SUPREME COURT OF QUEENSLAND

CITATION:	*Jelicic v. Salter* [2003] QSC 103
PARTIES:	**SNEZANA (SUSAN) JELICIC** (plaintiff) **v** **DAVID ROGER SALTER** (defendant)
FILE NO:	509 of 1995
DIVISION:	Trial
ORIGINATING COURT:	Supreme Court
DELIVERED ON:	29 April 2003
DELIVERED AT:	Brisbane
HEARING DATE:	3, 4, 5, 6, 7, 10 February 2003
JUDGE:	Helman J.
CATCHWORDS:	TORTS – MEDICAL NEGLIGENCE – DUTY OF CARE OWED TO PATIENT – whether patient was adequately advised of the risks of surgery – whether consent to operation – whether surgery necessary *Fair Trading Act* 1989
LITIGATION GUARDIAN:	Mr N. Vacic for the plaintiff
COUNSEL:	Mr G.W. Diehm for the defendant
SOLICITORS:	Flower & Hart for the defendant

[1] The plaintiff, formerly a real estate agent and now an unemployed disability pensioner, claims $14,752,000 damages for personal injury and other loss and damage caused, she says, by the defendant's 'negligence and/or breach of contract and/or misleading and/or deceptive conduct'. Her claim arises from surgery performed on her at St Andrew's War Memorial Hospital, Brisbane on 4 December 1992 by the defendant, who was then practising as an obstetrician and gynaecologist.

[2] The plaintiff says that as a result of that surgery she has suffered the following, as set out in para. 36(a) to (g) of her statement of claim:

(a) Total abdominal hysterectomy
(b) Left salipingo [*sic*]- oophorectomy
(c) Internal and external scarring.
(d) Fibroid growth on internal scarring.

(e) Infertility due to the loss of her reproductive organs.
(f) Instant artificial menopause causing:

(i) Hot flushes.
(ii) Cold flushes.
(iii) Mood swings.
(iv) Irritability.
(v) Nervousness.
(vi) Memory loss.
(vii) Hormonal chemical imbalance.
(viii) Low energy levels.
(ix) Lack of libido.
(x) Hair loss.
(xi) Auto immune disorder.
(xii) Chronic fatigue syndrome.
(xiii) Musculo-scalital [*sic*] pain.
(xiv) Rheumatoid arthritis.
(xv) Numbness and weakness in arms and legs.
(xvi) Back pain.
(xvii) Nausea.
(xviii) Weight gain.
(xix) Weight loss;
(xx) Restless sleep;
(xxi) Alteration to body odour.

(g) The Plaintiff has suffered psychiatric and psychological consequences including:

(i) Nervous break downs.
(ii) Confusion.
(iii) Grief.
(iv) Depression.
(v) Stress.
(vi) Personality disorder.
(vii) Lack of confidence.
(viii) Teariness.
(ix) Emotional lability.
(x) Lack of ability to cope.
(xi) Sensitivity to noise and light and smells.

The plaintiff also alleges, in para. 37:

37. Further as a result of the said injuries the Plaintiff has required extensive hospital and medical treatment. The Plaintiff has endured pain, suffering and reduced amenities of life, and will continue to endure severe and ongoing pain suffering indignity inconvenience and her amenities of life have been severely impaired. The Plaintiff has lost income and her capacity to earn income has been severely impaired or destroyed. The Plaintiff has required and will require in the future services in the nature of nursing and domestic assistance. The Plaintiff will require ongoing medical treatment and will incur expense in that regard.

[3] The defendant denies any liability to compensate the plaintiff.

[4] The plaintiff was born on 29 August 1961 in Serbia. She first came to this country in 1975 or 1976 with members of her family. She married Mr Sasha Jelicic in 1982 but has lived separately from him since 1992 and prefers to use her maiden name of Vacic. She has two children: Nikola, her litigation guardian, born on 22 November 1983, and Natalia, born on 5 April 1987. Each child was born by a normal delivery.

[5] The plaintiff was a patient of the defendant from October 1988 until August 1994. She had received treatment from other doctors prior to consulting the defendant, and some of the history of that treatment is relevant to her claim. She underwent a right ovarian cystectomy in 1980, tubal surgery in 1981, and laparoscopies in 1982 for ovarian cysts. In a letter dated 4 October 1985 to the Medical Superintendent of the Mater Mothers' Hospital Dr Neil McCormack recorded her telling him that she had had ten laparoscopies 'in the last 4 years'. She was seen at the Mater Adult Hospital on 6 June 1984 complaining of 'abdominal fullness and pressure plus abdominal pain'. A laparoscopy was performed on 7 June 1984. A cyst 4 cm in diameter on the left ovary was aspirated. There were found to be stitches on the left tube from a previous salpingolysis. On 19 March 1986 she was seen at the gynaecology outpatients department at the Mater hospital where she complained of a three-to-four-week history of pain on her right side. She was given a course of antibiotics, but the pain did not disappear completely so another laparoscopy was performed on 24 April 1986. A left ovarian cyst was aspirated but the pain was still present when she was seen on 21 May 1986. She complained of pain again on 30 July 1986. On 21 October 1987 she complained of a painful right iliac fossa. On 10 February 1988 she complained of pain again. On 23 March 1988 another laparoscopy was arranged, for 25 May 1988. On admission for the laparoscopy she was found to be pregnant. The laparoscopy was cancelled and on that day a termination of pregnancy was performed at a Greenslopes clinic. She was admitted again to the Mater hospital, and on 30 May 1988 a right salpingo-oophorectomy was performed. On 7 September 1988 she returned to the Mater hospital with a recurrence of right iliac fossa pain. Her general practitioner, Dr Ian Bentley, referred the plaintiff to Dr Philip Reasbeck, general and vascular surgeon, who carried out various tests and referred her to the defendant.

