Date: 20020515
Docket: Cr. S.P. No. 02726

IN THE SUPREME COURT OF NOVA SCOTIA

[Cite as: Windsor v. Poku, 2002 NSSC 137]

Between:

Genevieve Windsor

Plaintiff

-and-

Dr. Yaw Adu Poku

Defendant

D E C I S I O N

Heard Before: The Honourable Justice D.L. MacLellan

Place Heard: Pictou, Pictou County, Nova Scotia

Date Heard: December 14, 17, 18, 19, 20, 2001

Decision Date: May 15, 2002 **Written Release:** May 15, 2002

Counsel: Roseanne M. Skoke, for the plaintiff
Colin J. Clarke, Esq., for the defendant

MACLELLAN, J.

[1] The plaintiff Genevieve Windsor claims against the defendant Dr. Yaw Adu Poku, alleging negligence in regard to surgery performed by him on her in December 1991.

FACTS

[2] In the fall of 1991 the plaintiff who at that time was 59 years old was referred by her family doctor, Dr. John Forbes, to the defendant for assessment for a symptomatic cystocele. She was seen by the defendant who is a gynecologist and scheduled for a vault repair and repair of cystocele and rectocele. In his letter back to Dr. Forbes the defendant noted. [Exhibit 11, page 4].

> A pelvic examination revealed a very large cystocele, a moderate vault prolapse and a rectocele.

[3] The plaintiff was referred to Dr. Clarence Felderhof, her cardiologist to assess whether the proposed surgery would be a problem to her. He reported that: [Exhibit 11, page 7].

> There is no specific risk to surgical intervention.

[4] On December 10, 1991, the plaintiff had the surgery as recommended by the defendant. The surgery itself was uneventful, however, while still in the recovery room the plaintiff started to bleed from the surgical incision and had to be taken back to the O.R. for emergency surgery to deal with the bleeding. The report of the operation signed by the defendant at the Aberdeen Hospital notes as follows. [Exhibit 11, page 12].

> This patient had repair of vaginal vault, repair of of (sic) cystocele and rectocele performed. After about four hours in the recovery room the vagina packing inserted was expelled spontaneously. Upon examination she was found to be bleeding quite profusely. A decision was made to take her back to the Operating Room for further evaluation. In the Operating Room she was found to have tense anterior and posterior vaginal wall from collection of blood behind the incisional lines. Having divided the sutures she was found to be bleeding persistently and profusely from all the incisional lines and all other raw areas. All the area of brisk bleeding were clamped and under-run with #1 Vicryl. Very very difficult hemostasis was undertaken because of the inability of the blood to clot.
>
> The procedure took about four and a half to five hours at which time large amount of surgicel was pressed into the areas of dissection and the vaginal wall sutured over

> them. This was followed by firm continuous pressure manually. When the patient's condition stabilized a decision was made to send her down to the Intensive Care Unit in Halifax due to the massive transfusion and the delay in sending the necessary clotting factor products that she might need during the post-operative period.
>
> The operation was frustrating and prolonged and the patient was sent to the recovery room when the bleeding has subsided tremendously.

[5] The plaintiff was in hospital in Halifax until December 12th, when she returned to the Aberdeen and was there until December 24th, when she was discharged. She was at that time told by the defendant to come back to see him in three weeks, but she did not do so.

[6] In January 1992 Dr. Forbes referred her to Dr. Ormille A. Hayne, a hematologist in Halifax in an attempt to determine what had caused the excessive bleeding during her surgery.

[7] His referral letter indicated: [Exhibit 9, page 136]

> Please arrange an appointment date to assess this lady. You will remember seeing her in December of 1991 at which time she presented with a very difficult post-op hemorrhage following vaginal surgery. She was transferred to the Halifax Infirmary by Dr. MacNeil (anesthetist). I understand that you had been involved in her care while she was in Halifax. Her convolescence has subsequently been good; her general condition appears to have stabilized and she is improving generally. Her diagnosis however is a bit unclear. This concerns the patient and or course concerns me as well.

[8] In April 1992 she was referred to a Dr. John F. Jeffrey, a gynecologist in Halifax. Dr. Forbes referral letter to Dr. Jeffrey indicated as follows: [Exhibit 5, Tab 2]

> Please arrange an appointment date at your <u>earliest convenience</u> to assess this lady. She had a recent attempt at anterior and posterior repair because of cystocele and rectocele. This was carried out by Dr. Adu-Poku. Post-op she developed severe bleeding and was taken back to the OR and hemostasis was difficult to obtain, this woman was critically ill and required massive resuscitation with fresh frozen plasma and cryoprecipitate, etc.
>
> I will enclose a photocopy of her operative notes and her discharge summary. She was transferred to the Camp Hill Hospital on the 10th of December and I will enclose a photocopy of the report from that institution.

She declines to return to Dr. Adu-Poku for a follow-up examination and I have done a PV on her recently which showed marked scarring of her anterior and posterior vaginal walls. This woman is very upset and angry as regards her result.

Might you assess her. Do you have anything further to offer her?

[9] In June 1992 Dr. Hayne wrote to Dr. Forbes indicating: [Exhibit 5(A), Tab 2].

