COMMONWEALTH OF THE BAHAMAS
IN THE SUPREME COURT
COMMON LAW AND EQUITY DIVISION

2013/CLE/gen/01365
BETWEEN

LENDEISHA CULMER-HANNA

Plaintiff

-AND-

DR. LESLIE W. CULMER

First Defendant

-AND-

ACL MEDICAL OFFICE CENTER

Second Defendant

Before: The Honourable Madam Senior Justice Indra H. Charles

Appearances: Mrs. Yolanda Rolle of Kingdom Advocates & Associates for the Plaintiff
Mr. Mario McCartney of Lex Justis Chambers for the Defendants

Hearing Dates: 9 November 2021, 10 November 2021, 8 December 2021, 28 April 2022

Negligence – Professional negligence and breach of duty of a medical doctor – Whether the First Defendant met the standard of a reasonable doctor in the circumstances

The First Defendant is a medical doctor licensed to practise medicine in The Bahamas. He practises in the field of obstetrics and gynaecology. He is the beneficial owner of the Second Defendant (together “the Defendants”). The Plaintiff engaged the First Defendant’s services during her pregnancy. On or about 6 August 2012, the Plaintiff was admitted to the Princess Margaret Hospital after experiencing labour pains. Her baby died during the course of delivery. The Plaintiff commenced this action against the Defendants alleging professional negligence and/or breach of duty of care and/or contributory negligence. The Plaintiff averred that, in both her prenatal care and the delivery of her baby, the First Defendant acted below the standard required. As a result, she claimed special damages, general damages, interest and costs.

The Defendants denied negligence. They did not deny owing a duty of care to the Plaintiff, but denied breaching that duty. They contended that, at all material times, the care met the standard of a reasonable doctor in the circumstances.

HELD: Finding that the Defendants breached the duty of care which they owed to the Plaintiff; damages are to be assessed by the Registrar. The Plaintiff, as the successful party, is entitled to her costs to be taxed if not agreed.

1. A doctor is not guilty of negligence if he acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. Putting it the other way round, a doctor is not negligent if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view: **Bolam v Friern Hospital Committee** [1957] 2 All ER 118 applied.

2. A patient alleging negligence against a medical practitioner has to prove (1) that his mishap results from error and (2) that the error is one that a reasonably skilled and careful practitioner would not have made. It is therefore crucial to establish how the mishap occurred and that he/she should have expert evidence that any error made was a negligent error: **Lashonda Poitier v The Medi Centre and another** [2019] 1 BHS J No 58, para. 98 applied.

3. Not every accident is actionable in negligence, as "negligence" means more than careless conduct. It properly connotes the complex concept of duty, breach and damage: **Desmond Andrew Darville v Minister Responsible for Education Science & Technology and AG** 2017/CLE/gen/00377 referred to.

4. The test for medical negligence is not whether there was a mistake in diagnosis. Whether it amounts to negligence is a question of whether the doctor acted as a reasonable and competent medical practitioner in the circumstances: **Whitehouse v Jordan** [1981] 1 All ER 287 applied.

JUDGMENT

Charles Snr. J:

Introduction

[1] This is a claim in negligence brought by the Plaintiff ("Mrs. Hanna") against the First Defendant ("Dr. Culmer") and the Second Defendant ("the Clinic") (together "the Defendants") claiming special damages of $9,098.35 including funeral expenses and autopsy fee, general damages, interest and costs allegedly caused by the breach of duty of care, negligence and/or negligent management and/or contributory negligence of Dr. Culmer as a result of the unfortunate death of her first child ("baby Hanna").

[2] Mrs. Hanna alleged that the loss of baby Hanna was caused by Dr. Culmer's failure to exercise the duty of care expected of a reasonably skilled and competent physician in the field of Obstetrics and Gynaecology ("OB/GYN") in both his

prenatal care and delivery of baby Hanna. In her Statement of Claim, Mrs. Hanna listed 47 particulars of breach of duty and/or negligence and/or negligent management of treatment by the Defendants. Among them are:

a. Failing to properly assess Mrs. Hanna's overall condition if at all to effect a successful delivery and live birth;

b. Failing to instruct more than one scan of Mrs. Hanna during the course of her pregnancy to properly and/or accurately assess her overall condition;

c. Failing to observe the necessity of another scan of Mrs. Hanna prior to delivery;

d. Failing to provide Mrs. Hanna with a cogent birth plan or any at all before she went into labour and delivery;

e. Trivializing/ ignoring Mrs. Hanna's concerns over her excessive swelling, pain and weight gain during her pregnancy;

f. Failing to properly prepare the delivery room for the birth of Mrs. Hanna's baby;

g. Failing to advise and/or recommend other birthing options with Mrs. Hanna to minimize injury and loss if at all;

h. Failing to perform a caesarean section ("C-section") in all the circumstances as opposed to natural birth;

i. Using excessive force on Mrs. Hanna's pelvis and uterus;

j. Failing to take any or reasonable care for the safety of Mrs. Hanna during the delivery process;

k. Failing to exercise skill, care and diligence in the treatment of Mrs. Hanna

and her baby;

l. Failing to exercise skill, care and diligence in the delivery of Mrs. Hanna's baby;

m. Failing to make a proper or adequate assessment of Mrs. Hanna's condition during her pregnancy and delivery;

n. Failing to take any reasonable steps to investigate Mrs. Hanna's complaints during her pregnancy and/or delivery process to prevent injury to Mrs. Hanna and her child;

o. Failing to assess or properly assess Mrs. Hanna as a special case requiring a C-section section delivery;

p. Failing to perform, cut or make an incision or otherwise allow for greater vaginal opening for the delivery of Mrs. Hanna's baby;

q. Causing the death of Mrs. Hanna's baby;

r. Failing to recognise possible shoulder dystocia during delivery and make provision for or adjustment in delivery options;

s. Failing to anticipate possible shoulder dystocia and/or identify multiple risk factors for same;

t. Failing to employ various maneuvers to resolve shoulder dystocia in a careful, controlled, calm and organized fashion or at all; and

u. Panicking during delivery and/or losing composure during the delivery process.

[3] The Defendants denied that the Clinic owed to Mrs. Hanna a duty of care during the delivery of baby Hanna because the delivery did not take place there but at

Princess Margaret Hospital ("PMH"). The Defendants however admitted that Dr. Culmer owed a duty of care to Mrs. Hanna in relation to medical services performed at the facilities of PMH.

[4] The Defendants also denied that they acted negligently by performing a natural birth. They asserted that, based on Mrs. Hanna's prenatal care, she displayed no physical or medical irregularities that would have made it apparent that her ability to deliver naturally was affected. According to them, neither baby Hanna's weight nor her pre-existing back injury sustained in a car accident in 2009 were medical conditions that prevented her from delivering by natural birth. They contended that the prenatal care and delivery of baby Hanna was performed to the standard of a reasonable and competent physician.

Salient facts

[5] Some of the salient facts are agreed between the parties. To the extent that there is any departure from the agreed facts, then what is expressed must be taken as positive findings of facts made by me.