[6] In a letter dated 4 October 1988 to Dr Bentley, Dr Reasbeck referred to the plaintiff's 'rather odd symptoms' (right iliac fossa pain with a tender spot which he had previously reported to Dr Bentley in a letter dated 25 August 1988 'seemed to move in location when her attention was distracted'; headaches; sensations of abdominal distension; and a feeling that her whole body was heavy) and observed: 'I can't help wondering whether all her rather odd symptoms may be a manifestation of masked and prolonged post-natal depression. She does however deny any subjective feelings of depression'. Dr Reasbeck continued:

> I find it very difficult to put together her headaches, abdominal pain and other vague somatic symptoms on the basis of anything other than a psychogenic disorder, but nevertheless I feel it would be worthwhile at this point trying to positively exclude any intra-abdominal disorder. I have therefore arranged for her to have an abdominal C.T. scan, a tube small bowel meal and an I.V.P., and have also arranged to check her blood count, ESR and blood biochemistry. Assuming all these tests reveal no significant abnormality, I will colonoscope her in ten days' time. I expect that all these investigations will probably be normal, and if they are I would be rather reluctant to go any further at this point, as the next step surgically

> would probably be an exploratory laparotomy, which I suspect would do her no good at all. If all these investigations are in fact normal, I think a specialist psychiatric opinion might be a good idea before proceeding any further in a surgical direction.
>
> I will be in touch again after her colonoscopy.

In a letter dated 15 October 1988 Dr Reasbeck again reported to Dr Bentley:

> I saw Mrs. Jelicic again today, and colonoscoped her. The examination was quite normal as far as the caecum. Her abdominal C.T. scan, however, has shown a large (approximately 5cm diameter) cystic adnexal mass on the left side, which the Radiologist thinks may well represent a complicated ovarian cyst with either torsion, haemorrhage or infection associated with it.
>
> It seems quite likely that this may be the cause of all her symptoms, and I have therefore taken the liberty of referring her to my colleague, Dr. David Salter, for his gynaecological opinion. I have not arranged to see her again myself, but would be happy to do so if David Salter feels he cannot help her.

[7] The plaintiff first consulted the defendant on 19 October 1988 complaining of chronic pain in the lower abdomen, worse when menstruating, and leg pain. The defendant took a detailed history from her. She gave a long history of pelvic pain. She brought with her the report on an ultrasound scan. The defendant conducted an internal examination, and from it and the ultrasound report he concluded she had a simple cyst on the left ovary approximately 5 cm in diameter. Such cysts are common and over seventy-five per cent. of them subside spontaneously. The defendant advised the plaintiff to take simple analgesia and to return for review of her condition in about three to four weeks since the 'vast majority' of such cysts would 'settle'.

[8] I should record here that I accept as accurate the evidence the defendant gave concerning his dealings with the plaintiff, based as it was on his clinical notes and other records.

[9] The plaintiff returned to the defendant on 24 October 1988, however, complaining of pain in the right iliac fossa but with no pain in the left. On examination the defendant found that the left ovary had reduced in size, indicating that the cyst was becoming smaller. The defendant advised the plaintiff to be patient and to return for review a month later.

[10] When the defendant next saw the plaintiff, on 16 November 1988, she reported a painful left ovary, confirmed on physical examination. A new ultrasound scan dated 16 November 1988 showed the left ovary to be enlarged and round with a maximum diameter of 5.5 cm. The defendant again advised conservative treatment, keeping the cyst under observation, and simple pain relief.

[11] On 23 January 1989 the plaintiff told the defendant the pain was gradually getting worse. A physical examination showed a normal cervix and uterus but a left ovarian cyst approximately 4 cm in diameter. The defendant advised the plaintiff to undergo a laparoscopy. He told her what would be done and that the procedure enabled him to have a good look at her pelvis to see why she was suffering the pain

she reported – to see if there was any abnormality. The defendant told her he would aspirate the cyst in an effort to relieve the pressure on the ovary.

[12] The plaintiff agreed to the laparoscopy which the defendant performed at St Andrew's Hospital on 27 January 1989. The defendant found the right ovary absent. The left ovarian cyst was aspirated. There were adhesions of bowel and omentum to the left ovary and uterus consistent with inflammatory disease of the pelvis.

[13] On 10 February 1989 the plaintiff reported some bleeding after the laparoscopy, feeling hot and cold, poor memory, and some discomfort. On a pelvic examination the defendant found the left ovary back to normal, but gas in the caecum.

[14] On the next consultation, on 21 April 1989, the plaintiff reported that she had had pain on both sides of the pelvis for three days. She had pressure on her bladder. On examination of the plaintiff the defendant found another left ovarian cyst, which was very tender. The defendant prescribed a short-term solution to the plaintiff's problem: danazol, a synthetic progesterone used for suppressing ovarian function. The defendant determined to avoid recommending surgery and to be 'sympathetic and supportive' and to try to get the plaintiff through the 'painful episodes'.

