ANTIGUA AND BARBUDA

IN THE COURT OF APPEAL

HCVAP 2005/012

BETWEEN:

DANE ABBOTT

Appellant

and

SONIA HODGE

Respondent

Before:

The Hon. Mr. Justice Denys Barrow SC	Justice of Appeal
The Hon. Mde. Justice Dancia Penn-Sallah QC	Justice of Appeal [Ag.]
The Hon. Mde. Justice Ola Mae Edwards	Justice of Appeal [Ag.]

Appearances:

Sir Clare Roberts QC. for the Appellant
Mr. Gerald Watt QC. and Dr. David Dorsett for the Respondent.

2007: July 16;
2008: February 25.

Tort - Medical Negligence – standard of care – res ipsa loquitur

The appellant, an obstetrician gynaecologist, performed a hysterectomy and bilateral salpingo-oophorectomy on the respondent on 27th June, 2001. On the day following the operation and upon her discharge from the hospital on 3rd August, 2001, the respondent complained of a "tugging" sensation at the base of the operation incision, whenever she moved. The appellant assured her that there was no problem. The respondent's discomfort worsened and she was re-admitted to the hospital on 16th and 17th August, 2001. The respondent was diagnosed with a bowel obstruction by other doctors (while the appellant was abroad) and an emergency operation was performed on the 18th August, 2001. The respondent successfully claimed damages for professional negligence against the appellant in relation to his performance of the surgery (it being alleged that he had inadvertently sewn an area of her small intestines into the base of the sutures) and post-operative care, which decision the appellant has appealed against.

Held, allowing the appeal, reversing the decision of the trial judge, entering judgment for the appellant dismissing the claim and awarding costs to the appellant:

(1) The applicable law for testing whether the actions of a medical practitioner are negligent is whether or not the practitioner has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. The test is applicable to all aspects of a medical practitioner's work, including post-operative care.

Bolam v Friern Hospital Management Committee [1957] 2 All ER 118, Bolitho v City and Hackney Health Authority [1997] 4 All ER 771 and Sidaway v Bethlem Royal Hospital Governors and others [1985] 1 All ER 643 applied.

(2) The respondent, who had led no evidence on the standard of care, was not entitled to invoke the doctrine of res ipsa loquitur to establish the requisite want of care on the part of the appellant. Res ipsa loquitur will generally be applied where there is common ground as to the occurrence of the mishap, unlike the circumstances presented in this case.

Scott v London and St. Katherine's Docks Co. (1865) 3 Hurl & C 596 and Mahon v Osborne [1939] 1 All ER 535 applied.

(3) The respondent was entitled to rely upon any evidence given by any expert at the trial to prove that the requisite standard of care had been breached by the appellant. There was however no evidential basis for concluding that the appellant was negligent in his performance of the surgery or in his post-operative care.

JUDGMENT

[1] EDWARDS, J.A [AG.]: This is the judgment of the court. The appellant who is an obstetrician gynaecologist, has appealed against the judgment of Thomas J given on the 23rd June 2004, by which he held the appellant liable to the respondent in damages to be assessed, for professional negligence. The action arose from the appellant's performance of a hysterectomy, and bilateral salpingo-oophorectomy on the 'thin' 51 year-old respondent on the 27th June 2001 at the Holberton Hospital in St John's, Antigua, and his post-operative care of her up to the 3rd August 2001.

[2] The learned trial judge found that the appellant had failed to follow the standard procedure, had sutured an area of the respondent's small intestine to her vaginal stump during his performance of the surgery, and had failed to properly investigate the respondent's 4 complaints to him within 5 weeks of the operation, about her specific ill

feelings including a "tugging" sensation in her lower abdomen at the base of the operation incision. The judge found further that the respondent's bowel obstruction, which was diagnosed (while the appellant was abroad) by other doctors at the Holberton Hospital on the 18th August 2001, was due to the suturing of her bowel to her vaginal stump coupled with the development of adhesions. This resulted in that portion of her bowel which was compromised being removed by Dr. John and Dr. Mangenard in emergency surgery on the 18th August 2001. Thomas J concluded that the appellant was in breach of his duty of care and his actions caused the respondent injury, pain, physical agony, mental stress, severe weight loss and debilitation.

The Grounds of Appeal

[3] The 25 grounds of appeal collectively challenge: (a) the learned judge's assessment evaluation and interpretation of the evidence and his findings of facts concerning the conduct of the appellant, the adhesions on and suturing of the bowel, and (b) his application of the law in determining negligence and proof of causation. Grounds 1,2,19 and 20 in substance urge that the respondent failed to meet the burden of proof for the standard of care owed to the respondent in relation to surgery and post-operative care. Grounds 3, 5, 6 to 18, and 21 to 26 contest the judge's resolution of conflicts in the evidence, his determination of what the circumstances were and what the appellant did, his failure to consider the testimony of the appellant's expert witness, and some of the inferences drawn by him from his findings of facts. Ground 24 challenges the judge's decision on the facts found that the damage was caused by the appellant.

Jurisdiction of the Court

[4] Although the appellate court has jurisdiction to review the record of the evidence in order to determine whether the conclusions of Thomas J upon that evidence should stand, learned Queen's Counsel, Mr. Watt, has reminded us to exercise this jurisdiction with the requisite caution pronounced in a plethora of previously decided

cases including Watt (or Thomas) v Thomas[1] and Whitehouse v Jordan[2].

[5] The authorities repeatedly emphasise that the advantages which the judge derives from seeing and hearing the witnesses must always be respected by an appellate court. The main reason why, in the absence of an error of law, the judgment of the trial judge calls for the utmost respect," is that he has seen and heard the witnesses,...including the rival parties. The strength of this consideration will vary from case to case according as conclusions have to be reached as to credibility, or based on demeanour....[T]he ultimate conclusion to be drawn depends much more on the setting in which [this] evidence was given, and the relation which it must be thought to have to the events which occurred."[3]

[6] The importance of the part played by the advantages which the trial judge derives from seeing and hearing the witnesses "in assisting the judge to any particular conclusion of fact varies through a wide spectrum from, at one end, a straight conflict of primary fact between witnesses, where credibility is crucial and the appellate court can hardly ever interfere, to, at the other end, an inference from undisputed primary facts, where the appellate court is in just as good a position as the trial judge to make the decision." [4]

[7] Where the trial judge's decision on an issue of fact was an inference drawn from primary facts and depended on the evidentiary value he gave to witnesses' evidence and not on their credibility and demeanor, the appellate court is just as well placed as the trial judge to determine the proper inference to be drawn and is entitled to form its own opinion thereon.[5]

[8] The appellant's counsel contends that the trial judge "palpably misused his advantage" in arriving at certain fundamental findings which are inferences. Sir Clare, QC counsel

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[1] [1947] 1 All E.R. 582 HL
[2] [1981] 1 All E.R. 267
[3] Per Lord Bridge of Harwich at page 286 and Lord Wilberforce at page 270 in Whitehouse v Jordan supra.
[4] Per Lord Harwich at page 286 paragraph c in Whitehouse v Jordan supra.

for the appellant, has urged this court to interfere. In light of these contentions, a critical review of the relevant findings, evidence and pleadings ought to be carried out by this court.