[6] Dr. Culmer has been practicing OB/GYN since 1972 with 45 years of clinical and surgical experience which includes the birth of infants both naturally and by using alternative methods. He is the beneficial owner, Director and President of the Clinic.

[7] Mrs. Hanna was 30 years old in 2012 when she visited Dr. Culmer at the Clinic to be cared for during her pregnancy. She is of African/Caribbean ethnicity with a family history of diabetes and a pre-existing back injury which she suffered in a vehicular accident in 2009. She also has an evacuation of a Blighted Ovum in or around August 2010. She is also obese.

[8] During January 2012 to August 2012, Mrs. Hanna received prenatal care from the Defendants for the care and delivery of baby Hanna. She relied on Dr. Culmer's expertise and advices relative to her pregnancy and the delivery of baby Hanna.

[9] On or about 6 August 2012, Mrs. Hanna was admitted to the PMH after experiencing labour pain which commenced on or about 2:00 p.m. the day before.

[10] At 9.26 p.m. on 6 August 2012, Dr. Culmer decided to perform a natural birth. Mrs. Hanna's cervix was fully dilated and the delivery of baby Hanna's head occurred quickly. However, at the crowning of the head, Mrs. Hanna's body seized and she was either too weak and/or unable to push with baby Hanna's delivery as the cervix had ceased to contract. Believing that baby Hanna might be experiencing shoulder dystocia, Dr. Culmer intervened in the delivery by manually rotating baby Hanna's shoulders. He did not attempt other available maneuvers or a C-section.

[11] Baby Hanna, weighing 10 pounds and 10 ounces, was delivered at 9.50 p.m. with no heartbeat. The complete delivery of baby Hanna took 24 minutes which, by all accounts, was very long. Although Dr. Culmer had initially diagnosed that baby Hanna died of shoulder dystocia, in filing his witness statement some years later, he opined that baby Hanna died as a result of abruptio placentae, a term referring to the separation of the placenta from the uterus.

The evidence

[12] Mrs. Hanna testified on her own behalf and called Dr. Charles Stoopack as her expert witness. Dr. Stoopack was deemed an expert in OB/GYN. Dr. Culmer gave evidence on his behalf and the Clinic. He was also deemed an expert in OB/GYN and, consequently, he was permitted to give opinion evidence. He also called an expert in OB/GYN, Dr. Vrunda Dhawane Sakharkar.

[13] I set out the evidence of the witnesses in some detail as there are many conflicting factual issues as well as the opinions of the experts.

Lendeisha Culmer-Hanna

[14] Mrs. Hanna filed a Witness Statement on 3 February 2021 which stood as her evidence in chief at trial.

[15] She stated that, at her last pre-delivery weigh in, she weighed 286 lbs. She had swollen extremities, a swollen face and a super-large belly which made walking and breathing difficult. At 22 weeks gestation, she was given a referral to have an ultrasound at Doctors Hospital. At the eighth month of her pregnancy, she asked Dr. Culmer whether she would get another scan, to which he answered in the negative. He told her that it was unnecessary unless she felt that the baby was too large or that something was not right. She said that she trusted his professional judgment so she dismissed the thought of going on her own to do a scan.

[16] Mrs. Hanna further stated that her pregnancy was normal until her third trimester, when she began to double in weight and she looked and felt extremely swollen. Notwithstanding her bodily change, Dr. Culmer expressed no concern. She said that she questioned whether she had to carry the pregnancy for the full 40 weeks since she was concerned about her size. According to her, Dr. Culmer never gave a real answer or gave her a plan for her concerns. At appointments, Dr. Culmer would repeatedly ask her if she was sure that she was not carrying twins. During examinations and measurements of the stomach, Dr. Culmer would look confused and question her last menstrual cycle.

[17] Mrs. Hanna stated that, on the morning of 5 August 2012, she began having mild contractions. She contacted Dr. Culmer to inform him of what was happening. By the following afternoon, as the contractions got stronger, she checked into a private ward at the PMH. She was prepped and waited to be tended to. For the most part, she laid there waiting to dilate fully. She was given something and drifted off to a deep sleep. She could hear baby Hanna's heart beating over the monitor.

[18] Upon waking up, a nurse explained to her what contractions were and when she will be ready. At some point in time, she was given a "cocktail" of medication that made her drowsy and her body became heavy. Sometime later that evening, a nurse said to Dr. Culmer "oh yeah Doc, the head there, she ready!"

[19] Mrs. Hanna said that, as the medical personnel moved frantically across the room, she laid there fighting the urge to push while feeling to sleep. She was told to get up and push. According to her, the intense urges to push were subsiding as she wanted to sleep. She remarked that the room became a chaotic circus of voices saying "push, don't push, push when you feel contractions, stop screaming". She became confused. She was feeling an intense pain from her leg and lower back and she could no longer feel contractions. After several attempts at pushing, the head came out. She began yelling and a nurse told her to stop. She was told "to stop pushing, the shoulder stuck" and, from that point, she laid back on the bed and waited further instructions. She said that there was a tug of war between a nurse and Dr. Culmer pushing and pulling on baby Hanna, alternating between pulling on the baby and pressing her pelvic bone forcefully. She just laid there waiting on a command, waiting to hear baby Hanna cry while at the same time fighting to stay awake. Then, after a long time, the exceptionally large bluish body emerged. He was taken over to a corner table and the nurse placed a manual resuscitator over his mouth and nose. With no urgency, a female doctor came and a crew of interns leisurely walked behind. She laid there as Dr. Culmer repaired a "slight tear'" Sometime later, a doctor told her "the child did not make it…I'm sorry for your loss."

[20] Later on, her family asked "what happened?" and Dr. Culmer said "it was her fault, she wouldn't push."

[21] Under cross-examination by Mr. McCartney, who appeared as Counsel for the Defendants, Mrs. Hanna acknowledged that she now has three children. Around April 2013, she became pregnant with her second child. She admitted that she had been in three (3) car accidents prior to the pregnancy and that she had lumbar injections and pain medication and several sessions of physiotherapy to help relieve the back pain and herniated disc. She was referred to a clinical psychologist on 26 February 2010 for the post-traumatic stress disorder caused by the accident. After some time, she discontinued her visits with the psychologist and discontinued

taking Paxil, which was the drug prescribed by the psychologist. She was not told to discontinue Paxil but did so because it was making her “feel bad”.

[22] Under further cross-examination, Mrs. Hanna stated that an x-ray showed that she had a mildly herniated disc, as she did from the first accident. She did more physiotherapy after that accident but was not referred to a psychologist. However, she then admitted that she was referred to a clinical psychologist, Dr. Hutcheson, but she did not return after the initial visit.

[23] Mrs. Hanna did not recall whether she told Dr. Culmer that she was seeing a psychologist once she discovered she was pregnant and began seeing him. She stated that she had improved with the traumatic effects of the accident.

[24] She also stated that her swollenness is typical for pregnant women but not the way she looked. According to her, this was a concern that she expressed to Dr. Culmer at the time. She said that she was not eating excessively during her pregnancy. Dr. Culmer did not advise her on proper diet and exercise.

