be judged by that practice and standard of advice and care. Counsel noted that furthermore, the suggestion by the defendant that the claimant misused the priming agents is not supported by evidence; that the defendant offered no explanation as to the difference in her reference to aggressive use of the priming agents as against its normal application. He pointed out however, that it was negligent for the defendant not to properly instruct the claimant in the proper use of the priming agents before the chemical peel. This failure, it was submitted, was part of the negligent manner in which the defendant administered medical treatment to the claimant leading to the claimant's skin being damaged.

[50] It was pointed out that the chemical peel was administered by the nurse and that the claimant suffered sufficient stinging to cause her to cry out to the nurse who did not immediately attend to her to provide relief. This, he said, was contrary to the instructions the defendant claimed to have given.

[51] The court was also asked to note that that the defendant did not provide evidence of any instructions given for the application of the priming agents; the post peel instructions given being for patients who had done facial peels.

[52] It was argued that by the stage of the second peel, it had become clear that the claimant's skin was not in a condition for chemicals to be applied to it; the defendant nevertheless persisted with the treatment. That the planned time in which to expose the claimant's skin to the chemicals had to be aborted because of the painful distress the claimant was in. This, it was argued showed that the defendant's treatment was negligent.

**THE DEFENDANT'S SUBMISSIONS**

[53] The defendant's attorney denied that there was any negligence on the part of the defendant and submitted that any damage done to the claimant's skin was caused by or contributed to by the claimant's own negligence. It was pointed out that it was the claimant who aggressively applied the priming agent Retina A to her skin and it was the claimant who failed to attend on the defendant for the continued management and treatment after the peel.

[54] Counsel urged the court to find that the defendant acted in accordance with a practice which was accepted as proper by a reasonable body of medical practitioners skilled in the practice of dermatology. This he said was the test accepted in **Bolan v Friern Hospital Management Committee** [1957] 2 ALL E.R. 118 and approved as correct in **Sidaway v Governors of Bethlem Royal Hospital** [1985] 1 ALL E.R. 643.

[55] The court was asked to note that the claimant's expert Dr. Clare-Lyn Shue, herself a dermatologist, gave evidence that she had done chemical peels in the past and that it was not a rare or unacceptable method of treatment. It was further argued on behalf of the defendant, that chemical peeling was an acceptable treatment for the claimant even though the defendant's views on the procedure differed from that of Dr. Clare-Lyn Shue.

[56] Counsel submitted that the claimant was properly advised both verbally and in writing of what was involved in the process and the course of treatment; that she was also advised orally and in writing as to the risks and possible effects from the treatment. It was further submitted that the claimant had been made to and did recognize that any problem which may arise from the treatment to her skin was treatable.

[57] It was also pointed out that the claimant had sought guarantees and assurances from the defendant which she did not receive and as a result of that she terminated her treatment.

**THE LAW**

[58] Negligence in law means some failure to do some act which a reasonable man in the circumstances would do, or doing some act which a reasonable man in the circumstances would not do. If that failure results in injury then the defendant may be held liable. Where the defendant is possessed of special skills the test of whether there is negligence or not is that of the ordinary skilled man exercising and professing to have that special skill. It is sufficient if he is exercising the ordinary skill of an ordinary competent man exercising that particular art.

[59] The duty of a medical practitioner is to exercise reasonable skill and care: per McNair J in **Bolam.** He 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: per Lord Scarman in **Sidaway** approving the Bolam test. Such a person is not negligent merely because there was a body of opinion which would take a contrary view: **Hind v Craig** (1983) 19 JLR 81 judgment of Wolfe J (as he then was) applying the Bolam test. If there is a deviation from the normal practice it must be established that there was a normal and usual practice; that the defendant failed to follow that practice and that the course of action adopted by the defendant was one which no professional man of ordinary skill would have taken if he had been acting with ordinary care: **Hunter v Hanley** (1955) S.C. 200.

[60] The test of liability in respect of a doctor's duty to warn his patient of the risks inherent in any treatment recommended by him is the same as his duty regarding diagnosis and treatment. See also **Hills v Potter and others** [1983] 3 ALL ER 716, judgment of Hirst J. The doctor has a duty to inform of any significant risks and is required to act in accordance with a practice accepted at the time as proper by a responsible body of medical opinion; and that only required the doctor or surgeon to supply the patient with sufficient information to enable the patient to decide whether or not to undergo that treatment. This is a subjective test and is doctor centric.

[61] Medical opinion on the same matter may differ even amongst a competent body of professional men. So a medical man is not negligent merely because his conclusion is different from that of other professionals in his field. As long as he acts in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. If he acts in accordance with that practice he is not guilty simple because there is a body of opinion which takes a contrary view. Of course if a whole body of opinion shows a particular technique to be wrong or dangerous, he cannot continue to carry it out.