I have had an opportunity to review all the data on this lady and as you can see from my letter of June 1, 1992, I can find no evidence of an underlying hemostatic defect in this lady.

I would interpret therefore that this lady's hemostatic problem post-operatively was related to a coagulation factor, platelet, loss phenomenon.

I have no further comments. Thanks for referring her.

[10] Dr. Jeffrey wrote to Dr. Forbes on April 22nd, 1992 as follows: [Exhibit 9, page 143].

Examination today reveals a woman of stated age in no acute distress. There is no superficial lymphadenopathy. Abdominal exam is negative aside from her surgical scar. There are no mass lesions or organomegaly. The vulva appears parous. There is evidence of a recent mid-line incision in the perineal body which is healing nicely. Speculum exam reveals a foreshortened vagina which is conical at its apex with a large polyp or granulation tissue present. This was excised and the base was treated with Silver Nitrate. Total vaginal length at this time is 3.5 to 4 cms with a moderate degree of scarring at the apex. Pelvi-rectal exam discloses a thickening anterior to the rectal wall above the opened vagina for approximately 1-2 cms which may represent an aglutinated upper vagina but one cannot be certain on the basis of clinical exam that this is not just scar tissue. There is no nodularity or mass lesions.

In discussing the situation with Mrs. Windsor her bladder symptomatology at this time would not appear to be a major problem and as mentioned would appear to be improving. I have counselled her with respect to voiding frequently and to avoid over distention of the bladder which would aggravate any stress related symptoms that she has. It might be reasonable to consider reinstituting Premarin 0.625 mg daily. This would help her vasomotor symptoms and may maintain the integrity of her vaginal epithelium and minimize the support around her bladder neck which may improve what stress incontinence symptoms she is currently having. I do not think that Premarin would be contraindicated with her past history of myocardial infarction but I will leave this to your discretion.

> At this time Mrs. Windsor and her husband have not attempted to resume sexual relations following her surgery. I have advised her that they may do so but at the same time have counselled her that sensation may well be different both related to scarring and the foreshortening of the vagina. With time this may well improve and it may not be a problem for them. Most certainly I would not recommend any form of vaginoplasty at this time unless it is well documented that she and her husband are significantly compromised by the current situation.
>
> When we were finished I had the impression that Mrs. Windsor was relatively satisfied with our explanation and her current status and I have returned her to your care.

[11] In April 1993, she was referred back to Dr. Jeffrey. He wrote Dr. Forbes on May 17th, 1993. He indicated that he had diagnosed a pelvic cyst which was later surgically removed by him in June 1993.

[12] In November 1995, the plaintiff was referred by Dr. Forbes to Dr. Ian Slayter, a psychiatrist at the Mental Health Unit of the Aberdeen Hospital in New Glasgow. He reported to Dr. Forbes on November 22, 1995. [Exhibit 5(A), Tab 2].

> **Presenting Problem:** This 63 year old woman complains of difficulties following bladder repair surgery in December 1991. The surgery was complicated by a major post-operative hemmorrhage. She almost lost her life. She then had problems with infection. She has recovered from these problems but has been left with cicatricial closure of the vagina preventing sexual intercourse. She is also left with residual stress incontinence. She complains that she cannot lift her grand-children or heavy objects for fear of incontinence. She feels angry and bitter about what she alleges as badly performed surgery and about her inability to have sex. She launched a lawsuit against the surgeon, Dr. Adu-Poku, and the Aberdeen Hospital three years ago. She complains of thinking constantly about the surgery and the problems incurred. She worries that she could get cervical cancer as she cannot have Pap smears done. She wishes she could somehow get even with the surgeon.
>
> **Symptom Review:** She describes constant anger and bitterness. She describes intermittent mood depression, says that her mood is good most of the time. There is no diurnal variation of mood. She describes her appetite as good most of the time. Her weight is steady but she has not regained the weight she lost after the surgery. She describes initial and middle insomnia of marked degree with early morning awakening at 2:00 a.m. She occasionally falls back to sleep at 6:00 am. She describes decreased energy and interest. Her libido and concentration are good. She denies suicidal thoughts.
>
> . . .

ASSESSMENT

She does not have a major psychiatric disorder but perhaps can be said to have **Dysthymia** with **Obsessive Features.** She is preoccupied with the problems consequent to the bladder surgery. She also has a partial **Post-traumatic Stress Syndrome** with frequent nightmares involving the bladder surgery, recurrent thoughts of the surgery, closing of her eyes whenever she passes the Aberdeen Hospital, irritability, and insomnia.

In many respects, her complaints are understandable in the light of the serious difficulties which she has had consequent to the surgery. Nevertheless, one might expect her to have let go of the event by this point. Instead she remains preoccupied with the event and its consequences. She is unable to let go and get on with the rest of her life.

There is no evidence of danger to self or others.

[13] Originally the plaintiff commenced an action against the defendant, Dr. Forbes, Dr. Robert MacNeil, the anaesthetist, who assisted the defendant during the two surgical procedures and the Aberdeen Hospital. That action was started in December 1993. She later dismissed the action against all the other defendants except the present defendant.