The Burden of Proof

[9] We must first decide whether the respondent failed to meet the burden of proof for the standard of care owed to the respondent in relation to surgery and post -operative care (grounds 1,2,19 and 20) which is a matter of law. These are fundamental grounds upon which the judgment will stand or fall. We must also determine whether the legal conclusions reached by the trial judge that negligence and causation had been proven find support in the evidence and are legally and logically correct. We regard the other issues raised by the appellant as a subset of his contention about the trial judge's findings on the issue of negligence and causation. The inferences, failures and factual errors complained about in the grounds of appeal and submissions of Sir Clare,QC all relate to the issue of negligence and causation in our view. Accordingly, we treat the issues together.

[10] At paragraph 19 of his judgment, Thomas J correctly addressed the burden of proof in the following way: "The Claimant has the onus to prove her allegation that Dr. Abbott was negligent in the performance of the surgery and his post - operative care. Accordingly the Claimant must tender such evidence that the treatment or action of the Defendant fell below the standard of care of an ordinarily competent obstetrician and gynaecologist in the same circumstances and that his negligence caused her damage." At paragraph 23, Thomas J stated further that having established the duty of care, another part of the negligence equation is the standard of care appropriate or required in the particular situation. It is therefore crucial for this court to identify what the standard of care is, in deciding whether the respondent proved that the appellant failed to conform to it.

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[5] Lord Wilberforce at page 272 para h,page 273 para j, page 282 para g in Whitehouse v Jordan supra.

[11] The applicable law for testing whether the actions of a medical practitioner are negligent was stated by McNair J in Bolam v Friern Hospital Management Committee[6]: "The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.... A doctor is not guilty of negligence if he 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." The learned judge also considered and stated the relevant law as to breach of duty of care at paragraphs 163 to 167 of his judgment.

[12] In advancing his contention Sir Clare, QC referred to the learning on the subject matter in the text books; Clerk & Lindsell 17th ed. at paragraph 8-50 and Medical Negligence by Michael Jones at paragraph 3-003. We agree with the following exposition at paragraphs 8-50 in Clerk & Lindsell: "A patient alleging negligence against a medical practitioner has...to prove (1) that his mishap results from error and (2) that the error is one that a reasonably skilled and careful practitioner would not have made. It is therefore crucial to establish how the mishap occurred and that he should have expert evidence that any error made was a negligent error."

[13] Also at paragraph 3-130 in Medical Negligence it is pointed out that: "Medical evidence is invariably a vital element in an action for medical negligence, but the importance attached to expert opinion should not obscure the underlying basis for a finding that the defendant has been negligent, or not (as the case may be). This is that, in the light of the expert evidence, the defendant has taken an unjustified risk.... In other words, expert opinion about the defendant's conduct (whether favourable or unfavourable) should itself be measured against the general principles applied to the question of breach of duty."

[6] [1957] 2 ALL E.R. 118,121-122

[14] In discharging her burden of proof the respondent adduced her evidence, along with that of her daughter, Ms. Joseph, her sister, Ms. Kirchner, and her expert witness, Dr. Joseph John. On the pleadings and evidence the appellant strenuously challenged the respondent's allegations that during the performance of the surgery he had negligently sutured her incision: "In that he had inadvertently sewn an area of her small intestines into the base of the sutures, which had formed an adhesion of the intestines to the lower end of the incision and had healed onto the suture." At paragraph 11 of the statement of claim, the respondent alleged that the appellant failed to exercise proper care in suturing the incision, thereby inadvertently suturing a loop of distal ileum (the third portion of the small intestine between the jemunum and the caecum). It would seem therefore that the allegations of negligence were in general form, with no specific acts of negligence pleaded. Dr. Joseph John, who on the 18th August 2001 was the Chief Surgeon and Medical Superintendent of Holberton Hospital, performed the corrective surgery on the respondent. Assuming for the moment that the learned trial judge's findings of fact are correct, Dr. John's report and testimony only established that the mishap of the respondent's loop of distal ileum being sutured to her vaginal stump occurred. Dr. John did not identify or articulate the requisite standard of care under the circumstances, and thereafter establish that the appellant failed in some causally significant respect to conform to the required standard of care. Dr. John did not venture to give any opinion as to whether the error made was a negligent error or whether the appellant's post-operative care was substandard. We therefore agree with Sir Claire QC that the respondent led no evidence whatsoever on the standard of care. Was this fatal to the respondent's claim?

[15] Although the respondent's pleadings did not signal that she intended to rely on the maxim res ipsa loquitur to establish want of care on the part of the appellant, learned Queen's Counsel, Mr. Watt, contends that she was entitled to rely on this maxim. It appears that the trial judge did not address this in his judgment even though the claimant's skeleton arguments filed in July 2003 stated that the respondent was relying on the maxim. After finding that the appellant had sutured the bowel at paragraph

128, Thomas J posed the question "...but was he negligent?"; and then proceeded to refer to 7 English and Canadian cases which Sir Clare, QC contends, and we agree, apparently had no precedental value in assisting him to resolve the question he had posed. This omission of the trial judge, cannot in our opinion, prevent the appellate court from determining whether or not the maxim should have been applied in the existing circumstances.