[15] On 12 May 1989 the defendant referred the plaintiff to Dr Peter Mann, neurologist, for advice concerning headaches.

[16] There was then a lengthy gap before the next consultation, on 11 December 1990, when the plaintiff came to see the defendant for a general gynaecological examination. Her left ovary appeared somewhat enlarged but she was fit and well, reporting only odd episodes of pain. Her menstrual cycle was 'perfectly regular'. After that consultation the defendant sent a letter, dated 14 December 1990, to Dr Bentley:

> Thank you for referring Snazana for a gynaecological examination. I have seen her in the past with episodes of pelvic pain due to follicle cysts of the ovary, particularly on the left side, which I think are due to previous surgery.
>
> However, she has turned over a new leaf and has been fit and well recently with very little pelvic pain and a regular cycle. Blood pressure was 110/70, there were no palpable breast lumps and pelvic examination revealed a healthy cervix, a uterus that is anteverted, normal in size and shape and although the left ovary was easily palpable, I don't think it was particularly enlarged.
>
> I have reassured her she is fit and well and have taken a smear test from the cervix.

[17] There was another long gap between consultations, the next being on 30 January 1992. Dr Bentley had again referred the plaintiff to the defendant. She complained of menstrual 'disturbances': more frequent, painful menstruation. Pelvic pain was present but it was not as bad as it had been before. Examination revealed a cyst about 5 cm in diameter on her left ovary. The defendant advised her to continue 'as we had been', that she was generally fit and well, and that the cyst was not life- threatening. After that consultation the defendant sent a letter dated 31 January 1992 to Dr Bentley:

> Thank you for referring Mrs Jelicic for gynaecological examination. I think she looked fit and well but she has had a change in her cycle and is getting some suprapubic discomfort from time to time. She is even thinking about a pregnancy although she has two children and a busy workload.
>
> On examination her cervix was healthy, uterus anteverted normal in size and shape and the left ovary is definitely enlarged, probably about 5cm in diameter. She gets these cystic enlargements from time to time but usually they subside spontaneously. I will get a check ultrasound and hopefully this one will also subside and this will relieve her pelvic discomfort.

[18] It is relevant to mention here that in late 1991 Dr Bentley had referred the plaintiff to Dr John Webb, consultant rheumatologist, and Dr Derek Dickey, gastroenterologist, who reported to Dr Bentley in letters dated 16 October 1991 and 1 November 1991 respectively. Dr Webb said:

> Thank you for asking me to see this pleasant 30 year old with two children aged 8 and 4 years, who has been in a Real Estate Partership [*sic*] for 7 years with her husband, concerning her interesting and somewhat complex medical situation with respect to her aches and pains.
>
> For the past two months she has developed polyarthalgia [*sic*] and polymyalgia that may well be due to her chronic Hepatitis B antigenemia; this could of course be rheumatoid arthritis although chronic Hepatitis B antigenemia can also induce rheumatoid factors, and it is set on a two year or longer history of fibromyalgia syndrome.
>
> I have arranged some additional investigations and would like to see a skeletal Scintiscan. I have also given her a letter for you recommending referral onto your favourite gastroenterologist for consideration of liver biopsy. After all of this is completed I would like to see her again.
>
> She recently became ill on her birthday the 29th August with a 24 hour virus with fever, malaise, and vomiting which settled, but since then she has suffered a widespread polymyalgia and polyarthralgia affecting both large and small joints associated with morning stiffness, tiredness and malaise, hot and cold feelings, and headaches. She has noticed swelling of the ankles but nowhere else. There has been no rash.
>
> There is a long history of migrainous headaches that sound more like tension headaches to me, and three years ago she had a normal cerebral CATscan. For two years she has been suffering malaise and aches and pains in neck, interscapular, and peripelvic region, along with the headaches. She has been a known Hepatitis B carrier since her second pregnancy four years ago. Prior to that she had 10 operations for ovarian cysts and blocked tubes and the last operation was three years ago being a unilateral oophorectomy and removal of one tube.
>
> On examination BP = 120/70 with normal heart sounds and a clear chest, a 3 f.b. smooth non-tender liver with no splenomegaly, a few small glands in the left groin but nowhere else. There were about ½ dozen spider naevi on upper limbs and chest wall. There is no specific rash and the nails are normal except for one deformed by an injury as a child. There is a very mild synovial thickening at the right knee and both ankles but nowhere

> else. There are multiple tender fibrositic trigger zones in the suboccipital neck, interscapular, lumbo-sacral, paravertebral muscles, in the upper outer quadrants of buttocks, and both elbow lateral epicondyles; these being entirely typical of fibrositis. There is no muscle weakness.
>
> Presently until this is sorted out I do not believe any therapy should be given.

Dr Dickey said:

> Thank you for referring Susan who has been known to be hepatitis B positive for about four years. I note that she is E antigen negative. Her husband and son are also positive but her daughter was immunised at birth. Two months ago she developed pains and aches all over her body and lots of headaches. Perhaps the difficulties of running a Real Estate Agency are causing the headaches and possibly some of her other symptoms. She has had numerous pelvic operations because of infections but has been otherwise well. I note that LFTs are quite normal also.
>
> Looking at the whole picture Susan would appear to be a "well carrier". The exact state of the liver is not known but there is no obvious activity of the disease. In view of the fact that treatment of hepatitis B largely not a practical proposition I would not like to do a liver biopsy with treatment in mind.
>
> With regard to her rheumatic symptoms I am not persuaded that the histological examination of her liver would help greatly with her management. For the moment I have told her that I don't think that liver biopsy would benefit her however I would be happy to review her should there by any new development.

