Indexed as:
Baksh-White v. Cochen

Between
Rosalyn Baksh-White, plaintiff, and
Dr. A. Ronald Cochen and the Mississauga Hospital, defendant

[2001] O.J. No. 3397

[2001] O.T.C. 632

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Court File No. 98-BN-01350

Ontario Superior Court of Justice

Snowie J.

Heard: February 19-22, 2001.
Judgment: August 21, 2001.

(70 paras.)

Medicine -- Liability of practitioners -- Negligence or fault -- Standard of care -- Failure to inform or disclose -- Obstetrical or gynaecological care.

Action by Baksh-White against Dr. Cochen for damages for medical malpractice. Cochen performed an abdominal hysterectomy on Baksh-White, who had been diagnosed as suffering from uterine fibroids. Baksh-White's small bowel was perforated during the surgery. Baksh-White alleged that Cochen failed to inform her that her medical condition could be controlled by medication, and failed to advise her of the inherent risk of bowel perforation and the increased risk because of her three previous surgeries. Cochen confirmed that he did not advise Baksh-White of the risk of bowel perforation or of the more conservative management options. He stated that the risk of perforation was not material and that none of the more conservative management options was appropriate. Baksh-White was an experienced nurse. She had been advised of risk of injury to the ureters but decided to proceed with the surgery regardless. Despite having a cousin die from undergoing a general anesthetic, she was prepared to be anesthetized.

HELD: Action dismissed. There was no evidence that more conservative management options were available. The risk of bowel perforation was material, and Cochen's failure to disclose it was a breach of his duty to warn Baksh-White. However, Baksh-White was self-directed and focussed on obtaining an abdominal hysterectomy. Even if she had been properly advised of the risks, she would have proceeded with the surgery.

Counsel:

Raj Napal, for the plaintiff.
David E. Leonard and Michally Iny, for the defendant, Dr. Cochen.

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1 **SNOWIE J.**:-- This case involves an action for medical malpractice. The plaintiff, Rosalyn Baksh-White, then 41 years of age, underwent major surgery on February 11th, 1997, at the Mississauga Hospital for an abdominal hysterectomy. She had been diagnosed as suffering from uterine fibroids. The surgery was performed by the defendant Dr. A. Ronald Cochen. This action arises out of the perforation of the plaintiff's small bowel during this surgery. The action against the defendant, the Mississauga Hospital, has been previously dismissed, on consent.

2 As a result of a summary judgment motion brought by Dr. Cochen, previously, and not before myself, the only issues before this court are that of:

(1) informed consent, and
(2) damages

3 The previous summary judgment motion was consented to, in part, by the plaintiff, Ms. Baksh-White. The allegations of negligence concerning the decision to proceed with an abdominal hysterectomy and the perforation of the plaintiff's small bowel as a result have been dismissed. Ms. Baksh-White was previously granted leave to amend her Statement of Claim and add the allegations pertaining to informed consent.

4 The plaintiff alleges that Dr. Cochen breached the standard of care expected of a reasonable and prudent gynaecologist practising in Ontario in 1997 in respect of the informed consent discussion that took place on January 27th, 1997 between Dr. Cochen and the plaintiff, prior to the surgery as follows:

(3) Dr. Cochen failed to inform the plaintiff that her medical condition could be controlled by the injection of specific drugs and medication.
(4) Dr. Cochen failed to inform the plaintiff that as a consequence of her previous medical history there was a greater risk of operative complications.
(5) Dr. Cochen failed to ensure that the plaintiff understood the alternatives to surgery and the risks of surgical intervention so that the plaintiff could make an informed decision as to whether she would undergo the surgery recommended by the defendant Dr. Cochen.
(6) Dr. Cochen in all the circumstances failed to provide the kind of comprehensive advice that a competent gynaecologist practising in Ontario is ex-

pected to provide a patient prior to a surgical operation and more particularly the higher risks that this particular plaintiff would face with surgical intervention given her medical history.

More particularly,

(1) Dr. Cochen failed to advise Ms. Baksh-White of the risk of bowel perforation inherent in the proposed surgery and the increased risk that she was exposed to due to adhesions in her abdomen caused by three previous surgeries in the area.
(2) Dr. Cochen failed to advise the plaintiff of other more conservative management options available to treat her condition including the use of:

(i) Depo-lupron;
(ii) the use of the medication Danazol;
(iii) performing the less invasive procedure of endometrial ablation.

5 Dr. Cochen confirmed in his testimony that he did not advise the plaintiff of the risk of bowel perforation nor did he advise her of any of the more conservative management options, being:

(1) the use of the medication Depo-lupron;
(2) the use of the medication Danazol;
(3) the procedure of endometrial ablation.

6 It is the plaintiff's position that had she been informed of the risk or bowel perforation she would not have consented to and undergone the surgery. It is the plaintiff's position that had she been advised of the more conservative treatment options she would not have consented or undergone the surgery and would have opted for a more conservative management of her symptoms.