Res ipsa loquitur

[16] Res ipsa loquitur is a rule of evidence which is conveniently applied to those circumstances in which a claimant in negligence discharges his task of establishing want of care on the part of the defendant without having to prove any specific negligent act or omission by the defendant. This evidential rule is reflected in Scott v London and St Katherine's Docks Co[7] where a customs officer was injured by some sugar bags falling on him near the door of the defendant's warehouse. Erle C.J. justified the direction for a new trial by relying on the following rule which has since become known as res ipsa loquitur: "There must be reasonable evidence of negligence. But where the thing is shown to be under the management of the defendant or his servants, and the accident is such as in the ordinary course of things does not happen if those who have the management use proper care, it affords reasonable evidence, in the absence of explanation by the defendants, that the accident arose from want of care." [8]

[17] At paragraphs 8-51 to 8-52 in Clerk & Lindsell the applicability of this maxim to medical malpractice actions is explained as follows: “In establishing how the mishap occurred, the plaintiff may in certain circumstances be aided by the maxim res ipsa loquitur. An inference of negligence will arise against a medical practitioner when an accident occurs which in the ordinary course of things does not happen if the practitioner has exercised reasonable care and skill....To establish that the occurrence itself is

[7] (1865) 3 H&C 596 Ex Ch.
[8] Supra, at page 601

evidence of negligence it must be demonstrated that it is an occurrence which, generally, should not happen...Evidence that even in a small number of cases what has gone wrong goes wrong despite due care can prevent the application of res ipsa loquitur....The burden of proof of negligence does not as such shift from the plaintiff. Once an explanation consistent with the exercise of due care is advanced to explain a medical mishap, the issue becomes whether in light of that explanation, the plaintiff's injury was more likely than not to have ensued from an absence of care of skill."

[18] We must therefore examine the evidence to see whether it has been shown that the mishap in the ordinary course of things does not happen if those who have management use proper care.

[19] The testimony of Dr. John was that he found a loop of bowel stitched to the vaginal cuff/stump and that the brown suture that he saw and removed looked like a chromic catgut which was tied to a knot and stretched. What he saw was the suture which went into the serosa and the knot outside. The suture went into the bowel and came out. He testified: "It can only go in by a needle or if a loop got caught up. The only other way is by something going in the way. ..I saw the knot go into the serosa without a needle. The needle depends on the chromic used at the time, the bigger the needle, the more likely you get other areas." He did not agree with the evidence of the appellant and his expert Dr. Roberts that a chromic "O" needle (which was what the appellant had used) cannot pick up the serosa. Dr. John removed the stitch and sent the compromised portion of the bowel that he had cut out, down to pathology without the stitch. He did not remember if he had sent the appendix of the respondent which he had also removed for precaution, and he did not recall if he had received the pathological report. He testified: "I would not consider the suturing of the serosa to the vaginal stump to be serious. It is not common. I have seen bowel sutured to other tissue. I do not remember one of this nature."

[20] The appellant challenged Dr. John's conclusions by testifying as follows: "Had I done the practically impossible feat of suturing only the serosa of the distal ileum to the

vaginal stump then I and my assistant [Dr. Scotland] would surely have recognized this. This is not something which would have been missed or overlooked. Additionally, the chromic "O" sutures are thick and carry a large needle and could not possibly injure and hold onto the paper thin serosa of the small bowel and suture the bowel to the vaginal stump....[at page 15 of the notes of evidence] If by any chance it had been sutured up, that would have been recognized by myself or my assistant." Dr. John disagreed with the appellant and his expert about the practical impossibility of this, asserting that: "it happens all the time in surgery in all types of operations. Once you go into the belly in suturing in this area of the vaginal cup it is all the same space." Dr. John did not clarify whether it happened only where there is failure to take care.

[21] The learned trial judge neither adverted to nor resolved this conflict in Dr. John's evidence, but in light of the evidence of the appellant, in our view, it would have been open to the learned trial judge on applying the law, to reach the conclusion that in the ordinary course of things in a small number of cases such mishaps occur despite due care.

[22] In Mahon v Osborne[9] which was a medical negligence case, the issue was raised as to whether Erle C.J.'s reference to accidents happening "in the ordinary course of things" means that it must be a matter of common experience, or common knowledge, so that the experience of the expert is irrelevant. This was a case in which a swab was left under the part of the liver which was close to the stomach of the patient during the course of a difficult abdominal operation by the appellant who was the resident surgeon. The swab was discovered 2 months later as a result of a further operation. The patient died and it was common ground that his death was due to the leaving of the swab in the abdomen. The plaintiff's case was put forward at the trial on the footing that the principle of res ipsa loquitur applies to every surgical case where a swab is left in the patient. It was held (Goddard L.J. dissenting) that res ipsa loquitur did not apply in the case of a complicated surgical operation, since an ordinary reasonable man, knowing of the facts, could not, without the help of expert evidence know of the

[9] [1939] 1 ALL E.R. 535 C.A.

precautions necessary in such an operation, or say that the event which had happened must have been due to a failure on the part of the surgeon to exercise due care.

[23] Scott L.J. explained[10]: "Some positive evidence of neglect of duty is surely needed. It may be that a full description of the actual operation will disclose facts sufficiently indicative of want of skill or care to entitle a jury to find neglect of duty to the patient. It may be that expert evidence in addition will be requisite. To treat the maxim as applying in every case where a swab is left in the patient seems to me an error of law. The very essence of the rule, when applied to an action for negligence, is that, upon the mere fact of the event happening, for example, an injury to the plaintiff, there arise two presumptions of fact, (i) that the event was caused by a breach by somebody of the duty of care towards the plaintiff, and (ii) that the defendant was that somebody. The presumption of fact arises only because it is an inference which the reasonable man, knowing the facts, would naturally draw, and that is, in most cases, for two reasons, (i) that the control over the happening of such an event rested solely with the defendant, and (ii) that in the ordinary experience of mankind such an event does not happen unless the person in control has failed to exercise due care. The nature even of abdominal operations varies widely, and many considerations enter into it, the degree of urgency, the state of the patient's inside, the complication of his disorder or injury, the condition of his heart, the effects of the anaesthetic, the degree and kind of help which the surgeon has - for example, whether he is assisted by another surgeon - the efficiency of the team of theatre nurses, the extent of the surgeon's experience and the limits of wise discretion in the particular circumstances - for example, the complications arising out of the operation itself, and the fear of the patient's collapse. In the present case, all the above considerations combine to present a state of things of which the ordinary experience of mankind knows nothing, and, therefore, to make it unsafe to beg the question of proof."

[10] Ibid, at pages 540-541

[24] Mackinnon L.J. observed[11] that: "The proper question ... was whether, ...[the appellant] had exercised the reasonable degree of skill and care that a surgeon in his position ought to exercise - whether he had done anything that , exercising such skill and care, he ought not to have done, or left undone anything that, exercising such skill and care, he ought to have done. This question involves matters of fact as to which neither the court nor the jury has knowledge. The facts must be proved by the evidence of experts."

