

GRENADA

IN THE HIGH COURT OF JUSTICE

CLAIM NO: GDAHCV2001/0032

BETWEEN:

ANTHONY PETERS

(Personal Representative of the Estate of Glenna Peters, deceased)

GLENNA PETERS

Claimants

DR. TERRENCE MARRYSHOW

DR. FERMIN ROBAINA

Defendants

Appearances:

Mrs. Celia Edwards for the claimant

Mr. R.C Benjamin and Mr. C. Hood for the defendants

2002: April 29 & 30; 2003: January 30

[1] **BENJAMIN, J:** The present action has been brought by the Claimant in a representative capacity on behalf of the estate of his daughter, Glenna Peters, who tragically died on March 31, 2000. She was 36 years of age. Letters of administration of the said estate were granted to the Claimant on August 29, 2000.

[2] The Defendants are medical doctors. The first-named Defendant is the proprietor of Marryshow's Hospital and Health Clinic at Mt. Gay in the parish of St. George's, Grenada. The second-named Defendant practised at the said Hospital.

[3] By a Writ of Summons filed on January 15, 2001, the Claimant brought suit against the Defendants seeking damages for professional negligence in respect of surgical and/or medical procedures performed on the deceased by the second-named Defendant at the first-named Defendant's Hospital. Although the Statement of Claim stated that the said procedures were performed to have been performed on January 24, 2000 and the Defence

stated the procedure to have been performed on January, 26, 2000, there was no challenge to the evidence of both the deceased's mother and the first-named Defendant that the deceased was admitted to the Hospital on the latter date and the surgery was carried out on the following day – January 27, 2000.

[4] The Statement of claim alleged that in the treatment of the deceased, the Defendants were negligent in that they:

- (a) performed the wrong surgical procedures;
- (b) failed to administer treatment to the Claimant using all necessary care and diligence;
- (c) failed to adhere to recognised medical and/or surgical standards in the treatment of the Claimant's complaint;
- (d) failed to take proper steps to remedy the worsening condition of the Claimant.

It was further alleged that the deceased died as a result of the foregoing acts and omissions.

[5] Having caused an appearance to be entered, the Defendants pleaded in their Defence that the deceased had undergone a laparotomy for the removal of a suspected large ovarian cyst and that during the procedure, other problems presented themselves. These included "the presence of a volvulus, which involved adhesions from the large intestine to the uterus to the fallopian tube, which were both large and inflamed, a fibroid in the right fallopian tube and adhesions of the ovaries to the uterus." The Defendant denied being negligent as alleged in the particulars or otherwise and that the demise of the deceased was as a result of the negligence of both or either of them.

[6] The evidence laid before the Court as to the events prior to the surgical procedure itself came through the witness statements and testimonies of the deceased's mother, Edlyn Peters and of the first-named Defendant, Mrs. Peters could only say that her daughter had told her that the surgical procedure was for the removal of cysts and that the same was performed by Dr. Fermin Robina, a specialist gynaecologist of Cuban origin attached to the

Hospital. After the procedure, the deceased stayed at the Hospital to recuperate until she was discharged on January 31, 2000.

[7] The first-named Defendant wrote in his witness statement that he had seen and treated the deceased on three occasions in 1994 and 1996. She attended at his Clinic on January 18, 2000 and was seen and treated by the second-named Defendant for complaints including lower abdominal pain. She was again seen by the second-named Defendant on January 21, 2000 as a follow-up to the previous complaints; at the time, an ultra-sound examination revealed “a slightly enlarged uterus with the presence of a large mass which appeared to be a large ovarian cyst.” Surgery was recommended to remove the cyst and for exploration.