7 It is the defendant, Dr. Cochen's, position that the informed consent discussion he had with Ms. Baksh-White on January 27th, 1997, was both appropriate and within the expected standard of care for a competent gynaecologist practicing in 1997 in Ontario.

8 It is uncontested that Dr. Cochen was aware of the presence of adhesions in the plaintiff's pelvis area due to her previous surgeries and that as a result he advised Ms. Baksh-White of the risk of damage that could occur potentially to her ureters and/or bladder during the surgery. Dr. Cochen testified that he was concerned enough about potential damage to the ureters that he arranged for a urologist to place stents in the plaintiff's ureters preoperatively, to improve his ability to see them and avoid injury to them during the surgery.

9 It is the defendant, Dr. Cochen's, position that:

(1) He did not discuss the risk of bowel perforation with Ms. Baksh-White as he did not consider the risk to the bowel to be a material one.
(2) He did not discuss the more conservative management options with Ms. Baksh-White, as previously outlined, as he did not believe in his professional opinion any of them to be appropriate given the plaintiff's clinical presentation.

10 The legal principles are well established on the issue of medical disclosure. Laskin, J., speaking for the majority of the Supreme Court of Canada in Reibl v. Hughes, [1980] 2 S.C.R. 880 at page 884 stated:

> It is now undoubted that the relationship between surgeon and patient gives rise to a duty of the surgeon to make disclosure to the patient of what I would call all material risks attending the surgery which is recommended. The scope of the duty of disclosure was considered in Hopp v. Lepp, [1980] 2 S.C.R. 192, at page 210, where it was generalized as follows:
>
> > In summary, the decided cases appear to indicate that, in obtaining the consent of a patient for the performance upon him of a surgical operation, a surgeon, generally should answer any specific questions posed by the patient as to the risks involved and should without being questioned, disclose to him the nature of the proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the performance of the operation. However, having said that, it should be added that the scope of the duty of disclosure and whether or not it has been breached are matters which must be decided in relation to the circumstances of each particular case.
>
> The Court in Hopp v. Lepp, supra also pointed out that even if a certain risk is a mere possibility which ordinarily need not be disclosed, yet if its occurrence carried serious consequences, as for example, paralysis or even death, it should be regarded as material risk requiring disclosure.

ISSUES FOR THE COURT

11 In this case, counsel have decided that the questions the court must ask and answer are as follows:

(1) Was the risk of bowel perforation material, such that Dr. Cochen's failure to disclose it to Ms. Baksh-White was a breach of his duty to warn?
(2) Did Dr. Cochen have a duty to advise Ms. Baksh-White of more conservative management options?
(3) If the answer to (1) and/or (2) is yes, would Ms. Baksh-White, properly advised of the risks or of the more conservative management options have nonetheless gone ahead with the abdominal hysterectomy surgery?
(4) If the answer to (3) is no, would a reasonable person in Ms. Baksh-White's position have nonetheless gone ahead with the abdominal hysterectomy surgery?
(5) If the answer to (4) is no, what is the quantum of Ms. Baksh-White's damages?

The issues are not easy and it is understandable why this matter was litigated.

THE TEST

12 The test to be applied by this court is that enunciated in Reibl v. Hughes, [1980] 2 S.C.R. 880. It is as follows:

> ... it is the safer course on the issue of causation to consider objectively how far the balance in the risks of surgery or no surgery is in favour of undergoing surgery.
>
> The failure of proper disclosure pro and con becomes therefore very material. And so too are any special considerations affecting the particular patient. For example, the patient may have asked specific questions which were either brushed aside or were not fully answered or were answered wrongly. In the present case, the anticipation of a full pension would be a special consideration, and, while it would have to be viewed objectively, it emerges from the patient's particular circumstances. So too, other aspects of the objective standard would have to be geared to what the average prudent person, the reasonable person in the patient's particular position, would agree to or not agree to, if all material and special risks of going ahead with the surgery or foregoing it were made known to him. Far from making the patient's own testimony irrelevant, it is essential to his case that he put his own position forward.
>
> The adoption of an objective standard does not mean that the issue of causation is completely in the hands of the surgeon. Merely because medical evidence establishes the reasonableness of a recommended operation does not mean that a reasonable person in the patient's position would necessarily agree to it, if proper disclosure had been made of the risks attendant upon it, balanced by those against it. The patient's particular situation and the degree to which the risks of surgery or no surgery are balanced would reduce the force, on an objective appraisal, of the surgeon's recommendation. Admittedly, if the risk of foregoing the surgery would be considerably graver to a patient than the risks attendant upon it, the objective standard would favour exoneration of the surgeon who has not made the required disclosure. Since liability rests only in negligence, in a failure to disclose material risks, the issue of causation would be in the patient's hands on a subjective test, and would, if his evidence was accepted, result inevitably in liability unless, of course, there was a finding that there was no breach of the duty of disclosure. In my view, therefore, the objective standard is the preferable one on the issue of causation.
>
> In saying that the test is based on the decision that a reasonable person in the patient's position would have made, I should make it clear that the patient's particular concerns must also be reasonably based; otherwise, there would be more subjectivity than would be warranted under an objective test. Thus, for example, fears which are not related to the material risks which should have been but were not disclosed would not be causative factors. However, economic considerations could reasonably go to causation where, for example, the loss of an eye as a result of non-disclosure of a material risk brings about the loss of a job for which good eyesight is required. In short, although account must be taken of a patient's

> particular position, a position which will vary with the patient, it must be objectively assessed in terms of reasonableness.