[25] It can be said therefore that although the evidential rule of res ipsa loquitur permits a trial judge to infer negligence from the occurrence of a mishap under certain circumstances, there must be a basis either in common experience or common knowledge or expert testimony that when a mishap occurred it was more probable than not the result of the appellant's negligence. Looking at the nature of the abdominal surgery that the appellant performed on the respondent in the instant case, we are of the view that the ordinary reasonable judge could not without the help of expert evidence say that the alleged mishap must have been due to a failure or omission of the appellant. We therefore hold on the authority of Mahon, that the respondent was not permitted to invoke res ipsa loquitur, to establish the requisite want of care on the part of the appellant. There is one final observation that must be made. It concerns the relevance of res ipsa loquitur to a claim where the happening of the mishap is in dispute. From the previously decided cases where the maxim has been applied, generally, there usually exists common ground as to the occurrence of the mishap, unlike the circumstances presented in this case.

Proof of Standard of Care

[26] We have previously stated that the respondent adduced no evidence as to the standard of care. However, the appellant did call Dr. Gwendolyn Fevrier Roberts who established the requisite standard of care. As a result, the respondent was entitled to rely upon any evidence given by that expert as to the nature and extent of the

[11] Ibid, at page 553 F -G

appellant's duty as a reasonable skilful surgeon, in our view. The respondent could also rely on the appellant's evidence where it discloses any facts which illustrate the appellant's want of skill or care. The appellant's evidence therefore becomes very relevant at this point.

[27] The appellant described the surgery on the respondent as major and without complications. His evidence was that he entered the respondent's abdomen through a midline vertical incision and found large uterine fibroids and normal appearing tubes and ovaries. In performing the hysterectomy as always, he used wet packs to pack the bowels away out of the operative field. He used a self retaining retractor and deaver retractors for better exposure during the operation. He used a technique to close the abdomen which made it virtually impossible to sew any bowel into the incision. The abdominal packs and deaver retractors made it practically impossible for the small bowel to be injured or picked up by the needle during suturing. After performing the total abdominal hysterectomy and bilateral salpinggo - oophorectomy, he placed chromic "O" sutures around the edges of the vaginal vault for hetosis, and he left the vault open to allow for drainage of possible accumulations. He applied Kocker's clamps to each of the rectus fascia and pulled these up vertically. He did not include muscle and peritoneum to hold together. In closing the fascia he continually checked with his fingers the inside to check the strength of the closure as well as to be doubly sure no omentum or bowel was caught. He used catgut chromic "O" to suture the vessels and the vagina, and because this suture is absorbed rapidly after use within 6 to 8 weeks, he would not expect pulling or tugging in this area. The appellant said he had performed over 500 hysterectomies since his residency in Canada from 1986 to 1990.

[28] Looking at the only full description of the actual operation, which has not been challenged by Mr. Watt, QC by way of cross-examination, it seems clear to us that it does not disclose facts indicative of any want of skill or care. Some positive evidence of neglect of duty is surely needed. The evidence of Dr. Roberts who is also a consultant obstetrician and gynaecologist since 1988 bolsters the appellant's

testimony as to his conformity with the standard practice. There is therefore no evidential basis for learned Queen's Counsel, Mr. Watt's, contention that the trial judge correctly applied the law in concluding that the appellant was negligent. We agree with the submission of Sir Clare, QC that there is no evidence which establishes that the appellant fell below the standard of care in performing the surgery on the respondent. The appellant's relevant grounds of appeal must succeed in the circumstances since the trial judge made a fundamental error in law.

Post-operative Care

[29] This part of the respondent's case may be classified primarily as involving the appellant's clinical judgment and diagnosis, in our view. The doctor's duty to his patient encompasses diagnosis, advice and treatment. Diagnosis should be preceded by the taking of a full history from the patient, a physical examination, and where necessary diagnostic tests. Diagnosis should also be kept under review if the patient is failing to respond to the treatment. Diagnosis will normally be followed by advice, which may range from an assurance that there is nothing wrong with the patient through to the prescription of the medication together with a suggestion that the patient take the medication, to a recommendation that the patient undergo major surgery. Treatment extends to post-operative care.[12]

[30] The respondent alleged in her pleadings that the appellant owed her a duty of care in negligence to exercise reasonable care and skill during any post operative care; and that he failed to heed her several post operative complaints of a "tugging" in the area of the incision and to properly investigate the said complaints by x-ray, catscan, MRI or other medical examination.

[31] The respondent again relied on her evidence, and the testimony of her daughter, sister and Dr. John to prove her case. The respondent testified as to how she felt after her hysterectomy, the complaints she made to the appellant and other medical personnel,

[12] Medical Negligence supra at paragraphs 4-002- 4-007

and the treatment she received on these occasions. It is now necessary to consider this aspect of her evidence.

[32] The respondent complained to the appellant when he paid her a bed-side visit on the 28th June 2001, about a pulling at the bottom of the incision every time she moved around. She explained at the trial that it felt like a string or cord pulling on the inside, but she never told the appellant about the cord. She said that she felt the cord in the knot on the outside around the vaginal area. According to her, the appellant said: "Oh, I know what that is. As I was finishing off surgery I remember when I pushed the end of the suture it did not quite go down, but I said it would work its way in. It is because you do not have any fat on your stomach like most women that it did not get absorbed. It will go away in time." The suture that the appellant was then referring to was a bump outside, just beneath the surface of the skin, which she said remained there until the corrective surgery was performed by Dr. John.

[33] On the other hand, the appellant's version according to his notes was that the respondent complained of pinching and itching; and she pointed to the area where he had placed the knot of the PDS non-absorbable suture for her abdomen when closing the rectus muscles. The PDS suture can be there for 4 years. He felt that it was the PDS suture that was pulling. He had interpreted the pinching as coming from the knot of the PDS suture that she complained about from day 1 to post-operation. He understood her to be complaining about the abdominal sutures and the tugging and pulling was from the abdominal muscle whenever she moved. He had used another type of suture which was cat-gut chromic "O" to suture the vessels and the vagina. Chromic "O" suture is absorbed rapidly within 6 to 8 weeks. While Dr. Roberts agreed with the appellant about the absorption rate, Dr John testified that the absorption rate is 90 days later, and, from his experience it does not disappear in less than 42 days.

[34] On the morning of the 3rd July 2001, the day of her discharge from the hospital, the appellant described the episode on the evening of the 2nd July 2001, when the respondent had felt very sick and nauseated, had to walk in a stooped position, had

experienced profuse cold sweating, vomiting and excruciating pain, for which a female Indian doctor had ordered an EKG and prescribed large doses of antacid, as gas attacks which could be bad after surgery. This episode had lasted for approximately 2 hours. On the 3rd July after she was discharged, she developed fever, and headaches. Although she telephoned the appellant's office and left a message with the nurse there, the appellant never returned her call. Her daughter, Ms. Joseph, located the appellant later that afternoon at his friend's home. The appellant instructed that the respondent should take some paracetemol, and Ms. Joseph was to get a thermometer, take the respondent's body temperature, monitor it, and call him if it got worse. There is no evidence from her that it got worse.