[8] Medical and surgical work-up was carried out prior to surgery and an indication of infection was revealed from the patient’s white blood cell count. Laparotomy, or the surgical opening of the stomach of the deceased was performed under general anaesthesia by a team of doctors and nurses which was headed by the second-named Defendant as the surgeon specialist and included the first-named Defendant and another doctor as the anaesthetist. The large ovarian cyst previously diagnosed was discovered together with other problems about which the first-named Defendant said in his witness statement:

“There was the presence of a volvulus which involved adhesions from the large intestine to the uterus to the fallopian tubes which were both large and inflamed, a fibroid in the right fallopian tube, and adhesions of the ovaries to the uterus. The cyst on the right ovary was not only large but complex with several lobes. This was removed and the fibroid in the right tube was also removed. Because of the diseased nature of the left fallopian tube it was removed together with the ovary and it was decided not to remove the right fallopian tube and ovary..... Because of the septic nature of the operation, the abdominal cavity was washed with Ampicillin an antibiotic and then closed with the appropriate sutures....”

During the recovery the deceased was put on anti-biotic medication and a narcotic and painkiller.

- [9] No evidence was led to in any way impugn the advisability or correctness of the surgical procedure recommended and carried out by the Defendants. No doubt with this state of the evidence uppermost in his mind, learned Counsel for the Defendant's drew attention to paragraph 1 of the Statement of Claim which claimed damages for "professional negligence in medical and/or surgical procedures performed" on the Plaintiff (sic)." It was urged that there was no evidence led as to the surgical procedure having been negligently performed by the Defendants, but rather that the Claimant's case focused upon events which transpired subsequent to the surgery. However, it was tacitly conceded that paragraph (e) of the Particulars of negligence, previously set out in paragraph 4 herein encompassed the treatment of the deceased after the surgery had been performed.
- [10] The clear thrust of the Claimant's case was that the deceased died as a result of septic shock caused by the negligent treatment administered by the Defendants in the aftermath of the surgical operation. I do agree that paragraphs (b) and (c) of the Particulars of Negligence alleged breach of duty and failure to meet the requisite standard of care. However, there can be no doubt that paragraphs (d) and (e) are directed to the post-operative treatment of the deceased. It may be that the Claimant's pleading could have been set out in less ambiguous terms. Be that as it may, while setting up a complete denial of any negligence on their part causing the death of the deceased, the Defendants by the witness statement of the first-named Defendant thoroughly addressed the events subsequent to the surgery. The Court could discern no prejudice visited upon the Defendants by the Claimant's pleadings. In any event, the Statement of Facts, Issues, Law and Authority filed by the Claimant on September 21, 2001 pursuant to the Orders made at Case Management Conference pellicidly highlighted the issue of the care and treatment of the deceased between the day of the operation and the date of her demise.
- [11] Ahead of an analysis of the evidence, the Court ought to remind itself of the standard applied in cases of professional medical negligence. A medical practitioner is under a duty to exercise reasonable skill and care in the treatment of his patients. The standard of care required of medical practitioners has been expressed in the much-quoted of direction to the jury by McNair, J . in **Bolam v Friern Hospital Management Committee**. [1957] 2 All E.R 118 at p 121 D-E. His Lordship said:

“But where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising a professing to have that special skill. A man need not possess the highest expert skill, if he exercises the ordinary skill of an ordinary competent man exercising that particular art.”

- [12] This formulation has been approved by the Privy Council in **Chin Keow v Government of Malaysia** [1967] 1 WLR 813 and by the House of Lords in the cases of **Maynard v West Midlands RHA** [1984] 1 WLR 634 and **Sidaway v Governors of the Bethlem Royal Hospital** [1985] A.C. 871. In the latter case of **Sidaway**, a majority of the House accepted that the so-called **Bolam** test was applicable to all aspects of the work of a medical practitioner including diagnosis and treatment. Lord Diplock stated (at p. 893 D-E): -

“In English jurisprudence the doctor’s relationship with his patient which gives rise to the normal duty of care to exercise his skill and judgment to improve the patient’s health in any particular respect in which a doctor is called upon to exercise his skill and judgment in the improvement of the physical or mental condition of the patient for which his services either as a general practitioner or specialist have been engaged. This general duty is not subject to dissection into a number of component parts to which different criteria of what satisfy the duty of care apply, such as diagnosis, treatment advice....”

- [13] In **Bolam’s** case, Lord MacNair, J went on in his direction to the jury, to provide assistance as to the test for establishing negligence on the part of a medical practitioner. He said (at p. 122B-C,D): -

“I myself would prefer to put it in this way: 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 doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view.”