13 In Smith v. Arndt et al., (1997) 148 D.L.R. (4th) 48, at page 52, Cory J. speaking for the majority of the Supreme Court of Canada confirmed again this test stating:

> These words are as persuasive today as they were when they were written. The test enunciated relies on a combination of objective and subjective factors in order to determine whether the failure to disclose actually caused the harm of which the plaintiff complains. It requires that the court consider what the reasonable patient in the circumstances of the plaintiff would have done if faced with the same situation. The trier of fact must take into consideration any "particular concerns" of a patient and any "special considerations affecting the particular patient" in determining whether the patient would have refused treatment if given all the information about the possible risks.
>
> Was the risk of bowel perforation material such that Dr. Cochen's failure to disclose to it to Ms. Baksh-White was a breach of his duty to warn?

14 Dr. Braithwaite an obstetrician/gynaecologist specialist was offered as an expert by the plaintiff. On consent, Dr. Braithwaite's qualifications were accepted to offer expert opinion evidence in the area of gynaecology. Dr. Braithwaite is a member of the College of Physicians and Surgeons in both British Columbia and Ontario. He most recently was employed as the Administration Resident to the President and CEO at the Vancouver Health Sciences Centre. He has been a lecturer at both the University of Toronto and Queen's University and an Assistant Professor at the University of Toronto. Currently he works as a health care consultant and is completing his Masters degree.

15 Dr. Braithwaite gave his opinion in a clear and forthright manner. His opinion was that the plaintiff should have been given the information that there were options ranging from no treatment; to conservative treatment; to a hysterectomy, available to her prior to undergoing the surgery and that the plaintiff should have been advised of the risks and benefits of each option. Dr. Braithwaite testified that the plaintiff should have been informed by the defendant that there were all of the following risks associated with a hysterectomy:

(1) infection;
(2) haemorrhage requiring transfusion; and
(3) injury to surrounding organs. These organs he defined as the bladder, the bowel and the ureters.

16 It was his opinion that, damage to surrounding organs being the bladder, bowel and ureters is a material risk because this plaintiff had undergone a number of abdominal surgeries in the past. He testified that this plaintiff's risk of bowel perforation during abdominal surgery was increased as a result.

17 Dr. Braithwaite was asked on examination in-chief, for a percentage number that he felt represented fairly the risk factor involving perforation of the bowel in this type of surgery. He stated that the usual risk would be "one percent or less of bowel perforation during a hysterectomy". This percentage number, however, he felt would be increased in this case because of this plaintiff's 3 previous abdominal surgeries.

18 Dr. Braithwaite referred in his evidence to the S.O.G.C. Clinical Practice Guidelines #47 dated April of 1996. The objective of these Guidelines is as follows:

> To serve as a guideline to the indications for hysterectomy, preoperative assessment, and available alternatives for the most frequently encountered conditions. These guidelines are flexible to allow patients and physicians to individualize treatment when choosing among available options.

The Guideline Committee makes it clear that they were not minimizing the importance of alternative treatments but for the purpose of the Guidelines the focus is on hysterectomy. On page 14 of the Guidelines under the heading "Complications" the stated intent of the Committee with respect to disclosed complications by the surgeon to the patient is clear. It states

> ... the patient should also be informed of the risk of haemorrhage and damage to the surrounding organs.

19 Dr. Braithwaite testified that the risk of bowel injury in a hysterectomy is always something that he has discussed with his patients. He expressed surprise that Dr. Shier, the gynaecology expert, offered by the defendant does not specifically discuss bowel injury in his disclosure consultation with his abdominal hysterectomy patients. Dr. Braithwaite was clear that he disagrees with Dr. Shier on this point.

20 Under cross-examination with respect to the issue of "whether or not doctors could disagree on what a material risk is", Dr. Braithwaite concurred that doctors can disagree on what a material risk is in general. It was his opinion however, that it is normal for an abdominal hysterectomy, that a surgeon inform a patient about the risk of bowel perforation.

21 Dr. Braithwaite testified and Dr. Shier concurred that there are two occasions during abdominal surgery that a bowel perforation could occur:

> (1) upon entry into the abdomen (which is the situation in this case before the court), and;
> (2) upon the removal of the uterus.

22 The defendant argued that given these facts and the fact that the risk of such an occurrence would be divided approximately 50/50 between these two occasions in which the injury could occur, that this then reduced the risk by 50% to this particular plaintiff.