Dr Webb saw the plaintiff again on 22 January 1992 and wrote to Dr Bentley the same day:

> This lass eventually called back today. Thank you for organising to see Derek Dickey. I agree with his assessment that there is no ongoing evidence of any pathological effect from her chronic Australian (Hep. B) antigenaemia. The only positive feature here is that it has stimulated the production of rheumatoid factor.
>
> Over the past week she has again developed severe widespread pain, headaches, tiredness, and inability to think. The last such severe episode was back in October.
>
> On examination there are no signs at all of joint disease. There is no evidence of any organic neuro-muscular problem. What she has is multiple tender fibrositic points as noted previously.
>
> I think we can safely say that this lass does not have a rheumatic disease but has fibromyalgia syndrome. I discussed this with her as a reaction to stress etc. in her lifestyle situation. My standard recommendations are firstly, regular daily physical exercise such as by joining Tai Chi classes which will teach her relaxation techniques. Secondly, Tryptanol 10 – 20 mg nocte which helps provide refreshing sleep and give her some relaxation. If this should not be of help then professional counselling to teach strategies for symptomatic control of her symptoms maybe necessary.

[19] The plaintiff's next visit to the defendant was on 26 October 1992. An echoscopy report accompanying an echogram dated 23 October 1992 by Dr Michael McMahon described the left ovary as cystic, the cyst being complex with 'solid/cystic components' 6.3 cm by 4.9 cm by 4.8 cm. (The normal size of an ovary is about 4 cm by 3 cm by 2 cm.) The plaintiff complained of migraine headaches, severe dysmenorrhoea, and pelvic pain. An internal examination revealed that her left ovary was enlarged and tender, and confirmed the presence of a mass on the left side of the pelvis consistent with a tubo-ovarian inflammatory mass. The defendant then advised the plaintiff that the best treatment for her condition was a total abdominal hysterectomy and left salpingo-oophorectomy or pelvic clearance, i.e. removal of uterus, cervix, left tube and ovary, and dividing the adhesions. The defendant explained to the plaintiff that if she had the surgery she would no longer menstruate and would have no more children, and that she would require hormone replacement therapy in the form of a tablet taken daily. The defendant told the plaintiff that, by and large, women with pelvic inflammatory disease get relief from their pain from the proposed surgery, and that he was confident it would relieve her pelvic pain. Conservative surgery would not, he told her, give her any further relief: that had been tried and had proved 'totally ineffectual'. The defendant told her that without the surgery her condition would 'keep on going' until she stopped menstruating. The defendant advised the plaintiff that she would require a general anaesthetic and that there could be 'risks'; in a fit young woman the defendant did not expect 'any real risk' although there were risks with a general anaesthetic. He also mentioned the common problems with a hysterectomy: haemorrhage and wound infection. The defendant suggested to the plaintiff that she could seek a second opinion, but the plaintiff did not follow that suggestion. The plaintiff agreed to undergo the surgery recommended by the defendant and signed a consent form at his surgery and another at the hospital.

[20] A further echoscopy report dated 13 November 1992 by Dr McMahon referred to a complex cyst contained in the left ovary measuring 5.9 cm by 6.1 cm by 5.1 cm which, Dr McMahon said, 'may be a dermoid'. That report confirmed the continued presence of the complex mass. A total abdominal hysterectomy and left salpingo-oophorectomy was performed by the defendant assisted by his now deceased father, a retired gynaecological surgeon, on 4 December 1992 as I have related. The defendant found a conglomerate mass of adhesions the size of an orange between bowel, omentum, uterus, and left ovary. Blood loss was estimated at about 100 ml. There were no 'technical' difficulties or problems with the operation and the defendant inserted a drain to ensure that there would be no collection of blood under the wound which might result in infection.

[21] A histopathology report dated 4 December 1992 was prepared by Dr David Papadimos, pathologist employed by Sullivan Nicolaides Pathology, after examination of the plaintiff's organs removed by the defendant:

> MACROSCOPIC:
> (1) Specimen labelled 'Uterus': The specimen consists of a uterus weighing 100 grams and measuring 95 x 50 x 40 mm. The serosal surface is pink to tan and glistening with adhesions present anteriorly. The vaginal cervix has an antero-posterior diameter of 32 mm. The cervical os is transverse and 5 mm. wide. The endocervical canal is patent and 30 mm. long. The uterine cavity measuring 40 x 20 mm. The endometrium is cream, moderate in amount and focally congested. The endomyometrium

has an average thickness of 18 mm. On sectioning the myometrium, there are no gross abnormalities.
(2) Specimen is labelled 'L. Ovary and tubes': The specimen consists of a tubo-ovarian mass. The tube is closely adherent to the ovary. It is 50 mm. long with a mid-ampullary diameter of 12 mm. The serosal surface is grey and glistening. The fimbrial end is obstructed. The ovary measures 60 x 45 x 35 mm. Multiple cysts are evident. The tube is dilated and contains opalescent fluid. On sectioning multiple cysts containing clear straw-coloured fluid are present and others containing blood-stained coagulum are present. The largest with a maximum diameter of 15 mm.