This aspect of the direction accords with the speech of Lord Scarman in **Maynard v West Midlands Regional Health Authority** [1985] 1 ALL E.R 635. The learned law Lord said (at p. 639) : -

“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 specialty, if he be a specialist) is necessary.”

The cogency of the test propounded by these above passages was approved by Lord Browne-Wilkinson in **Bolitho v City Hackney Health Authority** [1997] 4 ALL E.R 771 at p. 776.

- [14] As earlier intimated, the Claimant did not adduce any evidence as to whether the Defendants did or did not act in accordance with a practice accepted by a respectable body of medical opinion in performing the surgical procedure. There was nothing in the evidence to suggest that the procedure carried out was ill-advised or in any way open to question. The evidence of Dr. Yearwood and the report of Dr. Rao did not broach any aspect of the surgical procedure of January 27, 2000.
- [15] I therefore turn to deal with the evidence as to events subsequent to the surgical operation. The deceased was discharged on January 31, 2000. The first-named Defendant provided the only evidence as to her post-operative recuperation and he described her evolution as normal with no post-operative complication or fever with the satisfactory healing of the surgical wound. As was pointed out, the deceased was placed on antibiotic medication with ampicillin together with a narcotic and painkiller – pethidine. This was borne out by the notes made under Physician’s Orders for the date of discharge.

- [16] The evidence on both sides was consistent as to the deceased attending at the Defendant's clinic after her discharge. The first-named defendant stated that the examinations conducted were normal and oral anti-biotic therapy and painkillers were prescribed. The deceased's mother said that the deceased went to have some of the stitches removed on February 3, 2002 and returned on February 4, 2000 to have the remainder removed because of a complaint of pain. She said in her witness statement, which was not challenged in cross-examination, that thereafter the deceased complained of abdominal pains and vomiting after meals. She said she spoke to the first-named Defendant in early February 2000 on two occasions and took the deceased to see the second-named Defendant on February 9, 2000; he prescribed medication for "gastro". The deceased, she said, was again seen by the second-named Defendant on February 11, 2000 complaining of intense pain to her stomach, feeling weak and run down. On February 14, 2000, upon the advice of the first-named Defendant, the deceased went to the Hospital where an ultrasound was carried out.
- [17] The deceased was re-admitted to the Hospital on February 20, 2000 after being seen by the second-named Defendant at the clinic. It was diagnosed that she had a haematoma at the site of the wound. The first-named Defendant said she was treated with antibiotics and painkillers. After a good evolution she was discharged on February 20, 2002. However, she stated that they could find 'no evidence' linking the severity of her pain with the extreme reaction to pain. The first-named Defendant told the Court, as was consistent with the medical records for that period of hospitalisation, that the deceased's clinical features did not accord with her complaints of severe abdominal pain and therefore a placebo was administered at the time and psychological treatment was considered as an option. The later course was intimated to the deceased's mother.
- [18] Edlyn Peters said her daughter complained of weakness, constant abdominal pain and continuous vomiting up to March 10, 2000. Visits were made to the first-named Defendant on March 10 and March 22, 2000 and on the latter date an ultra sound was again done. The evidence of the first-named Defendant was different. He said that she was seen on March 3, 2000 when her condition was good and again on March 9, 2000 when the results of the pathological examination of the specimens taken during surgery were discussed

with her. No medical records were disclosed for the period between February 20, and March 22, 2000. Given that the evidence of Edlyn Peters was not contradicted it can be accepted that there was complaint of abdominal pain and vomiting which was brought to the Defendants' attention during that period.