23 Dr. Shier is a gynaecological/obstetrician offered as an expert by the defendant. On consent Dr. Shier was qualified to offer expert opinion evidence in the area of gynaecology.

24 Dr. Shier has performed over 2,000 hysterectomies during his career. He is currently a member of the SOGC/GOC/SCC Policy and Practice Guidelines Committee; Chief, Divisions of General Gynaecology and Gynaecolic Oncology at Sunnybrook and Women's College Health Science Centre as well as a consultant at the University of Toronto Health Service and Director, Koffler Centre Colposcopy Unit and also a consultant for the Ontario Ministry of Health. He teaches at the University of Toronto, and is a member of various professional committees and organizations. It is Dr. Shier's opinion that Dr. Cochen, the defendant, did meet the standard of care for a doctor in Ontario in 1997. His opinion was that Dr. Cochen's care was meticulous and was above the standard of care required. It was his opinion that proper informed consent was provided. Questioned about the risk

of bowel perforation in abdominal hysterectomy surgery he stated the percentage in his opinion was between 0.1 to 0.8%. He went on to state that about half of those occurred upon entry therefore he felt the rate of risk, to this patient, for her particular perforation of the small bowel was approximately 0.05%. In his opinion 0.05% did not form a material risk. He testified that he informs patients at his disclosure meeting of the risk of:

(1) infection;
(2) haemorrhaging; and
(3) damage to surrounding organs which he defined as bladder, ureters only.

Additionally, he testified he gives all his own patients a copy of a handout brochure from the Patient Information Library that discusses the surgery and its possible complications in lay terms. This brochure is called A Guide to Understanding Hysterectomy and Related Surgeries (Exhibit #8). On page 11 it lists the possible complications as follows:

> With hysterectomy, as with any abdominal surgery, there is always a chance of complications or side effects such as infection, post operative bleeding, or wound separation. Possible problems resulting from hysterectomy can include damage to the bladder or the ureters, bowel adhesions and poorly functioning ovaries due to decreased circulation. There is also the risk of blood clots,(thrombobhletitis and pulmonary emboli), which can be caused by the slowed circulation during and immediately following a surgery.

25 Dr. Shier pointed out that no where in this brochure is perforation of the bowel referred to.

26 Dr. Shier's opinion was that the risk to this patient of .05% was a remote risk and/or not a material risk.

27 It was Dr. Shier's opinion, having reviewed the pleadings, the notes of Dr. Cochen, the examination transcripts and the report of Dr. Braithwaite that the defendant knew from the plaintiff's previous medical history that she would have abdominal adhesions and Dr. Cochen took extraordinary precautions preoperatively in his planning, as well as to have the ureters identified by means of the use of stents. In cross-examination, Dr. Shier stated that it would be his opinion that the risk of damage to the ureters would be between 10 and 15% in this case and therefore there was a material risk of damage to the ureters. With respect to the bladder he felt there was a risk of about 20% and therefore there was a material risk of damage to the bladder. Both these material risks were disclosed to the plaintiff.

28 Dr. Cochen in his testimony admitted that he did not advise the plaintiff of the risk of perforating her bowel as he was focused on the lower area of the abdomen where her pain was concentrated. He did not view perforation of the small bowel as material risk with respect to this surgery as it was his intent to perform a sub-total hysterectomy. He felt that the organs that were at risk would be:

(1) the bladder;
(2) the ureters.

29 He stated that because of the previous surgeries this plaintiff had undergone and the resulting adhesions, he felt the ureters were most at risk. As a result of this concern he asked Dr. Isaac to implant stents in the ureters in order that they would be easily identifiable during surgery. Dr. Cochen

held the disclosure meeting with the plaintiff at his office on January 27, 1997. The plaintiff signed a consent to diagnostic operative procedures/treatment. The consent identified the treatment as an "abdominal hysterectomy with catheter". The plaintiff consented to such additional or alternative procedures as may have been necessary or medically advisable during the course of this abdominal hysterectomy. As well, she consented to the administration of such anesthetics as were necessary by an anesthetist. The plaintiff confirmed that she had received information regarding the treatment and alternative courses of action, the material effects, risks and side effects in each case and the consequence of not having the treatment. She confirmed that her questions relating to the matter had all been answered.

30 Dr. Cochen testified that at the end of the January 27th, 1997 consultation, the plaintiff was totally aware of what the surgery entailed as well as its risks. Dr. Cochen knew that this plaintiff was herself a nurse, who was well experienced medically. As a result of the consultation, Dr. Cochen referred the plaintiff to an anesthetist to discuss directly her apprehension about the anesthetic due to the fact that she had a cousin die as a result of a complication of an anesthetic some two years previous. Dr. Cochen also referred the patient to an internist as this plaintiff suffered from thalassemia minor and he felt the surgery should be reviewed in light of the existence of this illness.