[25] During the time that she was in labour, Mrs. Hanna said that she could hear a strong and consistent heartbeat on the fetal monitor. She was given medication which made her numb, heavy and unable to move. Her body would raise from the side position and bear down to push because she felt the urge to do so but Dr. Culmer continuously told her not to do so yet.

[26] She said that she felt unable to move her body and was trying to adjust herself, but she was scolded by the medical staff for moving. Once the baby’s head crowned, she was told to stop pushing. Dr. Culmer said that the shoulders were stuck so he began pulling baby Hanna and the nurse pressed on her stomach. They alternated pulling and he pressed on her stomach, waist or pelvis. At this time, she said that she was alert and could see and hear everything.

[27] She stated that she believed her back pains affected her ability to push although the only pains she experienced during labour were labour pains. She also recalled

a nurse having to hold her legs down when it was falling out of the stirrup. She said she did not have an epidural and does not recall being offered one.

[28] Mrs. Hanna explained that since the death of baby Hanna, she has had nightmares for years. She lives with the constant pain and sadness of having lost her first child.

[29] She also stated that Dr. Culmer did not speak to her about the ways of delivering the baby. She said that "he never really had much to say." Once she was pregnant, she declined the advice of Dr. Grimes to get lumbar epidural injections despite assurance from the doctor that they would not affect the baby but she did not want to compromise her pregnancy.

[30] According to her, the size of baby Hanna was not an issue at the time of the ultrasound at four months but when she asked Dr. Culmer about a second ultrasound, she was eight months and very swollen. She also said she told Dr. Culmer that there were twins, diabetes, hypertension and epilepsy in her family. He was still measuring her stomach and doing normal checkups that included blood pressure. She said that she gained almost 100 pounds from the pregnancy. She insisted that she did not eat excessively due to nausea throughout her pregnancy. She admitted that she had sleep issues during the pregnancy and she was unable to sleep at night but slept during the day.

[31] She accepted that the nurses at the Clinic were accessible and that she had the mobile number of Dr. Culmer who told her to go to the hospital when she advised him of her contractions.

[32] Mrs. Hanna says that she now has three (3) children, all by elective C-section and with epidurals.

Dr. Leslie Culmer

[33] Dr. Culmer filed a Witness Statement on 19 March 2017 which stood as his evidence in chief at trial. He testified that he was aware of Mrs. Hanna's family history of diabetes, hypertension, twins and epilepsy. He was also aware of her

pre-existing back and neck injury from a traffic accident in or around December 2009 and an evacuation of her uterus from a Blighted Ovum in or around August 2010. Despite her history, Dr. Culmer stated that there were no aggravating factors that would have called for a C-section or alternative method of delivering the baby. He was of the opinion that she could deliver the baby by natural birth.

[34] Dr. Culmer further testified that the blood, urine laboratory tests and ultrasound scan showed no abnormalities with Mrs. Hanna or the fetus, and, in his opinion, Mrs. Hanna was in good health before going into labour. Throughout labour, her vitals and that of the baby were normal. Mrs. Hanna had no loss of P/V, her vital signs were normal, VE, vertex, head down, CX, (Cervix) 50% effaced, posterior and soft. Her membrane was intact and baby Hanna's heart rate 140/146 minute and regular. She was given Pethidine 100 mgs to relax while she was being observed and monitored. The labour continued normally until Mrs. Hanna's cervix was fully dilated at 9:26 p.m. and the delivery of the baby's head occurred quickly. Dr. Culmer testified that, at the crowning of the head, Mrs. Hanna's body began to seize and she was unable to push or further cooperate with the delivery, as the cervix ceased to contract.

[35] He said that, at the time, he believed that baby Hanna might have been experiencing shoulder dystocia so he intervened by manually rotating the baby's shoulders, which was easily executed since Mrs. Hanna's cervix ceased its contractions. He said that there was a small gush of blood and the baby was delivered at 9:50 p.m. with no heartbeat weighing 10 pounds and 10 ounces with an estimated blood loss of 200cc.

[36] Dr. Culmer opined that, although the condition of baby Hanna may have suggested shoulder dystocia, this could not have caused his death. He believed that it was the lack of cooperation from Mrs. Hanna that may have led to a prolonged shoulder dystocia. According to him, there were a number of occasions during the delivery process that she attempted to remove herself from the delivery bed which may have caused excessive stress to baby Hanna and/or the placenta. Despite the

appearance of shoulder dystocia and the umbilical cord wrapped around the baby's neck, those conditions would not have attributed to baby Hanna's death since neither state would restrict his inability to receive oxygen from Mrs. Hanna or otherwise place the baby's health in jeopardy.

[37] Dr. Culmer then stated that, after reviewing the events of delivery, his belief is that the baby's death was caused by abruptio placentae. This separation would have caused the abrupt cessation flow from mother to baby, which explains the gush of blood during delivery. Further, he believed that the ease of rotating the baby's shoulder was due to the uterine spasm which may have resulted from the abruptio placentae. According to him, the gush of blood observed during delivery further suggested that an abruptio placentae may have taken place since there were no tears in Mrs. Hanna's vagina or cervix after the delivery. However, under cross-examination, he accepted that there was a superficial tear where he put a few stitches. He did not have to do it but he did it to ensure that it healed properly. Dr. Culmer said that the reason he did not include abruptio placentae in his delivery notes is because he wanted to see what the pathologist would say about it. That said, he insisted that baby Hanna's death was caused by abruptio placentae.

[38] Dr. Culmer did not agree that an additional ultrasound, cutting Mrs. Hanna to widen the vagina, executing an emergency C-section or referring the matter to another OB/GYN would have avoided baby Hanna's death. According to him, once an abruptio placentae occurred, the baby would have been deprived of oxygen from Mrs. Hanna for over 10 minutes which would have caused his death, making it impossible to save his life even with alternative method of delivery.

[39] Dr. Culmer further stated that he is not permitted to offer a C-section if no aggravating factors exist. He does not normally care for patients who are diabetic from the onset. He would refer them to another physician with expertise in dealing with diabetic patients. He maintained that Mrs. Hanna was not diabetic.

[40] Under cross-examination by Mrs. Rolle, who appeared as Counsel for Mrs. Hanna, Dr. Culmer was asked whether he found out that Mrs. Hanna had gestational

diabetes mellitus ("GDM") during her pregnancy. He stated that it was not until late in her pregnancy that she showed sugar in her urine which would make you think about "that sort of thing" but she had other problems with her diet such as eating lots of sweets, which could manifest sugar in urine. He said that she admitted to eating a lot of pineapples and what not. He clarified, however, that he did not suspect diabetes. She merely presented with sugar in her urine which proved not to be diabetes. He stated that he tested her for sugar due to diabetes in her family history.