[62] A doctor who professes to exercise a special skill must exercise the ordinary skill of his specialty. Lord Scarman in delivering the judgment of the House of Lords in **Maynard v West Midlands Regional Health Authority** [1984] 1 W.L.R. 684 after quoting from Lord President Clyde in **Hunter v Hanley** on the scope for

genuine differences in opinion of professional men when it comes to diagnosis and treatment, went on to say;

> "**Differences of opinion and practice exist, and will always exist, in the medical as in other professions. There is seldom any one answer exclusive of all others to problems of professional judgment. A court may prefer one body of opinion to the other; but that is no basis for a conclusion of negligence."**

[63] In **Sidaway** the House of Lords by majority rejected the objective patient centric notion of a general doctrine of informed consent imported to Canada and Australia from the United States. The House declared that the doctrine of informed consent as it was applied in the Australian, Canadian and United States Courts did not form part of the English law. The English common law as it stood and as approved at the highest level of the English courts in **Sidaway** may be summarized as follows;-

(1) A decision on what risk to disclose to a particular patient in order that he may be able to make a rational choice whether to undergo the particular treatment recommended was primarily a matter of clinical judgment.

(2) The disclosure of a particular risk of serious adverse consequences might be so obviously necessary for the patient to make an informed choice that no reasonably prudent doctor would fail to disclose that risk.

(3) When advising a patient about a proposed or recommended treatment a doctor was under a duty to provide the patient with the information necessary to enable the patient to make a balanced judgment in deciding whether to submit to that treatment and that included a requirement to warn the patient of any dangers which were special in kind or magnitude or special to the patient. That duty was subject to the doctor's overriding duty to have regard to the best interests of the

> patient. Accordingly, it was for the doctor to decide what information should be given to the patient and the terms in which that information should be couched.

[64] In **Rogers v Whitaker**, a decision of the High Court of Australia, it was held that a medical practitioner had a duty to warn the patient of a material risk inherent in a proposed treatment, except in cases of medical emergencies. Here the Bolam test was discussed and rejected. The court held that a risk, in such a case is considered to be one where a reasonable person in the patient's position would likely attach significance to it. It is also one where the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. Based on this principle questions as to what is the standard medical practice is largely irrelevant. This is an objective test based on the patient's autonomy over their person and the right to know and make an informed choice. This is what is known in the United States as informed consent. In Canada the term was used with caution in **Reibl v Hughes** and in **Rogers v Whitaker** it was noted that the term was apt to mislead.

[65] In the Canadian case of **Reibl v Hughes** the Supreme Court of Canada separated the principles applicable to the question of whether a doctor carried out his professional duties by applicable medical standards from the question of his duty to disclose and the patient's right to know. The latter is to be left up to the determination of the courts based on an objective test (the American approach) while the former will be based on an application of medical standards that is, the subjective test (the English approach).

[66] The court went on to find that a failure to disclose was a question of negligence and did not vitiate consent. On the issue of causation the Supreme Court of Canada rejected the US standard of the subjective test as having the potential to leave the doctor at the mercy of the patient's hindsight and bitterness, while preferring the application of an objective test to causation (the English approach).

[67] In the more than twenty years since **Sidaway** was decided, the English Courts have begun to more widely recognize the patient's personal autonomy and right to choose**. Sidaway** therefore, now needs to be reconciled with the House of Lords decision in the case of **Chester v Afshar** [2005] 1 AC 134. In that case a surgeon advised the claimant to undergo an operation on her spine which carried a small risk of paralysis, even where the procedure was conducted without negligence. The patient consented to the operation but thereafter became paralyzed as a result.

[68] The trial judge found that the doctor had negligently failed to warn the claimant of the small risk of paralysis and in that respect he found the doctor negligent under the principles laid down in **Bolam**. He also found that had the patient been aware of the risk she would have sought alternative advice and delayed the surgery. There was no negligence in the conduct of the surgery. The judge held that there was sufficient causal link between the defendant's failure to warn and the damage sustained by the claimant. The defendant was held liable and the decision was upheld by the Court of Appeal.

[69] The case went to the House of Lords. The issue before the House was largely one of causation, as it was commonly agreed that the doctor had failed to properly advise the claimant of the small but serious risk inherent in the operation. Both Lord Walker of Gestingthorpe and Lord Hope of Craighead decided that the duty to warn and failure to do so was intricately tied to the issue of causation and went on to discuss the principles applicable to the duty to warn.
[70] Lord Steyn, in his judgment, in looking at the doctor's duty to warn a patient of a serious risk of injury referred to the decision of Lord Woolf MR in **Pearce v United Bristol Healthcare NHS Trust** (1999) PIQR P53, where he reviewed the decision in **Bolam**, **Sidaway** and **Bolitho v City and Hackney Health Authority** (1998) AC 232. Lord Woolf MR in **United Bristol Health Care** observed:

> "***In a case where it is being alleged that a plaintiff has been deprived of the opportunity to make a proper decision as to what course he or***

> ***she should take in relation to treatment, it seems to me to be the law, as indicated in the cases to which I have just referred, that if there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or she should adopt."***

[71] Lord Steyn held that a surgeon owed a legal duty to a patient to warn him or her in general terms of any possible serious risks involved in the procedure to be adopted for treatment. He held that the only qualification was if there existed any wholly exceptional cases where, objectively, in the best interests of the patient, the surgeon may be excused from giving a warning. This objective test alluded to by Lord Steyn is the American standard and not the English standard as hitherto applied. He declared that medical paternalism had no place in modern law. The patient had a prima facie right to be informed by a surgeon of a small, but well established risk of serious injury as a result of surgery. It is a right which was to be protected.