31 Dr. Cochen was cross-examined with reference to the study entitled Complications of Abdominal and Vaginal Hysterectomy Among Women of Reproductive Age in the United States. This study known as the Crest Study contains a breakdown of categorical complications among women aged 15-44 undergoing surgical hysterectomy between the years 1978 and 1981. Statistics quoted in the Crest Study for interoperative repair to bowel trauma are 0.3% and interoperative repair to bladder are 0.3%, and post operative repair to ureter trauma are 0.2%.

32 Dr. Cochen under cross-examination with respect to the Crest Study testified that he accepts that there are risks in abdominal surgery to the surrounding organs, although he doesn't agree with the percentages in the Crest Study of risk to the bladder. He does agree that there are risks however to the bladder in general and to the ureters and to the bowel. Dr. Cochen agreed that in this study there were not marked differences between the percentage risks to these different organs.

33 Dr. Cochen testified that in his 32 years of practice at that time (1997) he had performed approximately 2,000 hysterectomies. Dr. Cochen testified that in his professional experience it was not a material risk to perforate the bowel during hysterectomy surgery. Dr. Shier testified to a similar experience.

34 Given all of the above evidence and having duly weighed it, I find that Dr. Cochen's failure to disclose the risk of a bowel perforation was a breach of his duty to warn the plaintiff, Ms. Baksh-White. I find that the risk of bowel perforation is a material risk. There was no question in the testimony of all three doctors, Dr. Braithwaite, Dr. Cochen and Dr. Shier that there was material risk to the surrounding organs. All three doctors conclude that surrounding organs would include the ureters and bladder. Dr. Braithwaite was firm that the bowel would also be included as a surrounding organ. The bowel is a surrounding organ clearly from an anatomical point of view. I also am giving weight to the Crest Study and the complications that have been noted therein. The repair to the bowel statistic, along with that to the bladder and the ureters are very similar 0.3, 0.3 and 0.2 respectively. The evidence before me is conclusive that risk to the ureters and the bladder was considered material by gynaecologists practicing in Ontario in 1997 in respect to the informed consent discussion. I find that the risk to the bowel also should have been included in that discussion/disclosure.

Did Dr. Cochen have a duty to advise Ms. Baksh-White of the more conservative management options?

35 Dr. Cochen testified that he did not discuss alternate treatments with the plaintiff as he felt they were not appropriate to her situation.

36 Dr. Braithwaite, the plaintiff's expert witness testified that Dr. Cochen should have discussed conservative management options available to the plaintiff with her. The options he identified were:

(1) treatment with the medication Depo-lupron;
(2) the use of medication Danazol; and
(3) performing the less invasive procedure of endometrial ablation.

37 Dr. Cochen disagreed with Dr. Braithwaite. Dr. Cochen testified that in situations where it is his opinion that there are viable options to major surgery he not only informs his patients but encourages his patients to pursue medical options other than surgery first. He was very clear, however, that he would not confuse a patient of his by informing them of options that he does not see as viable in their particular circumstance. Dr. Cochen does not agree that he should educate the patient in order that she can make an informed decision when the education includes irrelevant material. He considered these 3 alleged options as irrelevant to this patient.

Depo-Lupron

38 With respect to the use of depo-lupron, Dr. Cochen agreed that he would use this medication to make fibroids smaller and surgery easier if it was necessary to do so. He would not use depo-lupron unless the uterus of his patient was about 20 weeks in size. The plaintiff's uterus was however only 14 weeks in size and as such it was his opinion that the use of depo-lupron was inappropriate.

39 Dr. Shier described depo-lupron as a GNRH antagonist. He explained that this medication causes the body to mimic menopause. It is an excellent drug to reduce vaginal bleeding. It pushes the body into a menopause state and will reduce the size of fibroids in about 50% of the cases. There are however problems when the patient ceases the use of depo-lupron in that the fibroids will often rebound. He testified that depo-lupron is a good medication to prescribe when a patient is just short of menopause, however, this plaintiff was only 41 years of age. The average age for a woman in menopause is 52 in Ontario. The plaintiff would have to be on this drug for 11 or 12 years. This was inappropriate he felt.

It's an expensive medication that most drug benefit plans will not provide coverage for on a lengthy basis. Additionally, there are numerous side effects that women generally do not like. Some side effects were symptoms that the plaintiff was in fact complaining of, such as bloating, weight gain, etc. Given all of these factors, Dr. Shier agreed with Dr. Cochen that he did not think that the use of depo-lupron was an appropriate treatment for this plaintiff. Dr. Shier further testified that it was known that the plaintiff had sub-mucus fibroids and, as such, she could have bleeding from the surface of the fibroid. He was candid in testifying that he might have offered it to the plaintiff as a short-term treatment only, to shrink the fibroid and treat her anemia, however, it would have made her bleeding and her pain worse in the short-term. These were the very symptoms she was trying to eliminate. Dr. Shier testified that this was not a course of treatment that he would have recommended to this patient. The plaintiff presented to Dr. Cochen crying, anxious, with heavy periods,

many clots and pain that had been ongoing in excess of a week. She had left work due to these symptoms. Her family doctor had referred her to Dr. Cochen at the Emergency Department initially where she was hospitalized overnight. She had an ultrasound, was discharged home and about a week later she went back to Dr. Cochen still complaining of the pain. Dr. Braithwaite on cross-examination admitted that it is possible that the bleeding and the fibroids would return when a patient is taken off depo-lupron and that the fibroids may well go back to their original size after treatment ceased.