[14] In her Statement of Claim the plaintiff alleges negligence by the defendant in the manner in which he did the surgery on her, his explanation of the risk of the surgery and the way in which he obtained her consent to the second surgicial procedure.

[15] At the trial of this action, the plaintiff called Dr. John Jeffrey who had treated her following the surgery. He explained his treatment of the plaintiff and during his direct evidence was asked by the plaintiff's counsel to give an opinion about the surgical procedures used by the defendant. This was objected to by counsel for the defendant based on the fact that Dr. Jeffrey had not filed an expert report indicating his opinion. That objection was sustained by the Court and he was not entitled to give such an opinion.

[16] The defendant testified himself and Dr. David R. Anderson and Dr. Thomas Perry Corkum. Both were qualified as expert witnesses, Dr. Anderson in the field of haematology and Dr. Corkum in the field of gynaecology. Both of them testified that based on the information supplied to them that the treatment provided by the defendant to the plaintiff was appropriate and met the standard required from a gynecologist doing this type of surgery.

[17] Dr. Corkum noted in his report: [Exhibit 20, page 6 and 7].

> In reviewing this case against Dr. Y. adu Poku one has to realize that we are dealing with a very rare occurrence. We have no idea as to what caused this patient's post-operative hemorrhage. It was felt that she probably had a bleeding diaphysis or bleed out secondary to massive blood loss. We really don't know why she lost this blood – she doesn't seem to have any coagulation defect. There is no way that Dr. Y.adu Poku could have forecast the surgery and the hemorrhage which supervened.
>
> I believe the surgery was initially carried out to December 10/91 in a standard fashion. The complication and post-operative hemorrhage was terribly unusual and I do believe that Dr. Y.adu Poku's attention was life saving for this patient. If Dr. Y.adu Poku had not persisted or had he transferred the patient prior to being stablilized, I am sure that Mrs. Windsor would have lost her life. It is regretful Mrs. Windsor does not have dyspareunia which probably is the only real problem resulting from her surgery. I do believe that foreshortening of the vagina was due to agglutination of the vagina secondary to her surgery and the raw surfaces created and I do believe had this patient kept her appointment as recommended that this also would not have been a problem. I believe that Mrs. Windsor owes her life to Dr. Y.adu Poku and the team of physicians who managed her care during this rarest of events.

[18] The defendant testified that the bleeding which occurred following the surgery on the plaintiff was most unusual and could not be explained. He said he worked very hard to stop the bleeding and eventually did so. During the four to five hours of emergency surgery on the plaintiff, he had occasion to consult on the telephone with Dr. Hayne in Halifax and also Dr. Cole a surgeon at the Aberdeen Hospital.

[19] The burden is on the plaintiff to establish negligence. I have no evidence before me to establish that the treatment of the plaintiff by the defendant was negligent. The fact that the plaintiff had post-operative problems does not establish that the initial surgical procedure caused these problems.

[20] The plaintiff, through counsel, suggests that the medical procedure used by the defendant was not appropriate. No evidence was offered to show that. It is also suggested that the defendant did not have proper consent to perform the second surgery which was acknowledged by all to have saved the plaintiff's life.

[21] I find this argument to be without any merit. The defendant acted appropriately when he became aware that there was a problem with bleeding. He did what was necessary in the circumstances. The plaintiff did sign a consent to that surgery, and I find no fault in how that consent was obtained considering the

circumstances. To not do that surgery would, I find, have probably resulted in the plaintiff's death.

[22] It is suggested that the plaintiff did not properly explain the risk of the initial surgery to the plaintiff. I reject that argument. The surgical procedure was properly explained including its normal risks. The fact that the defendant did not explain the possibility of what actually happened is not negligence.

[23] The type of bleeding which actually occurred here is, I find, not something that would normally be expected and therefore need not be explained to the plaintiff. The plaintiff was given an opportunity to discuss the surgery with her family doctor and her cardiologist and I find that she clearly understood the normal risks involved in the surgical procedure.

[24] I accept the submissions of defence counsel in regard to the fact that a doctor cannot guarantee that a surgical procedure will be successful, or that something unexpected will not happen.

[25] What happened here was simply a very unfortunate incident which cannot be properly explained and for which the defendant cannot be held responsible.

[26] I find that the plaintiff has not produced any evidence to show that the defendant was negligent and I would therefore dismiss the claim against him.

[27] The plaintiff in her post-trial brief suggests that by the Court refusing to permit Dr. Jeffrey to give an opinion that somehow this caused unfairness to her.

[28] I am not aware of what Dr. Jeffrey would have said if he had given his opinion, however, I believe it would have been very unfair to the defendant to be faced with such an opinion about negligence at trial when no expert report had been provided prior to trial. That would clearly violate the civil procedure rules and would not be fair to the defendant. The defendant is entitled to know prior to trial what is being alleged against him. There has been no explanation offered why Dr. Jeffrey, if he was in a position to provide an opinion, did not do so prior to trial.

[29] In light of my finding on the liability issue, I have decided not to provisionally assess damages.

[30] The plaintiff's claim is dismissed with costs to the defendant.

J.