[72] The House of Lords however, held that in Dr. Afshar's case there was no causal link between the risk, the failure to warn and the effective cause of the injury since there was no finding that even if she had been properly informed she would not have undergone the surgery and the risk was so random that it was likely to occur regardless of skill and care. The House held however, that the scope of the doctor's duty as held in all the speeches in **Sidaway**, was to advise his patient of the disadvantages or dangers of the treatment proposed. Such a duty was closely connected with the need for the patient's consent.

[73] This duty to inform was elevated by the House to a legal rule which served two purposes. It avoided the occurrence of a particular physical injury, the risk of which a patient is not prepared to accept. It also ensured that due respect was given to the autonomy and dignity of each patient. The right to be informed was thus equated with the right to choose.

[74] Though the Australian and Canadian approach (the objective test) was rejected in favour of the **Bolam** test in **Sidaway**, Lord Steyn in **Afshar** recognized that common in all the speeches of the Lords was a recognition of the fundamental importance that must be attached to the right of the patient to decide whether he will accept or reject the treatment which is being proposed by the doctor. What it recognized is that in the case of a recommended treatment which may have disadvantages or dangers, the final decision must be made by the patient and not by the doctor. The patient's right to make the final decision and the duty of the doctor to inform the patient if the treatment has special disadvantages or dangers go hand in hand.

[75] The difference between the **Bolam** test which was preferred in **Sidaway** and the United States, Australian and Canadian approaches is the medical standard (subjective test) as against the reasonable prudent patient standard (objective test). That is the subjective over the objective test. Lord Steyn, at least, would apply the objective standard in determining the patient's right to know. In his judgment he declared that surgery performed without the informed consent of the patient is unlawful. Informed consent, he said, constitutes a general warning of a significant risk of injury. Most importantly as to the standard he would apply he declared that the court was the final arbiter of what constitutes informed consent. This implies an embracing of the objective American standard.

[76] For Lord Hope however, where the giving of advice or professional opinion was concerned the standard remained that of competent professional opinion, that is, what the ordinary skilled man exercising and professing that special skill would do (the subjective test). He saw the difference in the two standards as one which was set by physicians for themselves and one which was set by the law independently of any medical opinion. He noted that the objective standard was rejected by the House in **Sidaway** for the subjective test in **Bolam**. In his view the English Courts always recognized the requirement for informed consent. The question was what standard to apply to it. His answer was that the English

Courts were to recognize the nature of the doctor's duty which was to inform and apply the Bolam test to it.

[77] The decision in **Afshar** and those on which it relied came into fundamental clash with the principle of causation. The facts in **Afshar** failed the 'but for test". The usual burden in cases of causation is for the claimant to prove that the defendant's breach caused the damage. Where the breach is a failure to warn of risk, the claimant must prove that he would have taken the opportunity to avoid or reduce the risk. However, the House of Lords went on to apply a strict liability where there is a failure to inform of a serious risk and that risk eventuated, holding that the court had a duty to vindicate the claimant's right to be informed by imposing damages against the defendant. Therefore, the court held that a narrow and modest departure from traditional causation principles, were justified in **Afshar's** case.

[78] In my view this policy of vindication is grounded in the law of restitution and not in negligence or the law of tort. Lord Hoffman in his dissenting judgment referred to it has a special rule to allow surgeons who fail to warn of risks becoming insurers against those risks.

[79] A defendant is not causally liable nor legally responsible for wrongful acts or omissions if those acts or omissions would not have caused the plaintiff to alter his or her course of action. A causal connection will exist between the failure to warn and the injury if in all probability the patient would have acted on the warning and refused treatment. This is causation in the easy cases. In the hard cases, according to the decision in **Afsha**r, the normal approach to causation may be modified as a matter of policy and in the interest of justice. The majority in **Afshar** applied and approved the reasoning in the case of **Chappel v Hart** 195 CLR 232, which was an Australian case with similar facts. Lord Hope stated categorically that although the approaches to the duty to warn was different in terms of the standard applied, he found common ground in the cases on the issue of causation.

[80] The reconciliation of **Sidaway** with **Afshar** case may be found in the understanding that the misnomer “doctrine of informed consent” imposes no duty which is any different from the duty imposed by the English common law. A reading of the English cases from **Bolam** to **Sidaway** shows quite clearly that the English law does require a doctor to provide the patient with sufficient information to enable the patient to decide whether to proceed with treatment or not. The difference with the Canadian, American and Australian approach is in the amount of information required to be given and the standard by which the doctor’s conduct is judged.

[81] What the House seems to be saying now is that the patient should be provided with sufficient information as to risk and dangers attendant on any recommended procedure to enable him or her to decide for himself whether or not to take the risk. This was subject to emergency or any exceptional circumstances. The House stopped short of saying that this was based on the prudent patient standard to be determined by the courts (objective standard) and not by the medical standard to be determined by what is the usual and current medical practice (subjective standard). The decision in **Sidaway** approving the subjective standard to the duty to inform in **Bolam,** therefore, still stands and is the applicable law in this jurisdiction.