[35] During her first week of recuperation at her sister, Ms. Kirchner's home, the respondent telephoned the appellant and complained about the pulling she was feeling on the inside. She asked him about the knot on the outside as to whether he could surgically snip it off as to make it more comfortable for her. The appellant said he could not do that as the whole suture would give way and the incision would open up. She asked the appellant how long it would be before the suture would be absorbed and the pain and discomfort go away. The appellant told her he could not say, she should wait and give it time. Later on in July, the respondent telephoned the appellant at the Women's Clinic, but was only able to speak to nurse Stanislaw Mason whom she told about these same symptoms and pain, and the burning in her urine. The nurse advised her to cease taking B Complex and the burning in her urine would stop, and to take panadol, as it was natural to feel some pain. (The appellant denied receiving any message from the nurse at the clinic concerning this call.)

[36] On the 3rd August 2001, which was her scheduled post-operation check-up appointment, the respondent complained about the pains she was feeling in the same area in her pelvis. The appellant told her she had healed well, that in a week or two the last of the pale yellow discharge would disappear, and that the pain she was still feeling was coming from the knot of the suture. She was placed on premarin for her hot flashes. This was her final visit with the appellant who thereafter went abroad on

vacation without referring her to anyone whom she should see in case of an emergency. However, the appellant explained that before the hysterectomy, the respondent was a patient of his partner, Dr. Kelsick, and so she would have been able to see Dr. Kelsick in his absence.

[37] On the 16th August 2001, whilst at church, the respondent experienced another episode of what had occurred on the 2nd July 2001, but this time far worse. She had pains and abdominal swelling and had to be taken to the hospital at about 11:00 pm. She was treated at the casualty emergency department by a doctor for gastroenteritis. On returning home, the pains which had subsided got excruciatingly worse and she vomited. At about 5:00 am on the 17th August 2001, she called 911 and the ambulance arrived. At the hospital, a check up including x-rays and blood work was done. She was admitted and throughout the next day Saturday 18th August a total of nine doctors attempted to diagnose her illness. Dr. Mangenard utilised ultrasound to view the respondent's internal organs and eventually scheduled her for the emergency surgery by Dr. John. The appellant's response to this was that when someone is diagnosed with bowel obstruction it comes from diagnosis; and these doctors were able to make a diagnosis because of the nature of the respondent's complaints then, and it turned out that they trusted her, and after 24 hours they decided to do surgery. Dr. John's evidence did not dispute this.

[38] Dr. John testified that the respondent had told him that when she woke up the next morning after the appellant's surgery she had a "tugging" sensation; and that she told him (Dr. John) she had the "tugging" sensation when he saw her 6 weeks later. He said that after the corrective surgery, the respondent asked him about the tugging pains and what he had found. His testimony was: "I told her that an area of her bowel was sutured. She said she knew because the tugging was not there after the second operation."

[39] In his medical report[13] Dr. John wrote that: "The patient complained that since the

[13] At page 178 of the Record of Appeal

operation she had had a non-subsiding pain described as a "tugging" sensation in her pelvis". Under cross-examination Dr. John said: "If someone complained of tugging I would not be unduly alarmed but would if it persisted. I would not do this right after the operation. If I got other indications I would investigate. People say they have pain. It is up to the clinical skills of the surgeon to determine where the pain is coming from. If they complained about pain coming from the knot. There is always pain after the surgery - bowels, cut healing etc. There are different types of pain. It is up to the clinical skill of the surgeon to determine where the pain is coming from. If I think the pain is due to the healing process - If someone said they had pain from hemorrhoids I would not jump to remove it if I thought the pain was in the abdominal wall."

Appellant's evidence

[40] The appellant explained that the large bowel is at the bottom while the small bowel which is loose in the abdomen is at the top. The small bowel is divided into three parts, and the distal ileum is the furthest part of the small intestines. Although the appellant agreed that if the ileum was sutured to the vaginal stump it could lead to a bowel obstruction, he said that if there was suturing this would not cause the pulling and tugging (presumedly because the small bowel is loose), and the person may not have any symptoms. A person can also have cramping, vomiting and cold sweat if she had an obstruction which would not relate to any pulling and tugging in the area of her pelvis. The appellant said that the respondent's post-operative course while in hospital was nothing out of the ordinary. The pulling sensation she complained about the day after the surgery is common. She felt this sensation at the base of the operation incision each time she moved. Patients are expected to have incision pain especially on moving about so pain medications are given. Patients react differently to pain, and patients have different thresholds for pain. After the operation he expected soreness and pain, and pain killers, injections, antibiotics, and blood thinners to prevent blood clots were ordered. On the 3rd August 2001, the respondent may have lost some weight, up to 4 lbs.

[41] The appellant and his expert witness, Dr. Gwendolyn Fevrier Roberts, opined that it is evident that what Dr. John saw was adhesions of the small bowel to the vaginal vault; and that the respondent had post operative adhesions which is a common occurrence which cannot be attributed to any negligence of the appellant. Learned Queen's Counsel, Mr. Watt, contends that this evidence was speculative and baseless. The appellant testified further that when someone is diagnosed with bowel obstruction it comes from diagnosis; and in any event MRI which is not available in Antigua, x-ray, and catscan would not have led to a diagnosis of adhesions. Dr. John's testimony did not refute this. The appellant testified also that the respondent never described to him the symptoms that the respondent experienced on the 16th August 2001, but what she described she experienced on the 2nd July 2001 were pain, cold sweat and vomiting. He stated that on the 3rd July 2001 if there were adhesions, the respondent would not feel anything; and adhesions may or may not cause any problems. An incision can take 2 months and up to two years, he said, so up to 5 weeks when he last saw the respondent he would expect the same complaints. The appellant opined[14] also that the respondent would have developed post-operation adhesions between the 16th and 18th July which caused her obstruction, and she would have had bowel obstruction from July. It is appropriate at this point to address some of the other collateral issues in this appeal which relate to adhesions and other relevant findings and inferences.