MICROSCOPIC:
(1) Specimen labelled 'Uterus'
Histological examination shows the following features:

Cervix:	Unremarkable.
Endometrium:	The endometrium is of early secretory pattern consistent with post ovulatory Day 4 – 5. There is no evidence of endometritis, endometrial hyperplasia or malignancy.
Myometrium:	Unremarkable.
Serosal surface:	Unremarkable.

(2) Specimen labelled 'L. Ovary and tubes':
Sections of the left fallopian tube show marked dilatation of the distal end of the tube with flattening of the plicae. There is no evidence of inflammation. Dense tubo-ovarian adhesions are confirmed. Sections of the ovary show several cystic follicles, a recent corpus luteum and a corpus luteum cyst which contains organising blood clot. There is no evidence of neoplasia.

SUMMARY:
1. HYSTERECTOMY:
   - EARLY SECRETORY PATTERN ENDOMETRIUM.
2. LEFT SALPINGO-OOPHORECTOMY:
   - DENSE TUBO-OVARIAN ADHESIONS.
   - BENIGN CORPUS LUTEUM CYST.

In a letter dated 5 December 2002 to the plaintiff Dr Papadimos recorded his views that a definitive diagnosis as to the nature of the tubo-ovarian mass could not be made on laparoscopic examination and that the mass and adhesions were probably the result of previous inflammation - the cause of which inflammation usually being prior infection, but occasionally previous surgery. Examination of the mass revealed, Dr Papadimos added, no evidence of a dermoid cyst or other neoplastic process.

[22] Asked by his counsel why the plaintiff's uterus and cervix had to be removed in addition to her left ovary, the defendant replied:

> There were a number of reasons. The uterus is part of the whole inflammatory process involving the tube and the ovary and the bowel stuck to it. So it is part of the pathology. The second one is that having to go on to hormone replacement therapy, if you just take the ovary away, then the uterus will respond to the – might I say, the commonest complaint that women make about hormone replacement therapy is bleeding – and I don't mean monthly bleeding, I mean bleeding at any time, which is very irksome, a nuisance, and it is by far the most common response to this

> hormone replacement therapy. So to avoid that. The other reason is that with this sort of inflammatory disease, if you leave anything behind, the pain persists. If you leave part of the ovary there, it continues to develop into cysts, and the common thing that happens is you have got to go back in there next year or the year after and take it out. So there is another surgical procedure.
>
> Yes?-- And it goes on, and, as you are aware, with each surgical procedure there is a risk of the patient's life, there is a risk from the anaesthetic, and there is untold risk from surgery. It is not the sort of thing we want to keep on doing every day.

[23] The plaintiff recovered well but she did suffer a localized urinary tract infection - of no consequence - from a bladder catheter. The defendant saw the plaintiff every day after the operation until she left the hospital. He saw her then on 31 December 1992 when she reported having had pain in the wound when she was pushing a shopping trolley. She also had hot flushes consistent with the onset of menopausal symptoms. The plaintiff made no mention of urinary symptoms at that consultation.

[24] The defendant saw the plaintiff on 21 January 1993 when he found the plaintiff's wound had healed 'nicely' and she had no pain or tenderness. The defendant discussed the histopathology report with her. An adjustment of her hormone replacement therapy was also discussed, as it was on 3 August 1993. In a letter dated 10 August 1993 to Dr Bentley, the defendant recorded that the plaintiff had complained of 'some hot flushes' but her pelvic pain had quite settled down'; she was 'generally fit and well'. The defendant spoke to the plaintiff on the telephone on 26 August 1993, and following that he referred her to Dr Margaret Williamson, endocrinologist, for her opinion on the plaintiff's hormone replacement therapy. He wrote to Dr Williamson on 27 August 1993. At a consultation on 29 July 1994 the hormone replacement therapy was again discussed. The plaintiff had been taking Premarin and had an endoscopy showing some gastric ulceration caused by it. The defendant recorded that the plaintiff was suffering from low grade depression. He advised her to change to a transdermal patch of Estraderm.

[25] The last occasion on which the plaintiff consulted the defendant was by telephone on 25 August 1994 when she reported that the Estraderm was causing nausea. The plaintiff has consulted and been seen by a number of the doctors since then.

[26] Dr David Wilkie, the plaintiff's current general practitioner whom she has consulted since February 1999, gave evidence of her making a variety of complaints: the effects of having and of not having the hormone replacement therapy; pain in her spine, joints, muscles, abdomen, and breasts; recurrent urinary tract infections; sensitivity to smells and fumes including those from perfumes, fuels, paints, aerosol deodorants, fly sprays, and washing detergent; intolerance of temperature change; hot flushes; nausea; hair loss; difficulties with bowel movements, headaches; depression; thought blanks; low energy; and embarrassment because of the scar left by the operation performed by the defendant.

[27] In his defence the defendant admits that it was an implied term of his retainer and employment by the plaintiff that he would, and/or it was his duty to, exercise all reasonable skill, care, and judgment in diagnosing, advising, and treating the plaintiff.

[28] In paragraph 28 of her statement of claim the plaintiff has given twelve particulars, (a) to (l), of the defendant's negligence and breach of his contract with her. They fall into three categories: failing to advise or inform her adequately or at all of certain things, doing certain things he should not have done, and failing to do certain things he should have done.