## **ANALYSIS**

[82] On the claimant becoming a patient the defendant assumed a professional duty with respect to her care to exercise reasonable skill and care in examining, diagnosing and treating her. If treatment was administered and required post treatment care, reasonable care and skill must be exercised in the supervision of her post treatment care. If there were significant risks or dangers involved in the treatment the defendant had a duty to inform the claimant of those risk or dangers prior to the treatment.

[83] The claimant brought evidence designed to show that the defendant's treatment fell below the standards required of her. I will now consider the medical opinion of the doctor called by her on her case.

**The Claimant's Expert Medical Opinion**

[84] Dr. Clare-Lyn Shue, dermatologist, gave evidence on the claimant's case. She is a medical doctor with an MBBS from the University of the West Indies and a Diploma in dermatology from the University of London. She is currently pursing doctorial studies on leg ulcers in sickle cell disease. She is a member of the Medical Association of Jamaica, the Dermatology Association of Jamaica and a Fellow of the American Academy of Dermatology. She is licensed to practice in Jamaica and Grand Cayman and has been in practice for 30 years.

[85] She saw the claimant on the 25th July 2007. On physical examination she noted that the claimant had a large atrophic scar with mottled pigmentation on her right posterior thigh. She described it as a depressed or sunken scar implying a loss of underlying tissue. It was pale. There was thin skin on both her inner thighs with marked red striae (stretch marks) on the inner areas extending from the inner knees to the upper thigh areas. She also had depressed scars with bleaching, on her right lateral thigh. Her trunk and arms were free of scars, striae and pigment changes. She diagnosed her as having chemical trauma to the legs and thighs resulting in scarring and bleaching. She said the scarring she saw could have been and was most likely caused from the chemical peeling. These scars she said were different from the claimant's childhood scars.

[86] According to the medical notes she made at the time of the examination of the claimant, she said the claimant gave a history of treatment with Klig-Man's formula. The doctor explained that this was a formula compounded by dermatologists. It was a cream. She stated that this cream resulted in bleaching on the legs as the claimant had been applying it to her legs. She noted that the claimant gave a history of dark spots on her legs. She also gave a history of

doing micro-dermabrasion on the leg. The doctor explained that this was a form of sanding of the leg or smoothing down of the leg. She also gave a history of chemical peeling resulting in scars and bleached areas.

[87] She noted that the claimant had differing scars. She had atrophic and depressed scars at different locations. Some were bleached some were hyper-pigmented and some were hypo-pigmented. She also had scars which were injected and were bleached.

[88] Dr. Clare-Lyn Shue indicated that she stopped doing chemical peels 2-3 years ago because it did not give her the results she liked in pigmented skin. She found she had better results with other modalities. She failed to state what those other modalities were. Over a period of 3-10 years she would have done between 20 or 30 peels. She was however, aware that it was a well known and accepted method of treating persons with skin disorders. She admitted that it was not a rare treatment although some persons in the profession did not use it.

[89] She had read Dr. Fitz–Henley's report. Dr. Fitz-Henley was the defendant's expert. She agreed with the statement in his report which said that chemical peeling was an invaluable accoutrements. She however, qualified her response by saying that this was true for caucasian skin. She said that a lot of articles have come out on caucasian skin. She admitted that there were articles which spoke about the complications and problems of peeling in black skin. She said that almost all the articles spoke of peeling to the face.

[90] She pointed out that there was a distinction between superficial chemical peels and medium to deep depth peels. There were also several chemicals that could be used depending on the depth of the peel. She referred to Salicylic acid, Glycolic acid, Gestnar's solution used for superficial peels; Trichloracitic acid (TCA) used for medium depth peels (could be used for superficial peeling based on the concentration used). The type used was dependent on the location, depth or thickness of the lesion. It also depends on the end results desired and colour

of the patient's skin. The depth of the peel would also depend on the problem being treated and the colour of the patient's skin.

[91] She noted that there were complications which could arise from peeling irrespective of skin colour. These include erythema (redness), pigmentation including hyper-pigmentation (darkening of the skin) and hypo-pigmentation (paling of the skin). One could also get scars, delineation of the skin and infection. The most common side effect in darker skin patients was hyper-pigmentation. She pointed out that this was paradoxical as it was this condition which most likely the patient had initially complained of and which was being treated. She said this complication could occur in patients of any colour.

[92] She admitted that she would recommend chemical peeling to a darker skin patient if the need arose. She however, would choose to do the superficial peel on dark skin. She would do it on the face. She said chemical peeling is not contra indicated in persons of dark skin, there was nothing to prevent it. She said the doctor would have to be mindful that pigmentation may occur and be careful how deep a peel was done.

**The Report of the Defendant's Expert**

[93] The report of Dr. Michel Fitz-Henley MBBS, M.Sc. D.M., Dip. Derm. was tendered into evidence for the Court's consideration. He is a Consultant Dermatologist fully registered with the Medical Council of Jamaica, a full member of the Medical Association of Jamaica, Dermatology Association of Jamaica, Caribbean Dermatology Association, International Society of Dermatology, American Society for Dermatologic Surgeons and the Council for Nail Disorders and the American Contact Dermatitis Society. He is also a part-time consultant at the University Hospital of the West Indies and an associate lecturer at the University of the West Indies.