40 I find that there is no evidence before me on which I could conclude that the more conservative management being the use of depo-lupron would have been a medical option that Dr. Cochen had a duty to advise the plaintiff of.

Danazol

41 Dr. Cochen testified that danazol was a drug that he did not feel was an appropriate treatment to use with this plaintiff. Dr. Shier concurred with this opinion and outlined in some detail the appropriate use of this medication. Dr. Shier testified that it was originally used for the management of endometriosis, for a temporary period of one to two years only. He further testified that it is extremely rare that danazol shrinks fibroids and so it is usually not effective for this purpose. Danazol does have serious side effects such as the promotion of masculine characteristics which make it an unattractive drug to many women. Dr. Shier testified clearly that danazol is not a drug that he would have prescribed to this patient, particularly due to the size of her specific fibroid.

42 Dr. Braithwaite under cross-examination testified that danazol may help a patient with bleeding but he admitted that it could impair liver function and needed to be monitored closely.

43 I find nothing in the evidence that would lead me to conclude that danazol would have been a conservative management option that Dr. Cochen had a duty to advise the plaintiff of.

Performing the less invasive
procedure of endometrial ablation

44 Dr. Cochen testified that ablation was not a procedure he would have ever considered for this patient. He testified that her uterus was large and as such it would not have been prudent to have performed an endometrial ablation. The consequences could have been very serious to use this technique with this plaintiff given her presenting circumstances. In any event, the ablation would not have been enough to solve this patient's problems. It would have also been required to perform a resection of the fibroid that was growing into the uterus. The fibroid was large and shaving it at the same time the uterus was being infused and flushed would have caused bleeding. This procedure can cause serious problems.

45 Dr. Shier concurred. He testified that with a fibroid the size present in this patient, there were more serious complications that could occur with this therapy than would occur by undergoing a hysterectomy. Dr. Shier testified further that because of the medical presentation of this patient, he would have a suspicion that this patient was also suffering from adnomiosis. Adnomiosis is not able to be confirmed diagnostically until after tissue is sent for biopsy. However, since this plaintiff presented in a manner that would be consistent with this diagnosis, he felt that ablation was out of the question as it is a contra-therapy for adnomiosis.

46 Dr. Shier testified that adnomiosis is a very common condition in women who have had children. There is a migration of glands into the walls of the uterus. Without the use of an MRI which this patient had not had, the diagnosis is rarely made before the surgery is undertaken. Based on this patient's presentation, a prudent doctor would have a suspicion that adnomiosis was present and would see it as a risk. He testified further that if he advised her of ablation, it would only be in order to advise her not to undertake this procedure. Dr. Shier made it clear that not discussing an inappropriate procedure, in his opinion, does not make a doctor fall below the standard. He also testified that one must be very vigilant with this particular plaintiff as it was known that she suffered from anemia as a result of thalassemia minor. There could as a result be serious complications from ablation in her case. I find that based on all of the evidence before me, that Dr. Cochen did not have a duty to advise Ms. Baksh-White of the more conservative management option of endometrial ablation.

47 In answering then the question of - "Did Dr. Cochen have a duty to advise Ms. Baksh-White of more conservative management options?" I find that he did not.

> Would Ms. Baksh-White, the plaintiff, properly advised of the risks or of the more conservative management options have nonetheless gone ahead with the abdominal hysterectomy surgery?

48 Dr. Cochen described the plaintiff as an enlightened, intelligent, professional medical nurse working in the health care field. He testified that she presented in his office looking for a definitive solution to her medical problems. She was a well-informed patient. She was not looking for a temporary solution. In his notes of the disclosure consultation that he held with her on January 27, 1997, he noted that she requested the hysterectomy. He was very clear that this would have been her request because in making his notes he used the word "requested" as he does when it is at the request of the patient. He uses the word "recommends" if it is at the recommendation of himself. This is his habit.

49 The plaintiff in examination in-chief described herself as a registered nurse with about 18 years experience. She has worked primarily in intensive care. She has never worked directly with hysterectomies or fibroids. She admitted under cross-examination that as a nurse in ICU she has seen patients who are in ICU as a result of complications of surgery. She admitted that she has seen patients with bowel surgery or with bowel perforations. She is aware that the bowel can be perforated during surgery and has in fact seen a few of these cases. In-chief and under cross-examination, the plaintiff was questioned extensively with respect to her medical history. She outlined that she had prior to this surgery undergone three previous abdominal surgeries. One for appendicitis, one for c-section and another to have an ovary removed. The surgery involving the removal of an ovary was performed in 1993 by Dr. Cowal who testified as a witness for the defence in these proceedings.