[41] Dr. Culmer acknowledged that Mrs. Hanna's body mass index ("BMI") was above average but said that she had an adequate pelvis to deliver a large baby. He was adamant in classifying Mrs. Hanna as belonging to the African-American/Caribbean ethnicity since he stated that he knows nothing about that. He accepted that the existence of her family history of diabetes and the above normal BMI are risk factors for GDM but said that she was tested at every visit from the onset with the possibility of having sugar or diabetes.

[42] Dr. Culmer said that a screening for GDM would not show up before 12 weeks. He accepted that the test done on Mrs. Hanna was a routine test for her sugar along with other test that had nothing to do with diabetes *per se*. He further stated that Mrs. Hanna did start her pregnancy with an above normal weight but that is not an indicator that she would end up being diabetic. Later in the pregnancy, when she started showing a rapid increase in weight, it presented a different problem, but, in talking to her, there was a problem with her eating habits. The kind of food she ate were highly salty seasoned foods that might have caused her to gain a lot of weight.

[43] Upon further cross-examination, Mr. Culmer was asked whether GDM became a concern at some point in the pregnancy and he replied "yes and no". He stated that the sugar in the urine was a cause for concern but, when the test was done, the results did not clearly show that she was diabetic. According to him, it could have been elevation from glucose or some other sugar that was not important. He

explained that anytime a pregnant woman shows sugar in her urine, she is tested with GDM in mind. He said that the results of the test showed that she was predisposed to developing diabetes but, all she required at that time, was a diet adjustment, which he drew to her attention.

[44] Dr. Culmer agreed that 4+ sugar is very high sugar. He did not accept that literature elucidates that anything above 92 to 100 is evidence of GDM especially at 32 weeks. He accepted that babies born to mothers with GDM are at a higher risk for shoulder dystocia. He said that baby Hanna came out quickly.

[45] Dr. Culmer said that the blood test one month before delivery showed ketones, which indicated that Mrs. Hanna was not eating much. He opined that an ultrasound on a mature baby is difficult and a waste of time because as Mrs. Hanna was approaching labour, her stomach was expected to look bigger.

The expert evidence

Dr. Charles Edward Stoopack

[46] Dr. Stoopack's evidence in chief is contained in his Witness Statement filed on 29 December 2020. Dr. Stoopack is a medical doctor board certified in OB/GYN, a Fellow of the American College of OB/GYN and a Diplomat of the American Board of OB/GYN. Because of his qualifications and vast experience, he was deemed an expert in OB/GYN. His evidence was that he is familiar with the diagnosis and management of GDM, the diagnosis and management of fetal macrosomia and the causative factors and management of shoulder dystocia.

[47] Dr. Stoopack opined that Dr. Culmer's care fell below the standard of care in his treatment of Mrs. Hanna in his failure to do the following:

1. perform early pregnancy testing for pre-pregnancy diabetes in an at-risk patient;
2. perform 2nd trimester testing for GDM;
3. recognise the diagnosis of GDM in the 3rd trimester;
4. perform the appropriate antenatal surveillance in the 3rd trimester;

5. perform an ultrasound in the late 3rd trimester for fetal macrosomia and;
6. perform the recommended maneuvers to resolve the shoulder dystocia.

[48] Expounding on the failure of Dr. Culmer, Dr. Stoopack's opined that Dr. Culmer tested for GDM far too late in the pregnancy and, as such, he did not realise that the results were abnormal because they showed GDM. He did not use treatment such as diet, exercise, blood sugar monitoring and possibly medication. He did not institute antenatal surveillance of monitoring baby Hanna, either ultrasound or fetal monitoring over the last month or so. As a result, he did not have the suspicion that baby Hanna was macrosomic so he did not order an ultrasound at the end of the pregnancy.

[49] Dr. Stoopack explained that, because baby Hanna weighed 4810g at birth, he satisfied all of the definitions of macrosomia. In addition, because Mrs. Hanna had a BMI of 32 at her initial prenatal visit, she should have been screened for diabetes. According to him, it is recommended that all pregnant women be screened for GDM between 24-28 weeks gestational age. Mrs. Hanna was not tested for diabetes early in her pregnancy despite her BMI and her African-American/Caribbean ethnicity, which is a high risk group. Other risk factors include a BMI over 30, family history of diabetes and family history of GDM. She was not tested for GDM until 32.3 weeks after a "random" blood glucose measurement returned elevated at 111. He said that the regular or random blood sugar test cannot be used to try to diagnose GDM. It does not replace the 2 or 3-hour test that needs to be done. It was a worthless test but even then, the value of 111 ought to raise suspicion because it is far above 92. He also said that we do not know what she ate or did not eat in the hours prior.

[50] She was tested for GDM at 32.3 weeks using the 2 hour glucola test, 4-8 weeks later than it normally would have been recommended for pregnant women without the high risks that Mrs. Hanna had. Dr. Stoopack testified that it is a satisfactory test for GDM but it was done too late. Mrs. Hanna had unrecognized GDM. She was administered 75 grams of glucola. Before she drank it, her blood was drawn

with a value of 104. After the 2 hours, it was 128, so the 104 is the elevated value. The threshold is 92 and based on that she had a diagnosis of GDM.

[51] According to Dr. Stoopack, macrosomia, which is an infant larger than usual, is the main risk of GDM. As macrosomia is distinctly more common in women with GDM and because shoulder dystocia is more likely at any given fetal weight in pregnancies complicated by diabetes than in pregnancies without it, clinicians should assess fetal growth by ultrasound and clinical exam in the late third trimester to attempt to identify macrosomia among women with GDM. He explained that an infant larger than normal causes birth trauma, where the baby has difficulty delivering the shoulders, which is called shoulder dystocia, which can lead to injuries to the baby's arm, brain or death.

[52] Dr. Stoopack said that the treatment for GDM is diet and exercise, a glucometer, which she should use to measure her blood sugar four times a day. This treatment, along with medication, if necessary, decreases the size of the baby because the baby gains less weight. It is very effective. Dr. Stoopack believed that Dr. Culmer ordered the diagnostic test due to the sugar that was present in her urine test, as it was done three (3) days later. He said that this test was abnormal. When the test was done at that stage, it was late but it is never too late to try because she still had 6-8 weeks remaining of pregnancy so the size of baby Hanna could have been influenced somewhat. Even then, the diagnosis of GDM indicates that baby Hanna is likely to be macrosomic, which helps with making a delivery plan. He said that, if you are not diabetic, it matters not what you eat. You would not have 4 + sugar in your urine, which is the maximum that you can get.

[53] With respect to Dr. Culmer's statement that Mrs. Hanna's lack of cooperation led to the prolonged shoulder dystocia, Dr. Stoopack explained different maneuvers in birthing done when shoulder dystocia presents itself failing which a C-section should have been done. He stated that once it presents itself, the doctor should order someone in the room to note the time and note when each minute passes because when it occurs, oxygen running through the umbilical cord is shut off to

the baby. You have about five (5) minutes to get the baby out before the brain is affected.

[54] He observed that Dr. Culmer, in his records, insisted that the fetal heart rate was fine up until birth, which meant that baby Hanna was healthy when the head came out. Therefore, baby Hanna died because oxygen was completely shut off.