[94] In compiling his report he analyzed the medical notes of the patient care given to him whilst at the same time referring to medical literature on the subject. This medical literature pointed to the fact that pigmentation was a problem in black skin and was also a potential problem in chemical peeling.

[95] According to his report the notes presented to him suggested that the claimant was seen by Dr. Dunwell on December 21, 2006. At that time she was diagnosed as having:-

1. Post-inflammatory hyper-pigmentation of the legs;
2. Stretch marks on the inner legs and thighs;
3. Keratosis pilaris on the legs;
4. Scars on the legs; and
5. Acne vulgaris on the face.

[96] Dr. Fitz-Henley began his assessment with the statement that there is no cure for the difficult problem of post inflammatory hyper-pigmentation (PIH) in the skin of black patients. He pointed to a survey of 2,000 black patients done in Washington D.C. in the United States, which showed a majority of patients having this condition. These patients were treated conservatively with topical bleaching agents or were offered no treatment at all. He noted that the problem with and treatment of PIH was universal.

[97] Despite quoting from literature which suggested that there was a dearth of published data regarding chemical peel in dark skin and even less on chemical peels in black skin other than on the face, he proffered the opinion that peeling offered one of the better options. He quoted from literature which suggested chemical peeling was an invaluable accoutrement for dermatologist when treating fine wrinkles, photo-aging, keratosis, acne, and dys-pigmentation. It is unclear whether this is in reference to treatment to the face only of darker skin persons.

[98] Again, based on the literature reviewed, the standard acids used in chemical peeling are Glycolic acids, Salicyclic and Trichloracetic acids. The expert noted that priming of the skin with Retin A and Glycolic acid is a commonly acceptable method of preparing the skin for chemical peeling. He concluded that the use of this by the defendant was an acceptable professional procedure to enhance the penetration of the peeling agents.

[99] He also noted that the follow-up times given to the patient were quite adequate, noting that the frequency of post-operative follow-up visits depended on the depth of the peel and the individual patient's needs.

[100] He accepted that there were potential side effects to every therapy and procedure in medicine. He noted in his report on the patient's notes that the usual and expected side effects experienced by the claimant after the peel initially was dryness and crusting. On the day of the second peel areas of irritation were noted on the inner thigh and posterior thigh. Three days after the second peel the claimant experienced crusting on the posterior thigh. Ten days after there was still some cracking on the thighs. Three weeks later small eczematous patches were seen on the thigh which was treated. Two months after the peel, scars were noted with deep pigmentation and showing a poor response to peel. The scars were injected with appropriate explanations to the patient noted on file.

[101] The notes showed the patient returned seven weeks later with concerns regarding stretch marks. Subsequently, a plan was prescribed for further priming and peeling and laser therapy for the stretch marks. After quoting from literature suggesting the varying side effects which a patient might experience after a chemical peel, he noted that the claimant experienced the expected side effects of dryness and crusting after the first peel. The expert made lengthy comments on the notes he reviewed and the treatment which I will not attempt to précis. I will therefore quote from it in its entirety. He said:

“In the **second peel** there seemed to have been more irritation than might have been expected as Dr. Dunwell had to record there was a time limit of application because of what was seen at the time of the peel. There were more follow-ups noted after the second peel so there must have been more concerns about the response. It has been already noted that there were various therapeutic attempts to deal with these concerns using agents which are the same as noted in the ‘guidelines’ (see #2a above). Hence Dr. Dunwell treatments would be considered appropriate.

In the notes from Dr. Clare-Lyn Shue, the patient noted that she had pain. Pain is variable and cannot ALWAYS be a guide to damage or outcome. One must remember that the peeling solutions are all acids and are therefore expected to be uncomfortable. The level of discomfort is very subjective among patients and is not an absolute guide to mistreatments or adverse reactions.

In the notes from Dr. Dunwell it was noted that erythema (redness) was observed and this led to the appropriate use of topical steroids. (See #2a above). Dr. Dunwell must have been sufficiently concerned to have used the most potent steroid dermovate for presumably a more rapid response. Dr. Makram noted that “Irritation leading to pigmentation might start as erythema, thus, the use of topical steroids three to four times a day for 1 week to decrease the irritation is advised. In susceptible individuals, treatment of the possible hyper-pigmentation should be considered prior to its appearance’. (Ref 6 and Ref 7)

What this is saying is that an astute physician should be able to pick up the potential risk of PIH BEFORE it happens by looking for the erythema and treating this aggressively. This is what I see happened in the notes given to me where a perceived problem was being dealt with aggressively. Regrettably, Ms. Smith appears to have done what many patients to do when there is a problem or side effect with their treatment.

Understandably, they will often seek other opinions, which can be a very good thing, but, they may not end up going to another who is ‘expert’ in pigment problems as this case warranted. Timing is of the essence. It has already been noted how important it is to treat potential PIH early.