Other Material Grounds of Appeal

[42] There is controversy concerning the learned trial judge's interpretation of the evidence relating to when the adhesions that Dr. John found, would have started to form after the hysterectomy surgery, and the inferences that he drew from his findings about the adhesions. These relate to grounds 17, and 7 to 9. Ground 17 urges that the trial judge: "failed to properly consider the question of the timing of the onset of the small bowel obstruction and therefore reached an incorrect conclusion as to its cause."

[43] Contrary to the contention of Sir Clare, QC that at paragraph 113 of his judgment the

[14] At page 86 of the Record of Appeal

learned judge misquoted the evidence as to when the appellant contended that the adhesions developed, the notes of evidence[15] confirm that the appellant testified that the respondent would have developed adhesions somewhere between the 16th and 18th July 2001 which caused her obstruction. The appellant also testified[16] that had the episode of the 2nd July, 2001 related to a bowel obstruction which had continued, it could not continue for 5 weeks because of its nature as a lock, and what occurred on the 16th August was a lock which required surgery. In his assessment of the evidence the learned judge obviously rejected the appellant's and Dr. Roberts' evidence, that the bowel obstruction probably started on the 16th August 2001. Ground 17 therefore is meritless in our view.

[44] Grounds 7 to 9 challenge the judge's finding at paragraph 139 of the judgment. There the learned judge rejected the undisputed evidence of the appellant that he had followed the standard procedure in performing the surgery; and ruled out the probability of adhesion formation on the day following the operation, despite Dr. Roberts' undisputed evidence that the process of adhesion formation begins almost immediately post surgery. It is obvious from paragraph 114 of his judgment that the learned judge in arriving at this conclusion relied on information in two anonymous internet articles, which were never canvassed or put to any of the experts at the trial for their response. The information in these articles certainly was not evidence that could be legitimately relied on by the trial judge to displace the evidence of Dr. Roberts or any other expert witness. The observations of Lord Diplock in the Privy Council case Mahon v Air New Zealand[17] are pertinent here: *'"Where facts are in dispute in civil litigation conducted under the common law system of procedure, the judge has to decide where on the balance of probabilities, he thinks that the truth lies as between the evidence which the parties to the litigation have thought it to be in their respective interests to adduce before him. He has no right to travel outside the evidence on an independent search on his own part for the truth; and if the parties' evidence is so inconclusive as to leave him uncertain where the balance between the conflicting*

[15] At page 86 of the Record of Appeal
[16] At page 91 of the Record of Appeal
[17] [1984] A.C. 808 at 814 G-H

*probabilities lies, he must decide the case by applying the rules as to the onus of proof in civil litigation. "*This reliance on the internet articles in our view, brings into question the legitimacy of the inference in the third sentence of the finding of the judge at paragraph 139 where he stated:

> "*The Defendant denies the finding of Dr. John that the bowel was sutured to the vaginal stump. However if the Defendant did in fact follow the standard procedure by using the wet pads and the retractors and the bowel was out of field at the time of the suturing, it is reasonable to infer that the Defendant did not tell the whole story. As Dr. John said, a suture can only go in by a needle and since the matter of adhesion on the day following the operation , must be ruled out this leads to the reasonable inference that the standard procedure was not followed and at least the bowel was not out of field."*

[45] Consequently, we agree with the contention of Sir Claire that since the matter of adhesion formation on the day following the operation ought not to have been ruled out, the premises on which the deduction was made are false. So the inference that the standard procedure was not followed is an unreasonable inference which cannot stand. Another reason why this inference should not stand in our view, apart from the error of law we have already found, is because of the contention in grounds 7 to 9 which state: "(7) The learned Judge misdirected himself in holding that if the Appellant did in fact follow the standard procedure by using wet pads and the retractors and the bowel was out of the field at the time of suturing, it is reasonable to infer that the Appellant did not tell the whole story. (8) That there was no evidence to support the finding of the learned Judge that the Appellant did not take the steps he said he took in performing the operation. The evidence of the Appellant as to the procedure he adopted was uncontroverted and should have been accepted by the learned judge. (9) The learned Judge was wrong in law in holding that the reasonable inference that the standard procedure was not followed and at least the bowel was not out of field. He erred in not holding that the Appellant followed the approved practice with respect to the surgery and was therefore not negligent."

[46] The judge's conclusions that the standard procedure was not followed by the appellant, depended on the evidentiary value that he gave to the appellant's undisputed testimony. Since the credibility of the appellant concerning the standard

practice he had adhered to in performing the surgery was not in issue, in our judgment, the proper conclusions would be that the appellant had followed the standard procedure; and the alleged suturing of the respondent's small bowel to her vaginal stump was not proved on a balance of probabilities. The respondent had proffered no evidence capable of showing want of care, skill and diligence on the part of the appellant. Grounds 7 and 8 are therefore well-founded in our view.

Testimony of Dr. Roberts

[47] Dr. Roberts testified that adhesions are almost inevitable after surgery and are not the fault of the surgeon. She stated that following abdominal surgery patients may report a variety of sensations for weeks - months. "These may include numbness, pinching, tugging and normally resolve with time. Furthermore there is no evidence that the tugging sensation noted post op was in anyway related to her post op complications. ... Bowel obstruction could not have been predicted by any available medical test or procedure.... A "petite frame" makes surgery easier and permits better visualisation of the field than in an obese patient, lessening the chances of complications."

[48] Dr. Roberts opined that the appellant's post operation review of the respondent at 5 weeks instead of the normal standard 6 weeks review indicated that he was ensuring that all was well before going on his vacation; and that the tugging sensation the respondent was experiencing then would be no cause for alarm. In her opinion, the appellant exercised due care and diligence in performing this surgery, and his follow-up of the respondent’s post-surgery was reasonable and adequate. The likeliest cause of the respondent's obstruction was adhesions facilitated by the raw, sutured vaginal vault.

The Applicable law

[49] The learned trial judge dealt with post-operative care at paragraphs 145 to 170 of his judgment. When considering the relevant law, he alluded to several Canadian cases

among others, including Tacknyk v Lake of the Woods Clinic.[18] He also referred to the Bolam test,[19] and the judicial statement of Lord Brown-Wilkinson in Bolitho v City and Hackney Health Authority.[20]

[50] It is well settled law that the Bolam test is applicable to all aspects of a medical practitioner's work.[21] The learned trial judge was guided by the following statement of the Ontario Court of Appeal in Tacknyk: "The obligation of a surgeon to this patient cannot and does not stop with the successful completion of the operation itself. A continuing duty rests upon the surgeon to provide adequate post-operative care or to give adequate advice and direction as to such care. The extent of that duty will vary widely. It is now clear that the standard of care is a matter for the Court and not for medical experts although their view will be taken into consideration in setting the appropriate standard. The degree of care the surgeon must provide and the extent of the advice he must give will depend on a long list of variables. They must include the gravity of the operation, the age and general health of the patient, the particular problems of the patient, the nature of the post-operative medication and treatment required, the degree of isolation of the patient, the availability and proximity of medical care and hospital facilities and the degree of risk to which the patient is susceptible either from post-operative complications or subsequent medications and treatment."