[55] With respect to abruptio placentae which was mentioned by Dr. Culmer, Dr. Stoopack said that there is no evidence to support it. Dr. Culmer's delivery notes did not mention it. He elucidated that this occurs when the placenta detaches from the uterine wall. When it happens, no oxygen is transferred to the baby. He highlighted that the pathology report states that the placenta was intact and the membranes were unremarkable. He stated that Dr. Culmer is opining that the abruption occurred at the time the head delivered but he expressed that beforehand, the fetal heart rate tracing looked fine. If you have an abruptio placentae, the fetal heart rate tracing starts showing concerning signs. He said that there were no risk factors for chromosomal abruption in Mrs. Hanna's case. Abruption and shoulder dystocia are unrelated.

[56] Under cross-examination by Mr. McCartney, Dr. Stoopack admitted that he did not review the Bahamas Medical Council's Code of Professional Conduct and he had no discussions with doctors in The Bahamas to assist him with this case. He agreed that natural births are Plan A and caesarean sections are Plan B especially for first time mothers. He also stated that C-section is a major surgery and the disadvantages are those of any surgery including blood loss, infection, injury and recovery for the mother. According to him, it is probably now the most frequently performed major operation in the world not only in the USA but in Europe also. It is considered routine and low risk.

[57] Dr. Stoopack further stated that the main reason for a C-section delivery is failure to progress in labour. Other reasons include fetal intolerance to labour, breeched babies, multiple gestation for example, twins or more, where both babies heads are not down, a mother with an active herpes lesion and women who had one C-

section and then a repeat C-section. He agreed that, with first time mothers, most practitioners would prefer the natural birth.

[58] Dr. Stoopack concluded that baby Hanna had fetal macrosomia. Mr. McCartney suggested that the only way to confirm with absolute certainty that baby Hanna had fetal macrosomia is to do so after birth. Dr. Stoopack agreed that the only way to get an exact birth weight is to put the baby on the scale after delivery. However, he explained that, if you do an ultrasound, you will have an idea so it is a judgment call. He further explained that there is a small degree of error in the ultrasound detecting the baby's weight but it is pretty accurate although it is not as accurate as a weighted scale.

[59] Dr. Stoopack further stated that, using the African-American range of "normal sized babies", baby Hanna was about 1 pound bigger. He also agreed that Mrs. Hanna did not recognize herself as diabetic. He disagreed with Mr. McCartney that the elevated sugar was being monitored by Dr. Culmer. He stated that, following the abnormal sugar test, all that was done was 'dipsticking' Mrs. Hanna's urine at each visit. On 4 July 2012, it came back 2+ sugar with a comment "history of eating pineapple" and on 25 July 2012 with 4+ sugar in the urine, with the comment "history of eating pancakes". He said that Dr. Culmer was trying to give an opinion that what she ate cause the sugar in her urine.

[60] Dr. Stoopack opined that women have given birth to 10-pound babies naturally. He insisted that there was no cause of death other than shoulder dystocia. When asked by Mr. McCartney whether it is possible for the pathologist to make a mistake or not see the blood clot that may have been on the placenta, he said that it is hard to think that a pathologist would decide not to document or ignore a blood clot on the placenta.

[61] Dr. Stoopack was questioned whether Dr. Culmer's performance fell below the standard of care because he missed a second oral glucose tolerance test ("OGTT test"), he said it created a domino effect. He did not realise or did not document that Mrs. Hanna had a diagnosis of GDM based on that test which meant that he

did not treat her for GDM. He did not prescribe diet and exercise. He was not concerned about macrosomia which should have concerned him and he did not perform an ultrasound towards the end of the pregnancy which meant that he had no idea of the estimation of the weight of baby Hanna. He opined that if the estimated weight of baby Hanna was 4,800 grams, he should have said to Mrs. Hanna that there is a high risk of shoulder dystocia with injury and explained to her about performing a C-section delivery before labour or at the time labour starts to prevent injury or death of the baby. He said that one test revealed a lot of things that ought to have been done but were not. It was the fork in the road and Dr. Culmer went down the wrong road by ignoring the results.

[62] When asked whether his views on standard of care would change if, in fact, there was a subsequent test done, he said that no subsequent GDM test was done. There were random blood sugars that were run which is unhelpful but to have 4+ sugar in your urine, your blood sugar has to be, at least, 200.

[63] During further cross-examination, Mr. McCartney posed the following questions to Dr. Stoopack: see Transcript of Proceedings on 9 November 2021 pages 109 -110 lines 8 et seq:

> "Q: If I may direct the Court's attention to tab 27 of the Plaintiff's Bundle of Documents….Have you seen this Report before….?
>
> A: Have I seen this report? I don't recall specifically; but, most likely….
>
> Q: The reading here is 84. Does that demonstrate the fact that her fasting blood sugar level was being monitored?
>
> A: I don't know if we know what this was. This was drawn on July 26th at 11:00 in the morning. I doubt it was fasting. Fasting you have in the morning before you have anything to eat or drink so I - unless she didn't eat anything before 11:00, it is not fasting….I don't know what she had to eat or drink that day; but once again, when the diagnosis of gestational diabetes is made, drawing an occasional random blood sugar is of no value.

Q: Well, I put it to you, Sir, that the Plaintiff's blood sugar levels were monitored properly and I put it to you that you wouldn't be aware of whether the child was delivered safely because you weren't there, in order to provide an opinion.

A: Are you asking a question?

Q: Yes. That's the question. You could respond to that.

A: Well, absolutely not. The patient's blood sugars are not monitored correctly because from the time she was diagnosed, she was supposed to have a home glucometer and have her blood sugar measured fasting and then after breakfast, lunch and dinner, four times a day. What we have here is once every few weeks, he drew one blood sugar measurement at a random time. That's not adequate blood sugar measuring for someone with a diagnosis of gestational diabetes. It doesn't help you at all.

Q: So, if a person was eating before the test was done, would that compromise the test itself?

A: Which test?

Q: the OGTT Test?

A: Well, they're instructed to fast but it shouldn't affect it. But patients are told to fast overnight before they do their gestational diabetes testing?"

[64] Upon re-examination, Dr. Stoopack was referred to the PMH General Case Summary dated 8 August 2012. It states that the admitting physician is Dr. Leslie Culmer and Mrs. Hanna was admitted on 6 August 2012 at 12:26 p.m. In the column, "complications" is notated: "Shoulder Dystocia, fetal demise. Under secondary diagnosis is notated: "Post-partem depression, Cord around neck (tight)". Under Principal Procedure is notated: "Suture of perineal laceration". Dr. Stoopack said that there is no notation of abruptio placentae.

[65] In summary, Dr. Stoopack stated that Dr. Culmer fell below the standard of care in the treatment of Mrs. Hanna by his failure to (1) diagnose and treat gestational diabetes and (2) recognise and appropriately manage fetal macrosomia. As a result, a severe shoulder dystocia occurred causing the demise of baby Hanna, a tragedy which, according to him, could have been avoided. Had Dr. Culmer resorted to deliver baby Hanna by C-section, he would have been alive today.