If PIH then develops, it must also be treated early and aggressively. The treatment of PIH has been likened unto treating a stain in one’s clothes. The sooner it is washed out the better chance there is of getting it out. The longer it remains, the more ‘fixated’ it becomes. Thus, IF what I see in the notes are correct, at one point Dr. Dunwell asked for a one week review but the next note is some 7 weeks later! Of course, there is NO guarantee that staying with an ‘expert’ or one who best knew the case is any guarantee of success. Continuity will often depend on the patient’s level of confidence and rapport with their physician.

The bleached atrophic sites, approximately noted in the letter from Dr. Clare-Lyn Shue therefore correspond with the expected therapeutic response to the necessary salvage steroid therapy which had been explained to the patient. Usually those side effects resolve over several months. The ‘marked red striae’ of the inner thigh were possibly new and MAY have been due to prolonged use of the steroids in someone who was by then in the phase when she was not following up with Dr. Dunwell. And, if the notes are correct it was during the time that the patient had missed an early follow-up request when possibly those potential side effects might have been detected and dealt with early.

**D. Comments**

Hyper-pigmentation is a common occurrence after irritation and healing in the black skin. Noted Professor of dermatology, Dr. Pearl Grimes, expert on the black skin at the Vitiligo & Pigmentation Institute of Southern California, Los Angeles, California, and Division of Dermatology, University of California, Los Angeles, California, commented on the

tendency of darker-skinned patients to develop dyschromias (pigmentary changes) in response to cutaneous injury in an article on chemical peeling entitled ‘The Safety and Efficacy of Salicylic Acid Chemical Peels in Darker Racial-ethnic Groups’. (Ref. 3).

Post-inflammatory hyperpigmentation is one of the limiting factors in conducting chemical peels in darker races.

In Makram’s study, 73.4% of the patients developed post-inflammatory pigmentation, none developed permanent sequelae, and the pigmentation resolved in all his patients after a maximum of 3 months. (Ref 6. “Similar results had been recorded with superficial peel of salicylic acid in darker-skinned groups.’ (Ref. 6.3) All patients were free of noticeable pigmentation 3 months after the final peel. Patients in whom hyper-pigmentation did not develop were of light brown complexion. He concluded that medium-depth chemical peels are a safe and effective method of treating……patients with dark complexion. (Ref. 6) (NB this reference had cases peeled on the face).

**In Summary**, we have an unfortunate case of a patient who reportedly developed undesirable changes on the skin in an effort to correct an initially difficult aesthetic concern. An analysis of the notes given to me has been done with reference to the medical literature on the subject. The notes do not allow me to infer why a side effect occurred but medical literature was presented to show that pigmentation is a problem in the black skin and is also a potential problem in chemical peeling. Appropriate measures were undertaken in keeping with the medical literature but regrettably the outcome was not satisfactory to the patient. Side effects of those measures were outlined as well as the possible role of delayed intervention.

[102] As a general comment on the evidence, it is clear that the literature on results from the treatment of hyper-pigmentation in dark skin other than the face is sparse. Unlike the face, treatment to the skin on other parts of the body seems to be largely un-documented. This does not make it prima facie wrong, negligent or inherently dangerous if done with due care by someone who is an expert in the field. The defendant herself claimed to have written on the subject. I will now examine the claimant's claim against the background of the medical evidence on both sides.

**Should the defendant have informed the claimant that there was no cure?**

[103] The claimant relied heavily on Dr. Fitz-Henley's statement that there is no cure. However, I find on the evidence that the defendant at no time indicated to the claimant that she could provide a cure. What she offered was a treatment option for aesthetic improvement. The patient herself testified that she was not given a 100% guarantee of success. Her evidence was that the doctor told her she could help the situation.

[104] At the time she was willing to accept the doctor's offer of help and work with her to see an improvement to her skin in time for her wedding. Now she feels that based on advice from Dr Clare-Lyn Shue and the colour of her skin, the procedure undertaken was not the best option. She also claimed that if she had been told there was no cure she would not have gone ahead with the treatment.

[105] This of course is the subjective standard of causation rejected by the Supreme Court of Canada in **Reibl** as being subject to placing the doctor at the mercy of a patient's bitterness and hindsight. On the objective test of causation which was the standard approved, the court must ask itself what would a reasonable person in the patient's position have done if there had been proper disclosure of attendant risks? Would the average prudent person in the patient's position forego the treatment on being told there was a risk it would not work as there was no cure and there were risk to trying? The average prudent patient

would weigh the risk of the trial against the risk of failure. On the one hand not to try would leave her in the same position as before, on the other hand a trial could mean success with minimal risks, which could be resolved. Failure would only put the patient back in the same position as if she had not tried. On a balance of probabilities a reasonable prudent patient in the claimant's position would have taken the treatment anyway.