[51] In Bolitho the House of Lords agreed with the submissions of Queen's Counsel for the appellant who argued that the trial judge was wrong in law because he wrongly treated the Bolam test as requiring him to accept the views of one truthful body of expert professional advice despite not being persuaded of its logical force. Lord Browne-Wilkinson stated[22]: " My Lords, I agree with these submissions to the extent that, in my view, the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of

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18 [1982] O.J. No. 170.
19 Reproduced at paragraph 11 of this judgment
20 [1997] 4 ALL E.R. 771.
21 Sidaway v Bethlem Royal Hospital Governors and others [1985] 1 All E.R. 643
22 At page 788 (C-G) of the judgment

medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. In Bolam's case...McNair J stated that the defendant had to have acted in accordance with the practice accepted as proper by a '*responsible body' of medical men'* [The other relevant statements of McNair J in Bolam having been analysed, Lord Browne-Wilkinson continued.] ...the court has to be satisfied that the exponents of the body of opinion relied on can demonstrate that such opinion has a logical basis. In particular, in cases involving, as they often do the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter. [At page 779 H] ....I emphasise that in my view, it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable."

Post- Operative Care Grounds

[52] The relevant grounds of appeal touching post-operative care are grounds 14 to 16,19, and 22. Grounds 14 and 15 which overlap, relate to paragraphs 158 and 169 of the judgment where the learned judge stated : "158. ...Dr. Abott was effectively seized of his patient's problem on 28th June. This problem, in his words, 'deteriorated ' over time and, objectively, was far worse on 3rd August, being the day of his departure. Even so, for him, there was nothing untoward and hence no need to leave any doctor to preside over her." "169. There is no other explanation contained in the evidence to account for the tugging of which the Claimant complained less than twenty-four hours after the operation so as to give the benefit of the doubt to the Defendant. Also there is nothing in the evidence to indicate that the Defendant even ordered a test especially after the episode of 2nd July and more so after complaints of pain, headaches, vomiting and latterly loss of weight. The most serious prescription was medicine for hot flashes."

[53] The grounds allege: "(14) The learned Judge was wrong in law when he failed to

consider that the tugging and pulling could have come from the sutures in the abdominal wall and skin wound. The learned Judge failed to consider that the preponderance of evidence including the evidence of the Respondent was that her complaint was about the sutures in the abdominal wall and skin wound. (15) The learned Judge erred in law in not recognizing that the evidence, including the evidence of the Respondent was that the tugging and pulling complained of were felt only when the Respondent moved which was an indication that it was not obstruction of the bowels. (16) That there was no evidence to support the finding of the learned judge that the Appellant was effectively seized of his patient's problem on 28th June or that the problem had deteriorated over time and objectively was far worse on 3rd August, being the day before the Appellant's departure. The learned judge failed to consider the evidence including the Appellant's contemporaneous notes of the treatment of the Respondent which led the Appellant to conclude that there was nothing untoward in the recovery of the Respondent."

[54] We find merit in these grounds, having regard to the evidence reproduced at paragraphs 31, 33, 34 and 38. This evidence speaks for itself. There was clearly evidence from the appellant explaining that based on the respondent's complaints, he had diagnosed from the 28th June, that the "pinching" was from the PDS non-absorbable suture knot in her abdomen, and the "tugging" was from the abdominal muscle whenever she moved, and this was a common phenomenon after surgery. He expected her to have incision pain after surgery given that incisions take 2 months and up to 2 years to heal. The vomiting and nausea she had on the 2nd July 2001, were consistent with a bad attack of gas after surgery, which was common, he said; and although it could be also symptomatic of a bowel obstruction, he obviously had ruled that out because of the lock down effect of the bowel obstruction which he testified could not have existed for 5 weeks. The fact that all of these persisted up to the 3rd August apparently did not raise any alarm for him, because he had continued to diagnose all of her symptoms as being incidental to her type of surgery. Although her pains and the "tugging" were persistent, these could not by themselves compel a reasonable conclusion that the respondent had deteriorated up to the 3rd August in

our view since the evidence of her deterioration materialised on the 16th August while the appellant was abroad. Based on the appellant's diagnosis and what Dr. John's surgery revealed, in our opinion, it would be an unreasonable inference to conclude that the appellant was "effectively seized of his patient's problem on the 28th June". The question in our respectful view would be: whether it was reasonable for him to have made such diagnosis where there was persistent complaint without carrying out further investigation and/or tests. Though Dr. Roberts' evidence suggests that the appellant acted reasonably, the evidence of Dr. John must be scrutinised.

[55] Thomas J specifically referred to Dr. John's evidence at paragraphs 159 to 161 in the following manner:

> "159.In cross-examination Dr. John was asked if after an operation a patient complained of a tugging he would be alarmed. This was his response: *"No, not necessarily. If it persisted, I would start to wonder what's going on, but certainly not someone coming in fresh after an operation saying I have a tugging in my incision."* 160. Learned Counsel for the Defendant further questioned the witness about x-ray, CAT scan, MRI or other medical examination where there is such complaint. He answered in this way:
> *"Again, not just based on one visit saying I have a tugging. If this was ongoing and this was a source of ...anxiety and discomfort to the patient... it would depend on a lot more. At that point I would have to pull a lot more detail from her in terms of this pain and so forth. And if I thought it was simply related to just the actual closure of the incision... then I would reassure. But if I got any indication that there was something also going on at that point, other investigations would be used."* 161. Further in the cross-examination Dr. John was asked about someone complaining about the pulling of the knot on the fascia. He answered by saying: *" Well, you would never get a patient complaining of pulling of the knot on the fascia. Most people don't know there is fascia there. What people come in telling you is that they have a pain; they have a pain here. It is up to the clinical skills of the surgeon taking care of her to really elicit where that pain is originating ...what is the cause of the pain."*

[56] Thomas J did not analyse this evidence in his judgment. He merely concluded that it was in alignment with the judicial statement of the Ontario Court of Appeal in Tacknyk, (discussed at paragraph 49 above), especially in respect of the variable of the particular problem of the patient, and the nature of the post-operative treatment required.