Dr. Vrunda Dhawane Sakharkar

[66] Dr. Sakharkar filed a Witness Statement on 14 July 2020 which stood as her evidence in chief at trial. She was called to give expert testimony by Dr. Culmer. She is a medical physician licensed to practise medicine in The Bahamas as a specialist in the field of OB/GYN and endoscopy and infertility with over 30 years of surgical and clinical experience including the delivery of infants. She is a consultant at PMH and she also lectures OB/GYN at the School of Clinical Medicine and Research at the University of the West Indies in Nassau. She has been doing so for 21 years. She has been involved in a number of recognized academic publications in the field. She was deemed an expert in OB/GYN.

[67] In summary, her evidence is that the care provided by the Defendants (prenatal and during delivery) met the standard of care of a reasonable OB/GYN.

[68] Under cross-examination, Dr. Sakharkar stated that she treats women with GDM and the practice at PMH is to give the random glucose test when the patient comes in. The second thing is, it is recommended that they do a 3-hour OGTT test but many times the labs do not have what is required for it so, most of the times, they use fasting and 2-hour Post Prandial ("PP"). If the patient has any family history and if she shows more than 2 abnormal values, they further investigate with a glycosylated hemoglobin test ("A1c"). This is based on the practice at PMH.

[69] Dr. Sakharkar further stated that she would not do the A1c test on Mrs. Hanna merely because she had three risk factors namely (i) family history of diabetes; (ii) BMI over 30 and (iii) black ethnicity. This is because she is a *primigravida* – she is

a young, healthy female without any pre-existing diabetes so she would fall in the normal or low-risk category.

[70] She stated that, sometime in June 2012, Mrs. Hanna did the fasting test and the value was 104 and the PP was 128 which are within the normal limit. She explained that if for screening they use lower values, there is a tendency to have over diagnoses and if they use higher values there would be less people diagnosed with GDM. So it is up to the discretion of the doctor. She said, using the national diabetes data, the fasting cut off point is 105 and their PP cut off is approximately 160, the values of Mrs. Hanna's test would still fall within normal limit. Dr. Sakharkar also explained that the diabetes, obesity rates in The Bahamas are high and that none of Mrs. Hanna's tests or symptoms were considered unusual for pregnant women in The Bahamas.

[71] She further explained that whenever they send blood samples to the laboratory, each laboratory, depending on which kind of testing they use and which kind of machine they use, has its own calibration. According to the calibration, the research would be flagged automatically.

[72] With respect to the sugar in the urine, Dr. Sakharkar said that it is called glycosuria in pregnancy. It occurs when the maximum amount of sugar transfers from mother to baby. She said that, as much as 50% to 60% of women will have spillage of sugar in the urine and this is why such spillage is not considered critical as it would be considered in a patient who is not pregnant. When this occurs, they double-check even though it is not significant but they will have to see what is happening in her blood level because it is in the urine. She stated that she noticed in July 2012, the two blood tests that showed sugar in the urine were within normal limit because they were less than 100. She opined that if Mrs. Hanna was diabetic, the values would have been higher.

[73] Dr. Sakharkar agreed that baby Hanna weighed 4,810 grams at birth and he was a macrosomic baby. At 23 weeks, he was 558 grams. She was questioned about the rapid weight of baby Hanna within 15 weeks being in excess of 4,000 grams

and whether it would show on Mrs. Hanna. She said "no." She explained that the birth of a baby is not a linear fashion. As the pregnancy advances, "there is more pounds put on the baby in the third trimester". She clarified that the weight that the mother gains, is not the weight of the baby itself.

[74] Under further cross-examination, Dr. Sakharkar was asked whether she has delivered babies before and she answered in the affirmative. She stated that the actual delivery process is time sensitive. She has delivered a macrosomic baby with shoulder dystocia before. She was also asked whether when the head is out but there seems to be some challenge with the shoulder being dislodged, whether it is an option for the head to be reinserted into the vaginal cavity. She said that she has never done that in her life. It is called Zavanelli maneuver and she read that people did that in the 50's and 60's but she does not believe that it is part of modern obstetrics.

[75] She stated that her belief is that baby Hanna was already dead by the time his head came out. She also said that if placenta abruption occurred quickly, it would not be able to be determined by a pathologist. The placental abruption diagnosis cannot be done on autopsy.

[76] Dr. Sakharkar said that she co-authored an article for the Journal of Obstetrics and Gynecology in 2015 that states that the ideal testing for women in the Caribbean is the 3 hour OGTT test. She said most of the laboratories in The Bahamas do not have the OGTT test. Therefore, the most common practice in The Bahamas is to do fasting and 2 hour test. If any of those values are abnormal, they do a glucose profile at the hospital.

[77] Dr. Sakharkar concluded her evidence, on re-examination, by reiterating that the care provided by the Defendants met the standard practice of care by an OB/GYN in The Bahamas.

Factual findings

[78] This is a civil case wherein the burden of proof is on a balance of probabilities.

Having had the opportunity to see, hear and observe the witnesses, I prefer the evidence adduced on behalf of Mrs. Hanna to that of Dr. Culmer. I did not believe him and, in my opinion, he changed his account to say that baby Hanna died of abruptio placentae instead of shoulder dystocia which he recorded contemporaneously in the delivery notes after baby Hanna's death. In any event, his recently-invented diagnosis or abruptio placentae did not accord with the pathologist report. Mr. McCartney cross-examined Dr. Stoopack on whether there could have been an error in the pathology report. Dr. Stoopack said that he was unable to answer that but he alluded to the fact that even Dr. Culmer's contemporaneous notation made no mention of abruptio placentae. This new diagnosis found its way on a separate page which was undated and which Dr. Culmer stated, was to be attached to his medical report. So, Dr. Culmer's credibility became questionable.

[79] I believe Mrs. Hanna when she stated that she was concerned about her weight and her size generally and when she asked Dr. Culmer, he expressed no concern. I also believe Mrs. Hanna that she was not eating as much pineapples, pancakes and salty foods as Dr. Culmer made it out to be. Instead, she was very nauseous during her pregnancy and that accounted for one of her tests one month before delivery showing ketones. In any event, as her OB/GYN, he ought to have advised her of the risks of over-eating and/or eating the wrong foods and/or to advise her to see a nutritionist and an exercise counsellor.

[80] I also believe Mrs. Hanna relative to what transpired in the delivery room at the PMH. She stated that she was given inconsistent directions with voices saying "push, don't push, push when you feel contractions, stop screaming" which confused her as a first time mother.

[81] In my considered opinion, Dr. Culmer misjudged the situation. Mrs. Hanna was a young woman so he equated "young" with 'healthy.' In the delivery room when baby Hanna's head crowned, I believe Mrs. Hanna's version that "there was a tug of war between a nurse and Dr. Culmer pushing and pulling on baby Hanna,

alternating between pulling on the baby and pressing her pelvic bone forcefully. She just laid there waiting on a command, waiting to hear baby Hanna cry while at the same time fighting to stay awake." I believed Dr. Culmer also panicked and/or loss his composure during the delivery process.