[106] On the evidence presented it cannot be said that the defendant's choice of treatment was wrong. Even though Dr. Clare-Lyn Shue indicated that she would not have chosen that method of treatment she did not opine that it was wrong. She accepted that it was an acceptable course of treatment. She herself stopped using it because her success rate in black skin was negligible. The defendant claimed to have had successes with the treatment. She had been successfully doing it for over fifteen years. In actual fact the evidence and an actual examination of the claimant's skin showed that the dark spots which were said to have been on her legs were no longer visible. Unfortunately, they were replaced by another different problem, a visible scar and stretch marks. I find that the defendant was not negligent in her choice of treatment for the claimant, or in not informing her that there was no cure.

[107] The remaining question is whether she ought to have been told specifically that chemical peeling had a poor response in black skin. Should she have been told that hyper-pigmentation was virtually untreatable in black skin? What if it turned out that it was treatable despite that body of medical opinion? Was there a body of opinion showing that the adverse effects from treating it was far greater than the problem itself? If there were adverse effects well known to the practitioner, could these have been avoided?

[108] The doctor testified that dark skin was more challenging to treat generally, even for surgery, as dark skin genetically tended to keloid while caucasian skin does not. She said she advised the claimant about the procedure but did not tell her about the lack of literature. She did not advise her of the literature or medical opinion that there was no cure for black skin. She said 90% of her practice was

for treatment of dark skin. She agreed there was not much data but there were some. She spoke of text books and she herself had a major publication. She denied that it was unchartered territory noting that many dermatologists practiced it. She herself had fifteen years of teaching it to other doctors and doing it herself.

[109] She did not agree that there was no cure as she could clear spots in skin of colour. The removal of the spots on the claimant's skin was proof positive of this. She said peeling and laser combined was used to treat stretch marks. We can only guess whether these complications would have been successfully treated as the claimant terminated before any attempt was made. According to defendant stretch marks are difficult to treat and would require repeated peeling, up to at least six over a long period of time. The peeling would not help the scars only injections or dermovate could be used to improve or clear it. If scars are caught early they disappear. This is borne out by the report of Dr. Fitz-Henley. The defendant did in fact prescribe dermovate and injection for the scars.

[110] The evidence from the defendant was that some complications clear up in three days some take up to 3-4 months. Scarring she said was treatable to full resolution or if not totally gone, it could be treated significantly. Complications usually occur in a small area. Again, the report from Dr. Fitz-Henley citing Dr. Markram's study also bore this out. In that study, of the numbers that developed complications, all were resolved in 3 months. Dr. Markram concluded that 'medium-depth chemical peels are a safe and effective method of treating…patients with dark complexion". In my view it makes no difference that this was a reference to peels to the face. There is no medical evidence before me to suggest that facial skin is more hardy and easier to treat than the skin on the legs.

[111] In this case whether there was a cure or not seem to be largely a matter of statistics. The defendant has had successes in this type of treatment for over fifteen years. Other doctors have practiced it without complaint. The claimant admitted she was not given any guarantees but was promised help. A failure to

mention statistics should not generally be seen as a breach of duty to inform; even more so where there was conflicting views amongst professionals as to the results from adopting a particular course of treatment.

**Was the claimant properly informed of the risks involved in the treatment?**

[112] This brings me to the issue of consent. On the evidence it is clear the claimant was given some forms and read and signed those forms. The question which arises is whether the claimant was sufficiently apprised of the nature of the treatment and any attendant risk involved in it. The claimant admitted to receiving various forms but insists she was not properly advised.

[113] There is a tendency for patients to leave diagnosis and treatment to doctors and to ask very little questions. Doctors provide very little information as long as patients sign the necessary consent forms. It had been recognized that there was a difference between ‘true’ consent (the English standard) and informed consent (the American Standard). ‘True’ consent had been held to be where the doctor explains to the patient the nature of the treatment he intended to provide; providing any material information which any other of his peers in good standing would provide. A doctor might be expected to withhold some information from the patient, that which he feels may do the patient more harm than good (therapeutic privilege). Based on this information the patient offers his consent to the treatment.

[114] “Informed consent” emphasized what the patient wants to know, including adverse effects, risk of failure, alternative choices and how that individual patient could be affected by the treatment or its lack thereof. Based on the notion of “informed consent” a patient decides on what he wants to know. Against that background any material risk that a doctor should disclose to a patient would be determined by evaluating whether a reasonable person in the patients position would attach any significance to it.

[115] The House of Lords has now indicated that patients are entitled to give informed consent subject to any exceptional circumstances, where the medical professional is allowed to retain therapeutic privileges. No such exceptional circumstance arises in this case.

[116] The question therefore, is whether the patient was advised of the risk or any potential dangers or adverse effects attached to the procedure before giving consent. She signed a document referring to informed consent. The claimant signed a consent form to the chemical peeling to her legs. This form stated that she was aware that it may be necessary to have repeated procedures. It also outlined the effect the process would have on her skin initially. During the healing process she was expected to have redness, flaking, scaling and crusting. Her skin was also expected to be pink and sensitive to sun. It stated some side effects were expected such as bruising, swelling, infection and scarring but were treatable. It also stated pigment changes were also expected but was also treatable. All this was discussed with her.

[117] She also consented to work along with the doctor in correcting or controlling side effects or complications if they occur. In evidence she admitted to reading it before signing. It is also clear from her evidence that the process was explained to her. It was her evidence that she asked no questions as she was confident in what she was being told by the doctor. She said also that based on the consent form she signed she was aware that something could go wrong and cause the process to be extended but that it was treatable.