[29] The things of which the plaintiff alleges the defendant failed to advise or inform her adequately or at all are: the nature and extent of the risks associated with the hysterectomy, especially the risk of the onset of early menopause and the need for hormone replacement therapy (particulars (a), (b), (c) and (i)); the nature of her illness, probable causes of her ovarian cysts, and available treatments together with their likely benefits and risks (d); the consequences of the procedure to her 'further fertility' (e); the preservation of her 'ovarian tissue, ova, and/or embryos for future pregnancies given the age of the Plaintiff' (f); and the nature and extent of risks associated with the hormone replacement therapy she was required to undergo as the result of the procedure (h).

[30] The things the defendant is alleged to have done that he should not have are: removing and disposing of her ovarian tissue and ova without her permission (particular (g)); and performing a hysterectomy unnecessarily when a reasonably skilled gynaecologist, having regard to the plaintiff's age and potential fertility, would have performed a laparoscopy, or a laparotomy followed by a cystectomy (l).

[31] The things that the defendant is alleged to have failed to do that he should have done are: investigate the nature of the plaintiff's illness, probable causes of her ovarian cysts, and available treatments together with their likely benefit and risks (d); provide any or any adequate counselling or referral to counsellors to the plaintiff prior to the surgical procedure to enable her to make an informed decision regarding the procedure (j); and exercise the care and skill reasonably to be expected of a competent obstetrician and gynaecologist in the circumstances (k).

[32] It is admitted in the defence that at all times material to the action the defendant acted in trade or commerce within the meaning of that term as it is used in the *Fair Trading Act* 1989. The plaintiff alleges that the defendant, in trade or commerce, represented to the plaintiff that there was little or no risk or complication as a result of the hysterectomy procedure, which representation was, she alleges, in fact false, and misleading and/or deceptive within the meaning of those terms as they are used in s.38 of the Act. She alleges further that the alleged representation caused or induced her to undergo the hysterectomy procedure and that the defendant has breached the provisions of the Act, which breaches have caused her injury, loss and damage in that she would not have undergone the surgery or suffered the consequences but for the representation. The defendant denies making the representation alleged, and says that any representations he made were not false, or misleading or deceptive as alleged. The defendant denies any breach of the provisions of the Act.

[33] I am not satisfied that the plaintiff has established that the defendant was guilty of the negligence or breaches of contract alleged or that he made the misleading or deceptive representations alleged. The defendant's conduct at and immediately before his performing the surgery he did on 4 December 1992 must of course be seen in the context of his having advised and treated the plaintiff from the time of

the first consultation on 19 October 1988 - over four years before the surgery. The plaintiff, who had a history of having complained of abdominal pain and discomfort before she consulted the defendant, continued to do so to him. His treatment followed a conservative course until he determined, competently and reasonably I find, that the surgery performed on 4 December 1992 was the only permanent solution to the plaintiff's difficulties which were not caused by any malignancy but by adhesions.

[34] The defendant advised the plaintiff consistently with his assessment while also explaining that her condition would not improve without the surgery until she stopped menstruating. The defendant found the plaintiff to be an intelligent woman, an assessment confirmed, notwithstanding her mental disorder to which I shall refer later, by my observations of her at the trial. As I have related, the defendant explained the proposed operation fully to the plaintiff: what it was, what the effects of it would be upon her ovulating, and her fertility. He explained the risks inherent in the operation, in particular the risks of haemorrhage and infection and the risks associated with a general anaesthetic. At no time did the defendant tell the plaintiff her life would be 'irrevocably changed', as he has admitted in paragraph 10(b) of his defence, but it was unnecessary to do so in those words because he had explained in detail the effects of the operation. At no time did the defendant tell the plaintiff that she would be at risk of developing a 'psychiatric condition', as he has admitted in paragraph 10(c) of his defence, but it was unnecessary to do so as such an effect could not possibly have been predicted before the operation. On the latter point I accept the opinion of Dr Edward Ringrose, consultant physician, recorded in a report I shall quote later. The defendant invited the plaintiff to seek a second opinion but she chose not to. The operation was performed competently and successfully upon a patient who was fully informed of its effects and the risks associated with it before she consented to undergo it. There was no haemorrhaging, or ill effect from the anaesthetic. There was a minor infection to the urinary tract caused by the insertion of a catheter but that infection was of no consequence. There was no false, misleading, or deceptive representation. At the time when the operation was performed there was no technique available whereby any of the plaintiff's tissues could be preserved for future pregnancies. The defendant disposed of the removed organs in the orthodox way.

[35] In arriving at my conclusion that the defendant's assessment of the plaintiff's condition, and his opinion as to the treatment it called for was competent and reasonable, I have accepted the evidence of the defendant himself and that of Dr Douglas Keeping, obstetrician and gynaecologist, who provided a report dated 11 December 2002 to the solicitors for the defendant. Dr Keeping summarized his conclusions as follows:

> In the circumstances of this poor lady's long drawn-out gynaecological history, with more invasive investigation than anyone should put up with, and with continuing symptoms, and in the face of the remaining ovary being diseased, I think that the treatment carried out by Dr. Salter was the most desirable one in terms of trying to cure the patient.
>
> Patients understand that if the uterus is removed they cannot have more children, and also that removal of their remaining ovary will deprive them of hormones. Providing that patient was of sound mind at the time and understood that, then it was the best course of action and is what most average concerned and conservative gynaecologists would do.