- [19] The deceased was re-admitted to the Hospital on March 23, 2000 for abdominal pain. Edlyn Peters said that she became extremely ill with pains and constant vomiting.
- [20] The medical records disclosed by the Defendants are useful. The diagnoses on the Admission/Discharge Summary were stated to be abdominal pain, gastritis and pelvic inflammation. The second-named Defendant wrote that the patient had complained of lower abdominal pains and that it was decided to re-start with anti-biotic therapy. He also made a note that it was decided to discuss the case with the psychologist. The notes suggested that after being admitted with complaint of severe abdominal pain, the patient's condition improved over the next three days. The first-named Defendant wrote at 8 a.m. on February 27, 2000 that the patient complained of severe abdominal pain and upon being questioned she spoke of a pain in the left chest. The intense pain complaint was corroborated by Edlyn Peters. In his witness statement, the first-named Defendant stated that the complaints of the deceased during this period of hospitalisation that presented an evolution and clinical scenario that was confusing.
- [21] The first-named Defendant said that out of concern about the constant pain the deceased's mother decided to take her daughter to Trinidad for further evaluation and treatment. Mrs. Peters said she did express her desire so to do and both Defendants sought to persuade the deceased to have her mother change her mind. During cross-examination, the first-named Defendant said that the deceased was discharged "under pressure before treatment was effective."
- [22] The deceased was discharged on March 27, 2000 in the evening. The first-named Defendant said she was feeling much better notwithstanding the complaint of pain in the morning. He said that the patient asked about being discharged and was subsequently discharged in satisfactory condition. The notes of both Defendant's made in relation to the patient's discharge are helpful. The first-named Defendant wrote at 6.25 p.m.

"Pte. refers to be feeling much better and asks when she is going home. Some inquiry from mother. Spoke to father on phone and told him she should stay overnight as she was having severe pains this AM. He agreed. However on discussion with Dr. Robaina and Pte, decision taken to D/C and be followed up in clinic."

He later wrote:

"Pte. D/C in satisfactory condition."

The second-named Defendant wrote thereafter:

"According to what we (?) talked to the pte. and her mother, we decided to discharge her Home (accepting) her request and to continue her treatment together with the psychologist."

It is noteworthy that no mention was made of any examination being carried out on the patient or of any medication prescribed at the time of discharge.

- [23] The deceased's mother contacted the first-named Defendant in the early hours of the morning of March 28, 2000 with a complaint of the deceased being in severe pain and she was advised as to temporary measures for the pain and she was advised to bring the deceased to the clinic for evaluation. The deceased was later taken to see Dr. Subba Rao at the St. George's University Clinic.
- [24] The report of Dr. Rao dated May 4, 2000 spoke of the patient having a history of abdominal pains for one week. It was written that the patient's vital signs were Bp-90/60 Mm.Hg., pulse-regular, that she was anaemic and her abdomen was distended and tender all over. The diagnosis was given as "intestinal obstruction with peritonitis and septic shock." The patient was rushed to the Hospital for emergency care by Dr. Robert Yearwood. Dr. Rao was not presented for cross-examination as he was not so required by the Defendants.
- 25] The medical report of Dr. Yearwood dated March 1, 2001 noted that the deceased complained of abdominal pain and distention for five days and upon examination inter alia,

her abdomen was found to be distended. The diagnosis was of 'septic shock due to intra-abdominal sepsis'. Exploratory surgery was carried out after the patient was resuscitated with crystalloids and plasma and given broad-spectrum antibiotics. The surgery revealed 'non-foul smelling pus throughout the abdominal cavity, with sub-hepatic, sub-phrenic, intra-loop and pelvic collections." The report further stated that the patient developed multiple organ failure as a result of overwhelming sepsis and her condition worsened until her demise on March 31, 2000.

[26] When cross-examined, Dr. Yearwood explained that the pus was non-anaerobic and that it was unlikely to have originated in the intestines or the bowel. He said that he drew an inference that the pus and the evidence of prior surgery were related.

[27] In his witness statement, the first-named Defendant stated in relation to the condition of the deceased prior to the discharge on March 27, 2000 as follows:

"At no time did she present with abdominal distention or fever two very important clinical signs that are used to guide the surgeon as to the feasibility of surgical re-intervention."

During his lengthy cross-examination he said that the abdominal distention found by Dr. Yearwood was a mystery to him as he had examined the deceased prior to her discharge although he made no record of it. While agreeing that a distended abdomen is an indication of intra-abdominal sepsis as diagnosed by Dr. Yearwood, he insisted that no such indication was presented to him although the deceased, by virtue of her history of pelvic inflammatory disease, was at all times being treated as a case of sepsis for which broad-based anti-biotic treatment was given.