[118] She said she asked no questions because it was clear cut. If something went wrong it would be corrected and controlled. She said when she got the first scar she was not apprehensive based on the consent form. It was only when her legs got worse and the doctor could give no guarantee of fixing it that she became apprehensive. She decided to get a second opinion because of the

doctor’s recommendation for more peeling and laser treatment to correct the problem.

[119] She was also given a patient advice form on pre- and post-operative instructions for chemical peeling. It was indicated on that form that peeling would only be done if the patient was willing to be reviewed 1-3 days after the peel and as frequently as was deemed necessary. It also encouraged the patient to write down any last minute questions and take it with them. It indicated how the patient would feel during the process. It gave several other patient advice and information.

[120] It is clear to me that the claimant was given sufficient information as to the possible results, complications or side effects attendant to the type of treatment she received. I find that when she consented she gave informed consent. I find this to be so based on any of the standards required whether by the standards set by the English common law or on the Canadian or Australian principles.

[121] She testified that the doctor told her that as part of the process there would be damage to her skin. She was also told that it could be fixed. She cannot now complain of lack of disclosure in this regard. She might complain that she was misled that the complications could be resolved. But such a complaint was bound to fail since she did not continue treatment to resolve the side effects and chose to follow the advice of a doctor with less experience in these matters than the defendant. She agreed that she stopped going to the defendant before the problem was corrected. She made up her mind not to continue the peels after being told not to by Dr. Clare-Lyn Shue. Of course once she became discouraged and lost confidence in the defendant, it was entirely in her purview to stop the treatment. I find however, on the medical evidence, that appropriate measures were being taken by the defendant to correct the side effects at the time the claimant terminated her treatment.

**Was the defendant negligent in the application of the chemical peel?**

[122] From the reports of both Dr. Clare-Lyn Shue and Dr. Fitz-Henley the chemicals used by the defendant in the peeling of the claimant's skin was in keeping with normal practice. I therefore find that there was no negligence in the choice of chemicals used by the defendant on the claimant's skin.

[123] I also accept that on a balance of probability the chemical peeling did not cause the stretch marks. The claimant had been using bleaching creams to the area and the uncontroverted evidence is that bleaching creams can cause stretch marks. She has also had micro-dermabrasion which is the removal of the epidermis. The evidence is that for stretch marks to occur damage must be done to the collagen in the dermis which is the second layer of the skin. The defendant denied that the controlled wounding of the dermis in chemical peeling could lead to stretch marks. She in fact testified that this would stimulate collagen. No evidence was lead by the claimant from her expert to contradict this assertion by the defendant.

[124] It is to be noted that when the claimant presented for the chemicals to be applied the defendant was aware that areas of the claimant's skin was irritated and was in no condition to take a chemical peel. Her evidence was that she took precaution in covering the affected areas from the chemicals. She denied that the scars were a result of the peel. This raises the question whether the defendant should have gone ahead with the peel in those circumstances.

[125] This, I admit was a difficult question to resolve. There was no evidence from the claimant to suggest that the chemicals were negligently applied. It was clear the claimant's skin was more sensitive by the time of the second peel, due to some irritation. It is tempting to hold that the defendant should have aborted the procedure because of the irritation. However, that would not be a clinical assessment of the situation. The irritated areas were pointed out to the claimant and the defendant explained the use of the petrolatum to protect those areas.

The patient notes indicated that time was abridged for the application of the second peel. The claimant within a short period of time experienced pain from the chemical. However, it has not been conclusively shown that the pain was from the chemicals being applied to the irritated areas. Certainly the claimant would not have been able to withstand chemicals being applied to broken skin. I accept therefore, that when the peel was done the irritated areas were protected and there was no negligence in the application of chemicals for the second peel.

**CONCLUSION**

[126] The medical evidence is that with irritation to the skin timing is everything. Dr. Fitz-Henley noted that the timing of the claimant's appointments was crucial to resolving the side effects. Her missing her appointment and waiting a whole month to return to the defendant's office meant that crucial time had passed which allowed pigmentation and scarring to become more embedded without treatment.

[127] Even though three peels were planned the dark spots disappeared only after two peels. She had presented with stretch marks and it is quite possible that there were more developments due to the use of bleaching creams and steroids. It is clear that they were not formed from the peels as this was not a side effect noted in the report of Dr. Fitz-Henley or in the evidence of Dr. Clare-Lyn Shue. As for the scar at the back of the leg, it is clear that it was not a result of the peel. It was not caused by any negligent action on the part of the defendant and as noted by the expert her actions were appropriate in attempting to deal with the problem early on.

[128] Whilst I do not know what the claimant's legs looked like before, I repeat that they are not know, to the naked eye, what she had described them to be. Perhaps if the doctor was more patient, less arrogant and had a better bedside manner towards an obviously sensitive patient, this case would never have been

brought. In the premise the claimant's case fails. I now therefore, make the following orders;

1. Judgment for the defendant.
2. Cost to the defendant against the claimant, to be taxed if not agreed.