> I am sorry that Mrs Vacic has had such profound psychotic problems since her surgery. In general patients respond well to hormone replacement therapy after the removal of ovaries. There may need to be some fiddling with types of oestrogen and doses, but that is all. I would offer my sympathy to Mrs Vacic and her family, and hope that her condition improves.

[36] A report dated 18 July 1996 by Professor Dr Spasoje Petkovic and Assistant Professor Vesna Kesic of the Institute of Obstetrics and Gynaecology of the Clinical Centre of Serbia in Belgrade was admitted into evidence. Neither author of the report gave oral evidence, and so it was not possible to examine them as to any matters that might not be clear in their report. The plaintiff made a number of attempts during the trial to arrange for Professor Petkovic to give evidence by telephone link but to no avail.

[37] The Belgrade authors expressed the view that 'an ordinary skilled gynaecologist' dealing with the plaintiff's condition in late 1992 would have advised her to submit to a laparoscopy or laparotomy, making every effort to preserve her remaining left ovarian tissue. A cystectomy should then have been 'an appropriate procedure, except if malignancy was suspected by clinical findings or by frozen section of ovarian tissue (ex-tempore biopsy)'. While that opinion appears a valid one on the facts as they were presented to the authors, they had, as they record in the report, only a statement by the plaintiff upon which to base their 'observation'. That statement, which the authors quote extensively, included an account of the reason given by Dr Salter of the operation of 4 December 1992 as the presence of a large cyst on the left ovary. There is reference in some detail to the contents of the echoscopy reports of 23 October 1992 and 13 November 1992, but it is not clear whether they had copies of the reports themselves or just accounts of their contents by the plaintiff. There is a reference by the authors to 'the post operation analyses', but in the absence of a further reference to any such analysis, and, more importantly, in the absence of any specific reference to Dr Papadimos's histopathology report – let alone its contents – I conclude that they did not have it provided to them.

[38] That omission, together with an absence of anything at all from the defendant, leads me to conclude that the Belgrade authors were not able to express an opinion on the real reason for the defendant's advising the plaintiff to undergo the operation: the presence of the dense tubo-ovarian adhesions confirmed by Dr Papadimos's report. The Belgrade authors' opinion may then be regarded as correct in isolation from the true facts of the case, but, as it was given in ignorance of those facts, I conclude that it is of no assistance in resolving the central issue in the case, whereas the opinions of the defendant and Dr Keeping do assist in that task and I accept them as correct.

[39] Dr Ringrose examined the plaintiff on 17 January 2000 and sent a report dated the next day to the defendant's solicitors. In the report Dr Ringrose set out the plaintiff's history as she gave it to him and her many complaints. Dr Ringrose gave the results of his clinical examination and his assessment of the plaintiff's condition and prognosis as follows:

> **Clinical Examination:**

> I thought she looked well. On a couple of occasions when I mentioned her children and husband and her general condition she became slightly tearful but this does not last long. She is articulate, slim and looked well. Blood pressure was 110/70, examination of the cardiovascular system and respiratory systems were normal. She had a few minor breast lumps, which were not significant and examination of the abdomen was unremarkable. She was slightly tender in the upper part of the abdomen. There were no abnormalities on examination of her central nervous system, her reticuloendothelial system or her joints.
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> **Current Condition and Prognosis:**
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> I could really find very little wrong with this lady. I shall discuss her theories about her illness and allude to her psychiatric status later on in this report. However from a purely physical point of view I could detect very little in the way of abnormality. From the point of view of her physical illness I think she has excellent prognosis. She looks very well, looks fit and tanned and she certainly does not look like a chronic invalid.

[40] Dr Ringrose reviewed the plaintiff's test results and noted that she had a persistently positive rheumatoid serology consistent with having rheumatoid arthritis, but at no stage displayed any typical arthritis. He concluded that it was 'probably reasonable' to say that she had low-grade rheumatoid arthritis but that her main problem was fibromyalgia, a much less serious condition. She also had persistent findings of positive serology for Hepatitis B infection, but Dr Ringrose agreed with Dr Dickey's comment that she is a 'well carrier'. There was no evidence of underlying systemic lupus erythematosus.

[41] Referring to the statement of claim Dr Ringrose expressed these views concerning the plaintiff's reported physical symptoms:

> I will now turn my attention to commenting on the statement of claim. I shall confine my comments to the symptoms she describes, as it is not my role as a Physician to comment on the surgical aspects of this case. I can, however, comment on the many medical symptoms she suffers and to a lesser extent on the pathology found in the specimen removed. The pathology results from Sullivan & Nicolaides on the operative specimen removed in December 1992 described dense tube and ovary adhesions consistent with Dr Salter's operative findings. In other words she had scarring (adhesions are a result of scarring) before the operation.
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> She also states that one of her problems is infertility due to loss of her reproductive organs and I would have thought that that was self evident if one tube and ovary had been previously removed and the remaining tube and ovary and uterus were removed. Miss Vacic then goes on to describe a large number of symptoms as a result of the instant artificial menopause. Undoubtedly she had an instant artificial menopause but I can not agree that many of her symptoms were caused by it. Certainly hot flushes and perhaps even cold flushes could be caused, as could mood swings. I don't think memory loss, hair loss, auto-immune disorder, chronic fatigue syndrome, musculo-skeletal pain, rheumatoid arthritis, numbness and weakness in the arms and legs, back pain, weight changes, restless sleep and alteration to body odour have anything to do with her instant menopause nor with the surgery that was undertaken.