50 Dr. Cowal is an obstetrician-gynaecologist who has been practicing since 1991. Prior to the 1993 surgery, Dr. Cowal met with the plaintiff on December 10th, 1993 and in her progress notes on the letterhead of Mississauga Hospital it is clear that the doctor "discussed at great length" with this plaintiff a diagnostic laparoscopy verses discharge home and observation. The plaintiff was aware of the risk of bowel perforation. The plan was made that this patient enter into a diagnostic laparoscopy and possible laparotomy. In Dr. Cowal's summary of hospitalization dated January 17th, 1994, the doctor stated:

The decision to proceed with a diagnostic laparscopy was made by the patient as she did not feel she was in sufficient condition to be discharged home.

51 This decision to proceed with surgery in 1993 was contrary to Dr. Cowal's preference as to how to proceed. Dr. Cowal stated in her evidence as follows:

Q. ... Tell Her Honour about the discussion you had with Ms. Baksh-White?
A. I had reviewed her ultra sound, her blood work and discussed with her two options. The first option was basically to conservatively follow her. I did not see anything serious on her ultra sound. Provide her with analgesia and suggest follow up to her family doctor.
Q. By conservative treatment is that what you meant, discharged home, analgesia and follow up with family doctor?
A. Correct. Or the other option was to because we did not know the cause of her left quadrant pain perhaps she -- to proceed with diagnostic laproscopy.
Q. And did you express to Ms. Baksh-White a recommendation as between those two courses of treatment?
A. I weighed more in favour of conservative management.
Q. Why was that?
A. Two reasons, she -- I did not think she was significantly ill enough. Her white count was very mildly elevated. There was again nothing very serious on her ultra sound. I thought she had clinically -- I hadn't seen her previously but from her accounts I thought she had clinically improved a small amount. She was not deteriorating and the second reason was that she had previous surgery. She had had a cesarean section, myomectomy and a remote appendectomy which presented her a increased operative risk so for doing a diagnostic laproscopy it wasn't without its risks.
Q. And what course of management did Ms. Baksh-White decide upon?
A. As I recollect, she felt she was in too much pain and she could not cope with just analgesia and she could not cope with going home and therefore she wanted to get to the bottom of it and proceed with a laproscopy.
Q. Was that contrary to your advice to her or consistent with your advice to her?
A. It was -- it was -- she was choosing one of the options I had given her but she certainly wasn't considering my first option.
Q. As a result of her decision to proceed with the surgical option, if I can call it that, did you have a discussion with her about the risks attendant to that procedure?
A. Yes.
Q. And have you made a note of that discussion?
A. Yes.
Q. Alright. Could you just read the note for Her Honour that appears at Tab 6?
A. From the beginning?
Q. Yes please.
A. "Discussed at great length with patient diagnostic laproscopy verses discharge home and observe. Aware of the risk of bowel perforation. Plan: Diagnostic laproscopy, possible laparotomy.

Q. And I think we've talked about the first part of the note in terms of the discussion about the two courses of treatment you were recommending. What would you have told Ms. Baksh-White about the risk of bowel perforation?
A. That with doing a laparoscopy with someone with a previous abdominal surgery there is a chance of perforation of the bowel either with the verres needle or the trocar that could be repaired intra-operatively, may have to make use of a surgeon. I don't recall if I went into details about requiring a colostomy at all or that much detail.

52 The doctor then testified in some detail in her examination in-chief with respect to the procedure in a laparoscoptomy, including the insertion of the trocar into the abdominal cavity blindly and the inherent risks of bowel perforation as a result. Counsel then asked the following:

Q. ... What is it that you specifically can recall sort of independent of your note about this patient and that discussion?
A. I -- I just found that she was a bit more directive in what she wanted to have done. In think that -- when I put "discussed at great length" it means that we had a -- quite a long discussion about what to do, that I don't think I was extremely anxious to proceed with a diagnostic laparoscopy. She was kind of going against what my opinion was, but she had her own opinion and -- what she wanted to do. I think she was concerned, she had pain and she was very directive in what she wanted done.
Q. Is that unusual in your experience or usual?
A. Less common, not terribly usual but less common.
Q. And you carried out that procedure?
A. Uhm-hum.
Q. Yes?
A. Yes.

53 Near the completion of examination in-chief, counsel for the defendant asked the following:

Q. And you've written at the end of the first paragraph referring to the summary of hospitalization. "The decision to proceed with the diagnostic laparoscopy was made by the patient and she did not feel that she was in sufficient condition to be discharged home". You wrote that?
A. Yes.
Q. Can you explain to Her Honour why you made that comment in the summary of hospitalization?
A. Cause I didn't feel that the -- her medical condition objectively necessarily warranted doing a diagnostic laparoscopy. The reason we proceeded with it was that she felt symptomatically and her degree of pain warranted proceeding with a diagnostic procedure.
Q. And that was even after you'd advised her of your concerns about perforating the bowel?
A. Correct.