[57] We have considered the submissions of Sir Clare,QC in relation to ground 19 which urges that "The learned Judge erred in law in finding that the post-operative treatment attributable to the Appellant fell below standard without any expert or any evidence as to what were acceptable standards. There was no evidence that the Appellant's post-operative treatment of the Respondent was negligent."

[58] Sir Clares, QC's submissions were that the learned trial judge ought to have established what the appellant ought to have done and whether he had fallen below acceptable standards. He submitted that there was no evidence to suggest that the appellant should have found anything untoward about the respondent's complaints between 28th June to 3rd August. Neither was there evidence as to what the standard should have been in this case. Consequently, the judge's findings were without the requisite foundation.

[59] In our judgment there was expert medical evidence from Dr. John and Dr. Roberts which established to some extent how the appellant ought to have behaved. But was this sufficient to discharge the burden of proof? Regrettably, there are gaps in the evidence relating to standard of care which in our view cannot be filled by inferences. Dr. John used the words "so forth" and "other investigations" in his testimony which did not assist the respondent in defining the standard of care. From Dr. John's testimony the following objective standards could have been extrapolated:

(a) On the 28th June which would be fresh after the operation, the respondent's complaints about pain and the "tugging" in her incision would not necessarily cause alarm to a competent surgeon who performed the operation

(b) Since such complaints were persistent, and were a source of anxiety and discomfort to the respondent, the appellant ought to have "pulled a lot more detail from her in terms of the pain and so forth" In other words he ought to have got additional information from her specifically about the

complaint in order to determine whether her complaint related either to the actual closure of the incision or something else which required further investigation.

(c) If the additional information from her led the appellant to conclude that the pain and tugging related to the closure of the incision, merely reassuring the respondent would be enough.

(d) But if the additional information indicated that there was something else going on, at that point the appellant should have carried out other investigations. Dr John did not establish what other investigations could or should have been carried out. He did not state what investigations he would have done up to the 3rd August 2001 if he had attended to the respondent. He did not state by what procedure or practice was the source and cause to be elicited. He never specified any tests that could have been done. He merely left it up to the clinical skills of the surgeon, in this case the appellant, to determine the source and cause of the pain. This evidence in our view was crucial, having regard to the evidence that it took 9 doctors over a 2 day period to diagnose her bowel obstruction.

[60] Looking back at the evidence of the appellant, there is nothing to suggest that the appellant attempted to, or did in fact pull out more detail from the respondent concerning her persistent complaint. Applying the Dr. John approach, this may have been an omission on the part of the appellant, based on his diagnosis as to what was causing her pain and "tugging". "In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men.... The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill [of his speciality] would be guilty of if acting with ordinary care...."[23]

[23] Per Lord President Clyde in Hunter v Hanley, (1955) SLT 213 at 217, relied on by Lord Scarman in Maynard v West Midlands Regional Health Authority [1985] 1 ALL E.R. 635, at 638 F.

[61] Dr. Roberts on the other hand approved the appellant's treatment of the respondent in connection with her complaints as the standard acceptable practice. She testified that the "tugging" is not indicative that something is wrong although this and the respondent's level of pain would be causes for concern. She did not regard the symptoms recorded for the respondent as unusual. On the authority of Bolam and Bolitho, despite Dr. Roberts' testimony which sanctioned the appellant's diagnosis and treatment of the respondent, the learned trial judge would have been entitled to hold the appellant liable for negligence if there had been credible evidence from the respondent's expert witness that the appellant had failed to take the necessary care.

[62] Ground 21 alleges that: "The learned Judge was wrong in law in failing to accept the expert evidence that X-ray, CAT scan or MRI would not have led to a diagnosis of adhesions." We are of the view that though this evidence came only from the appellant, since it was not challenged it ought to have been accepted by the learned trial judge. Had the learned trial judge accepted this evidence, it would have impacted, in our view, on Dr. John's opinion that "other investigations" ought to be carried out where there is indication that something else other than the closure of the incision was causing the pain and "tugging". This begs the question: What other investigation would another competent surgeon in the appellant's place have carried out in such circumstances up to the 3rd August 2001? Learned Queen's Counsel, Mr. Watt, submitted that the appellant should have ordered x-rays, other tests and blood work, as Dr. John had done after the respondent was admitted on the 17th August. This he submitted would have enabled diagnosis, as it did on the 18th August.

[63] Looking back at the evidence of Dr. John, he testified that he could not remember if he entered the picture before the x-rays were done or after. He did not remember if the respondent had been seen by 9 doctors as she and her witnesses had said, but he stated in his report that a work up including x-rays and blood work were done, and diagnosis of bowel obstruction made. In the realm of diagnosis and treatment involving the weighing of risks against benefits, negligence ought not to be established

on the evidence of an expert witness which demonstrates no logical basis, and by extension uncertainty.[24] There was no competent and reasonable body of opinion before the trial judge that had the appellant carried out x-rays, blood work and ultra sound or other specific diagnostic test, between the 28th June and 3rd August, the adhesions and suture attached to the bowel which subsequently caused the bowel obstruction could have, or probably would have been diagnosed. The trial judge at paragraphs 168 and 170, seems to have used the fact that the appellant had found nothing untoward about the respondent's complaints, along with the absence of further investigation, and the judge's mistaken conclusion that there was no other explanation in the evidence to account for the "tugging", to conclude that the appellant was in breach of his duty of care. He did this after reviewing and applying the relevant evidence of Dr. John which fell short of establishing the requisite standard of care. In our respectful view, this was an error in law, even though he had correctly stated the law to be applied.

[64] There remains for determination grounds 24 and 25 relating to the issue of causation, and six other grounds. Ground 27 alleges that the judgment of the learned Judge was wrong and ought to be set aside; and this we agree with in light of the conclusions we have reached concerning the respondent's failure to adduce evidence on the standard of care. In our view, there is no need for us to consider the other outstanding grounds because of our conclusions on grounds 1, 2, 7, 8, 9 and 27. The appellant has succeeded on grounds 1, 2, 5, 7 to 9, 14 to 16, 19 to 22, and 27, and failed on grounds 11, 17, 18, and 23. Grounds 3, 4, 6, 10, 12, 13, 24, 25 and 26 have not been determined.

[65] We would allow the appeal, reverse the decision of Thomas J, enter judgment for the appellant dismissing the claim, and order that the respondent pay the costs of the appellant in the court below to be determined pursuant to CPR 65.5 (2) (b) (ii); and that the costs of the appeal be two thirds of the costs below, pursuant to CPR 65 (13) (b).

[24] Bolitho supra, page 778 D-G