[28] His evidence at one stage appeared to the Court to be contradictory when he testified that septic shock can arise within 2-8 hours or suddenly. However, he clarified this by saying that septic shock is the culmination of sepsis developing over time and not overnight. After so stating, he said that the deceased's case was at time confusing and that it did occur to him to seek a second opinion but did not do so given Dr. Robaina's assessment of the circumstances. He later explained that it was the complaints of pain that were confusing;

this can be linked to his earlier testimony that pain as against a distended abdomen is not a sign of sepsis.

- [29] It was further suggested to the first-named Defendant that during the surgery non-foul smelling pus was found free in the abdominal cavity. He rejected this suggestion and insisted that pus was found only in one of the fallopian tubes that was diseased.
- [30] It was argued on behalf of the Claimant that the only explanation for the demise of the deceased from septic shock was that the Defendants had acted negligently. It was urged that the Defendants failed to recognise the onset of sepsis and to effectively treat same. The argument was based on the premise that the death of the deceased was the result of the surgical procedure performed by the Defendants on January 27, 2000.
- [31] The evidence pointed to the deceased suffering from septic shock when she was admitted to the General Hospital under the care of Dr. Yearwood. The latter in no way impugned the surgical procedure but nevertheless linked the prior surgery to the presence of non foul-smelling pus in the deceased's abdominal cavity; no explanation was offered for this inference which was elicited during Dr. Yearwood's re-examination. The Court was therefore left without any basis for assessing the logical foundation of that conclusion. In this regard, unlike in cases of solicitors' negligence, the Court must be mindful of the dictum of Lord Browne-Wilkinson in **Bolitho's** case where he cautioned (at p. 779): -

"I emphasize that, in my view, it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medial expert are unreasonable.... It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the bench mark by reference to which the defendant's conduct falls to be assessed."

The Court relies on expert evidence to, inter alia, provide guidance as to whether the acts or omissions of a defendant amount to negligence. Though not bound by such expert evidence, the Court must decide, viewing the evidence in the round, whether the requisite degree of skill and care was utilised by the Defendant.

- [32] In the present case, the testimony of Dr. Yearwood was of little assistance in the application of the **Bolam** test to the post-operation treatment of the deceased by the Defendants. The first-named Defendant testified that throughout her care the deceased was put on broad-based anti-biotic therapy to address her septic condition. No contrary evidence was presented to challenge the advisability or adequacy of this treatment.
- [33] Dr. Yearwood elected to pursue a surgical intervention, he, like Dr. Rao, having found the patient's abdomen to be distended, an admitted sign of sepsis. Th report of Dr. Yearwood recorded a history of a distended abdomen of five days' standing. This history was not accepted by the first-named Defendant who specifically said that upon examination prior to discharge the deceased's abdomen was not distended. It seems to me that whether or not a patient's stomach is distended is determinable by an examination by someone skilled in such matters. The bald statement of the history in Dr. Yearwood's report is unhelpful as to whether anyone made such an examination and if so, whom. Equally, the first-named Defendant evidence about having examined the deceased prior to her discharge from the Hospital on March 27, 2000 was not supported by any note in the patient's medical records. Even so, there is nothing to counteract the first-named Defendant's evidence that Dr. Yearwood's finding could have manifested overnight, that is to say, between the time of the deceased's discharge and her subsequent examination by Dr. Rao on the next day.
- [35] The Court must also consider the issue of causation. Could it be said that the resulting death is causally linked to the surgical procedure of January 27, 2000? No evidence was presented in answer to this question and the Court has been left to speculate during the submissions by Counsel for the Claimant. To say that the sepsis developed while the deceased was under the care of the Defendants, which I do accept, is not sufficient to link the surgery to the ultimate diagnosis of sepsis.
- [36] In the premises as tragic as the deceased's demise must be to her parents and loved ones, the claim must fail on the evidence. Accordingly, it is ordered that the action be dismissed.

[37] On the question of costs, to which the Defendants would be entitled, it is noted that the Statement of Claim sought only general damages and no amendment was sought to include the special damages referred to in the Claimant's witness statement. Taking into account all the circumstances, I consider it reasonable that costs be fixed in the sum of \$12,500.

Kenneth Benjamin
High Court Judge