54 Dr. Cochen in his examination in-chief referred to his disclosure meeting notes of January 27th, 1997 in which he wrote:

"Requested abdominal hysterectomy possible sub-total."

55 I find that the plaintiff continued on January 27th, 1997 with Dr. Cochen to demonstrate the same pattern of conduct she had demonstrated with Dr. Cowal in 1993 prior to her surgery. Her conduct being that of an independent, self-directed, well-informed medical professional focussed on a treatment she wished to obtain.

56 The evidence with respect to the material risks of injury to the ureters was not disputed. The fact that Dr. Cochen was concerned enough to have stents placed in the ureters pre-operatively and that this procedure was discussed with the plaintiff clearly establishes the fact that the plaintiff was prepared to take risk in the surgery. The plaintiff testified that this precautionary step made her more comfortable with the risk to the ureters and I accept her explanation. However, there still remain some risk to the ureters that she was prepared to take.

57 The plaintiff testified that she had concern with respect to undergoing a general anesthetic as she had a cousin who died as a result of a general anesthetic two years previously. Notwithstanding this personal experience, with an adverse outcome in her family, the defendant advised Dr. Eileen Huang, the anesthetist, at their consultation on January 30th, 1997 that she was apprehensive about the surgery but declined to have the procedure under local anesthetic. The plaintiff wished to go ahead with a general anesthetic despite the tragedy of her cousin's death two years ago.

58 The question then remains: "Would Ms. Baksh-White, properly advised of the risks, have nonetheless gone ahead with the abdominal hysterectomy surgery?" I find that on the balance of probability, she would.

> Would a reasonable person in Ms. Baksh-White's position have nonetheless gone ahead with the abdominal hysterectomy surgery?

59 It is unnecessary to answer this question as my answer to question #3 was "no".

CREDIBILITY

60 I found the plaintiff, in her cross-examination in particular, very evasive and indirect in her answers.

61 It was clear that during the course of the plaintiff's examination in-chief, despite the fact that this file has undergone extensive scrutiny over the period of three years, including examinations for discovery, that new statements were being made by the plaintiff that the defendant had no previous knowledge of. For example, the plaintiff stated in her examination in-chief that she had been forced by Dr. Cochen to have this sub-total hysterectomy having been told by the doctor that there was no alternative but surgery. The plaintiff would have this court now believe that she was the victim of Dr. Cochen. I reject her evidence on this point. Dr. Cochen denied that he had ever made this statement to her and his notes made at the time of his disclosure consultation with her, clearly state that she requested the hysterectomy from him. I accept Dr. Cochen's evidence on this point. I conclude that this was an attempt by the plaintiff to bolster her own case. Generally I found that throughout her cross-examination the plaintiff was evasive and unwilling to give answers that she felt would potentially damage her case despite the fact that counsel for the defendant put the same questions to her on numerous occasions throughout this examination.

62 I conclude that this evasiveness was an attempt by the plaintiff to try to portray herself as an uninformed individual rather than a registered medical nurse with 18 years experience who worked in ICU with experience of bowel perforations due to surgeries.

63 The plaintiff's claim is hereby dismissed.

DAMAGES

64 Notwithstanding the result which I have reached, I must assess the plaintiff's damages.

65 The plaintiff suffered a perforation of her bowel during abdominal surgery. This perforation was recognized and repaired immediately. The plaintiff suffered after this surgery and the repair to her bowel, nausea, vomiting, irritable bowel syndrome and dumping syndrome. As a result of these symptoms the plaintiff had three hospital admissions in 1997/98. Causation of the symptoms remains in question. The treatment was not invasive and was conservative. I assess her general damages for physical injury, pain and discomfort at the sum of $14,000.00.

66 The following special damages were incurred by the plaintiff:

Loss of income from April 1, 1997 to October 31, 1997 = $22,166.90.

67 The plaintiff's annual salary at the time of the surgery was $38,000.00 per annum. The surgery was February 11, 1997 and the normal post-operative recovery period is six weeks thus the plaintiff would normally have returned to work on or about April 1, 1997. The plaintiff however was not cleared by her Doctor to return to work until May 7, 1998 as the plaintiff's last hospitalization for these symptoms was in 1998. (The plaintiff suffered an unrelated injury to her knee on October 31, 1997.) Her loss of income therefore was for 13.25 months (3,166.70 x 13.25 = 41,958.75).

68 Therefore the total amount of damages payable to the plaintiff is $14,000.00 plus $41,958.75 = $55,958.75.

69 With respect to the Family Law Claim I make no award. The plaintiff's husband has not been named as a plaintiff in these proceedings, although the plaintiff's solicitor has made oral argument for such an award.

70 The plaintiff's action is dismissed. While I have dismissed the action, I have serious reservations whether this is an appropriate case for costs. I would be pleased to accept written submission on costs within 30 days of this judgment - I am particularly interested in any offers to settle.

SNOWIE J.