[42] Dr Ringrose said that '[f]rom a physical point of view' he thought the plaintiff was quite capable of returning to work - although part-time initially - working up to full-time employment over three or four months. Dr Ringrose's final comments were these:

> You have asked the extent to which the operation performed by Dr Salter has caused or contributed to Miss Vacic's current condition. From the point of view of the history it would appear that her current condition has followed the operation. However the operation seems to have been done for the right indications, it was a largely uneventful procedure, there were no significant surgical complications and it is my opinion that most of her current symptoms, although they followed the operation, could not be directly attributed to it. I think she has had an abnormal psychological or psychiatric reaction, which could not possibly have been predicted pre-operatively. I would not expect any Surgeon to have warned the patient they may develop psychiatric symptoms after such a simple and relatively common procedure as was performed here.

[43] Dr Jill Reddan, consultant psychiatrist, interviewed and assessed the plaintiff on 19 January 2000 and provided reports dated 3 May 2000 and 9 September 2002 to the defendant's solicitors. Taking into account the history the plaintiff gave her, Dr Reddan's mental-state examination of the plaintiff, the plaintiff's responses to the Minnesota Multiphasic Personality Inventory (MMPI-2), numerous reports by other doctors on the plaintiff's condition, and other relevant records and documents, Dr Reddan reached the conclusion that the plaintiff was suffering from schizophrenia of paranoid sub-type. The plaintiff's mental disorder was not the result of any surgery performed on her, but is a genetically and biologically determined illness, although its symptoms may be exacerbated by 'stress', Dr Reddan said. Dr Reddan concluded that the plaintiff's psychotic disorder, which had been untreated, significantly impaired her capacity to work, but had not arisen from any gynaecological disorder; the defendant's treatment of the plaintiff had not caused or contributed to any impairment in her capacity to work.

[44] The plaintiff told Dr Reddan that all the gynaecological procedures she had undergone were performed on her in order to harvest her eggs for nefarious purposes, that in 1992 an embryo was removed from her body, and that she had seen a child who grew up from the embryo removed from her. Dr Reddan assessed those beliefs, first revealed in 1994, as delusional. Dr Reddan referred to the 'wide range of unusual somatic symptoms' attributed by the plaintiff to the surgery performed on 4 December 1992 and concluded that the plaintiff's somatization was one of the symptoms of the prodrome to her schizophrenia. Dr Reddan noted that the plaintiff was complaining of many of the symptoms attributed by her to the surgery well before it took place.

[45] The plaintiff's lack of insight and family support were 'poor prognostic factors', but the plaintiff's reasonably normal affect and her lack of the so-called negative symptoms of schizophrenia were good prognostic factors, Dr Reddan reported. The plaintiff requires, Dr Reddan concluded, long-term psychiatric treatment. In her oral evidence Dr Reddan said that the plaintiff was tormented by delusional beliefs and her mental illness, and that there is treatment available and that it is very unfortunate she had not received it.

[46] Associate Professor Francis Varghese, consultant psychiatrist, in a report dated 3 April 1996 to Dr Andrew Leggatt, psychiatrist, who had diagnosed the plaintiff as suffering from schizophrenia, said he could not convince himself that she did have that condition. Associate Professor Varghese expressed the opinion that the plaintiff was suffering from a chronic dysthymia with complicating major depression following what was a psychologically highly traumatic operation, the oophorectomy with hysterectomy, adding, 'The hormonal changes following this may also be implicated. Somatisation is also an issue but this may be secondary to depression'. While, Associate Professor Varhese said, he would not rule out schizophrenia, he would consider that the vigorous treatment of affective illness ought to be considered in the first instance. In his oral evidence Associate Professor Varghese said, however, that as a result of subsequent consultations, he had come to the view that it was likely that the plaintiff suffered from schizophrenia or a chronic delusional state.

[47] I accept the evidence of Dr Ringrose as to the plaintiff's physical condition, and that of Dr Reddan as to her mental condition. There were no untoward effects of the operation performed by Dr Salter in December 1992 apart from a urinary tract infection of no moment. The plaintiff has little physically wrong with her apart from low-grade rheumatoid arthritis, fibromyalgia, and Hepatitis B of which she is a 'well carrier' – none of which conditions is causally related in any way to the operation. The operation left her with some external scarring which, as may be seen from a video tape (exhibit 73), is not disfiguring, and of course she is infertile as Dr Salter told her before the operation she would be if she underwent it. The plaintiff has suffered from hot and cold flushes and mood swings as a result of her difficulty in adjusting to hormone replacement therapy, but her mental disorder has interfered with the effectiveness of that therapy. The plaintiff has failed to prove that the operation caused any effects other than those for which it was performed and which were properly explained to the plaintiff by the defendant before she underwent it. Any other condition from which she is suffering - or from which she believes she is suffering - is causally unrelated to the procedure. The plaintiff's mental disorder and the associated delusions have had the effect of tormenting her and causing her to suffer from a wide range of unusual somatic symptoms.

[48] There is, I think, no doubt that the plaintiff has suffered much mental anguish as a result of her mental disorder. She has been unable to continue to work as a real estate agent and has incurred, and will in the future incur, a good deal of expense on *inter alia* obtaining medical advice, but I assess her damages as a result of any act of, or omission by, the defendant at nil.

[49] There will be judgment for the defendant. I shall invite further submissions on costs.