[82] With respect to the respective experts, Dr. Stoopack and Dr. Sakharkar did not come to the same conclusion on whether Dr. Culmer's actions met the acceptable medical standards. In this regard, I am guided by the dicta of Bingham LJ in **Eckersley v Binnie** [1988] 18 Con LR 1. See also **Deonarine v Ramlal** [2007] T & T CA, per Mendoca JA at paras 30-41. Bingham LJ in **Eckersley** said:

> **"<u>In resolving conflicts of expert evidence the judge remains the judge. He is not obligated to accept evidence simply because it comes from an illustrious source: he can take account of demonstrated partisanship and lack of objectivity</u>. But save where an expert is guilty of deliberate attempt to mislead (as happened very rarely), a coherent reasoned opinion expressed by a suitable qualified expert shall be the subject of a coherent reasoned rebuttal, unless it can be discounted for other good reason."**[Emphasis added]

[83] While Dr. Sakharkar is a very highly qualified OB/GYN in this jurisdiction and has practiced her profession here for over 30 years, I still prefer Dr. Stoopack's evidence to hers. Her evidence was premised upon review of Mrs. Hanna's medical records which the Defendants provided to her. She had never spoken to Mrs. Hanna and, according to her, Dr. Culmer. She just looked at the medical records of Mrs. Hanna and came to the conclusion that the care provided by the Defendants met the standard of a reasonable OB/GYN. She opined that Mrs. Hanna had undergone the ordinary pregnancy screenings prescribed *during the early stages of pregnancy* including the prescription of prenatal vitamins and regular monitoring of her vital signs, measurement of her stomach, fetal heartbeat and ultrasound scan, all of which suggested that Mrs. Hanna experienced conditions of a normal pregnancy. She opined that *the records* (notations made by Dr. Culmer) did not suggest that Mrs. Hanna pre-existing back and neck injury sustained in a traffic accident in 2009 and an evacuation of her uterus from a Blighted Ovum in 2010 would affect her pregnancy in a detrimental manner nor

would it direct a licensed OB/GYN to prescribe a C-section as a means of delivery.

[84] Dr. Sakharkar also stated that, having reviewed Mrs. Hanna's medical records at the time that she was admitted to the PMH, she opined that Mrs. Hanna was properly monitored. She stated that Dr. Culmer's decision to manually rotate baby Hanna's shoulders due to possible shoulder dystocia also met the standard of care of a medical practitioner.

[85] I shall return to the evidence and opinions of these two experts when I anaylse the broad issues.

The law

[86] In the tort of negligence, liability is based on the conduct of the defendant and has three elements or requirements namely:

1. The existence of a duty of care situation (i.e. one which the law attaches liability to carelessness). There has to be a recognition by law that the careless infliction of the kind of damage complained of on the class of person to which the plaintiff belongs by the class of person to which the defendant belongs is actionable;

2. Breach of the duty of care by the defendant, i.e. he failed to measure up to the standard set by law; and

3. A casual connection between the defendant's careless conduct and the damage.

Existence of a duty of care

[87] In general, a duty of care will be owed wherever in the circumstances it is foreseeable that if the defendant does not exercise due care the plaintiff will be harmed: see **Clerk & Lindsell on Torts (9th Ed)**, at paras. 8:05 et seq. It is the law that a physician "…owes a duty of care to the patient to use diligence, care, knowledge and skill in administering the treatment. No contractual relationship is

necessary, nor is it necessary that the service be rendered for reward. The law requires a fair and reasonable standard of care and competence." In **Cephas Marshall v F.H.H. Emergency Medical Associates et al**, Suit No. 1023/2002 [unreported], Cornelius J said:

> **"By the very existence of doctor and patient relationship, a medical doctor has a duty to use reasonable care and skill in examination, diagnosis and treatment of his patient."**

[88] In the present case, the Defendants accepted that Dr. Culmer owed a duty of care to Mrs. Hanna.

Breach of the duty of care/ professional negligence

[89] A defendant will be regarded as having breached his duty of care if his conduct falls below the standard required by law. The standard normally set is that of a reasonable and prudent man. In **Blyth v Birmingham Water Works** [1856] 11 Exch. 781 at 784, Anderson B said:

> **"Negligence is the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do."**

[90] Negligence, as defined by Anderson B. is in ordinary or general language but the standard required by law with respect to medical doctors, has developed over the century. There is now a myriad of cases which set out the test that the Court must apply in determining whether a medical practitioner breached his duty of care and was negligent. The *locus classicus* is **Bolam v Friern Hospital Management Committee** [1957] 2 All E.R. 118. At pages 121-122. McNair J laid down the following test:

> **"The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.... A doctor is not guilty of negligence if he acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in**

that particular art. Putting it the other way round, a doctor is not negligent if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view." [Emphasis added]

[91] The **Bolam** test was further explained in light of the role of expert opinions in **Bolitho v City and Hackney Authority** [1997] 3 WLR 1151. Lord Browne-Wilkinson explained that negligence is for the Court to determine. In making that determination, the Court must be satisfied that the medical opinion relied on is sufficiently logical. At page 1159, Lord Browne-Wilkinson stated:

> **"My Lords, I agree with these submissions to the extent that, in my view, the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. In the *Bolam* case itself, McNair J. [1957] 1 W.L.R. 583, 587 stated that the defendant had to have acted in accordance with the practice accepted as proper by a "*responsible* body of medical men." Later, at p. 588, he referred to "a standard of practice recognised as proper by a competent *reasonable* body of opinion." Again, in the passage which I have cited from *Maynard's* case [1984] 1 W.L.R. 634, 639, Lord Scarman refers to a "respectable" body of professional opinion. The use of these adjectives—responsible, reasonable and respectable—all show that the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter."**[Emphasis added]

[92] In **Lashonda Poitier v The Medi Centre and another** [2019] 1 BHS J No 58, this Court explained what a plaintiff patient is required to prove in order to establish negligence. At para 113, I stated**:**

> **113 Having accepted that Dr. Basden owed a duty of care to Ms. Poitier, the next part of the negligence equation is the standard of care appropriate or required in the particular situation. At para. 8:50 in Clerk & Lindsell (17th ed), the learned authors put it this way:**

> **"A patient alleging negligence against a medical practitioner has … to prove (1) that his mishap results from error and (2) that the error is one that a reasonably skilled and careful practitioner would not have made. It is therefore crucial to establish how the mishap occurred and that he should have expert evidence that any error made was a negligent error."**

Discussion, analysis and findings

[93] Mrs. Hanna bears the burden to prove her allegation that Dr. Culmer was negligent in her treatment. Accordingly, she must present cogent evidence that the treatment or action of Dr. Culmer fell below the standard of care of an ordinary competent OB/GYN (which he held out to be) in the same circumstances and that his negligence caused her damage. In **Halsbury's Laws of England, 4th edn re-issue,** Vol. 30 para 35, the learned authors stated:

> **"A person who holds himself out … ready to give medical advice or treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Whether or not he is a registered medical practitioner, such a person who is consulted by a patient owes him certain duties, namely a duty of care in deciding what treatment to give, and a duty of care in his administration of that treatment."**

[94] Having accepted that Dr. Culmer owed a duty of care to Mrs. Hanna, the next part of the negligence equation is the standard of care appropriate or required in the particular situation. At para. 8:50 in **Clerk & Lindsell (17th ed)**, the learned authors put it this way:

> **"A patient alleging negligence against a medical practitioner has … to prove (1) that his mishap results from error and (2) that the error is one that a reasonably skilled and careful practitioner would not have made. It is therefore crucial to establish how the mishap occurred and that he should have expert evidence that any error made was a negligent error."**

[95] Also, at para. 3:130 of the treatise, **Medical Negligence** by Michael Jones, the learned author pointed out that:

> **"Medical evidence is invariably a vital element in an action for medical negligence, but the importance attached to expert opinion should not obscure the underlying basis for a finding that the defendant has been negligent, or not (as the case may be). This is that, in the light of the expert evidence, the defendant has taken an unjustified risk….In other words, expert opinion about the defendant's conduct (whether favourable or unfavourable) should itself be measured against the general principles applied to the question of breach of duty."**

[96] Learned Counsel Mrs. Rolle submitted that both Dr. Culmer's prenatal care of Mrs. Hanna and delivery of baby Hanna fell below the standard of a reasonable doctor. In order to determine whether Dr. Culmer was negligent, it is necessary to determine the cause of baby Hanna's death.

[97] In his evidence, Dr. Culmer stated that, after reviewing the events of the delivery, it is his belief that baby Hanna's death was as a result of abruptio placentae: a separation of the placenta from the uterus. This is however not borne out in his contemporaneous delivery notes which penned shoulder dystocia. His expert witness, Dr. Sakharkar opined that baby Hanna was a still born without giving any reason to substantiate her finding.

[98] On the other hand, Dr. Stoopack opined that baby Hanna died as a result of shoulder dystocia which caused him to be deprived of oxygen. Dr. Stoopack explained that abruptio placentae occurs when the placenta detaches from the uterine wall. He correctly stated that the pathology report states that the placenta was intact and the membranes were unremarkable.

[99] Having regard to the cause of death as determined by the pathologist and all of the other evidence, in my judgment, baby Hanna's death was caused by shoulder dystocia which caused him to be deprived of oxygen. I am unable to accept Dr. Culmer's evidence and that of Dr. Sakharkar. Worst yet, could there be any suggestion that Mrs. Hanna's lack of cooperation during delivery caused baby Hanna's demise.

Negligence with respect to the delivery

[100] The evidence of each of the expert witnesses was that once there was shoulder dystocia, there was very little room for error; that saving the life of the baby at that point was a matter of minutes. Time was of the essence.

[101] I accept Dr. Stoopack's evidence that once a shoulder dystocia occurs, there is a series of maneuvers available to the delivering physician to dislodge the impacted shoulder. These include the McRoberts position, suprapubic pressure, Woods screw maneuver, delivery of the posterior arm and – if all else fails, the Zavanelli maneuver which is the last resort.

[102] Dr. Stoopack noted that Dr. Culmer stated that the only maneuver employed in the delivery of baby Hanna was shoulder rotation. At paragraph 9 of his witness statement, Dr. Culmer averred:

> **"Having believed that the infant might be experiencing shoulder dystocia, I intervened in the delivery by manually rotating the infant's shoulders, which was easily executed as the Plaintiff's cervix had ceased its contractions…."**

[103] Under cross-examination, Dr. Culmer stated (Transcript of Proceedings-10 November 2021 at pages 68-69 lines 22-32 and lines 14-29):

> **"Q: Can you just tell me what was the maneuver you indicated you attempted to perform?**
>
> **A: The only necessary maneuver was to just shift the shoulder slightly, and put it in the plane for delivery, that is all.**
>
> **Q: Is that the only maneuver or option?**
>
> **A: I didn't go inside to pull a shoulder out. I didn't do anything like that. All I needed to do was just rotate it slightly because it was not a problem at that stage. Sure it was in the plane that you would say okay, it is dystocia, but have you to realise to that she was not contracting like she should have been contracting normally.**
>
> **……**
>
> **Q: And Mrs. Hanna in her evidence indicated that you and the**

nurse at some point in time then occupied the position at the top, at one point you pushing, nurse attempting to press and another option was nurse pressing while you were attempting to maneuver did that happen?

A: That was because we had to rotate the shoulders. My hands are big. I don't want to go and make other incision down there because it wasn't called for. So, because my hands are big, I got her and told her what to do.

Q: Did you and the nurse swap positions. That is my question?

A: Yes, we did"

[104] Later on, during further cross-examination, Dr. Culmer was asked how long did it take from the time the head crowned to the full delivery of baby Hanna and after much effort, he stated "about 25 minutes maybe, I don't know 24 minutes".

[105] Dr. Stoopack stated that, once shoulder dystocia was recognized, Dr. Culmer should have resorted to the series of maneuvers available to him. Dr. Culmer should have immediately requested that Mrs. Hanna's legs be flexed into the McRoberts position by recruiting staff to flex both hips as far back as her abdomen as possible. Suprapubic pressure should have been provided by a staff member standing on a stool and pressing firmly above the pubic bone. If this was unsuccessful, the Woods screw maneuver should have been used. If unsuccessful, the next maneuver was for Dr. Culmer to reach into the posterior vagina to locate and deliver the posterior arm. If none of these maneuvers were successful, the last resort to be employed is the Zavanelli maneuver whereby the physician replaces the fetal head into the vagina and perform an immediate caesarean delivery.

[106] In my judgment, Dr. Culmer was negligent in the delivery of baby Hanna. Baby Hanna died of shoulder dystocia which was entirely preventable.

Negligence with respect to prenatal care

[107] Having established that the cause of death was shoulder dystocia, learned Counsel Mrs. Rolle argued that Dr. Culmer also fell below the standard of care in

his treatment of Mrs. Hanna during the prenatal care period. All experts agreed (and Mrs. Hanna asserted) that the shoulder dystocia was likely caused by unidentified GDM. I accept Dr. Stoopack's evidence that it was the failure to foresee that shoulder dystocia would be an issue during delivery and that had the domino effect. As such, the more important question is whether Dr. Culmer's failure to avoid shoulder dystocia during birth was negligent. Put differently, did he act reasonably in his care for Mrs. Hanna?

[108] In the recent decision of **Desmond Andrew Darville v Minister Responsible for Education Science & Technology and AG** 2017/CLE/gen/00377, this Court reiterated the elements necessary to prove negligence in tort at para. 49. The Court also made it clear that not every accident is actionable in negligence, as "negligence" means more than careless conduct. It properly connotes the complex concept of duty, breach and damage:

> **"[49] It is trite that to successfully prove a negligence cause of action, the plaintiff must prove that the defendant acted negligently and that such negligence caused the plaintiff's damage. <u>The plaintiff bears the burden of proving that (i) the defendant owed him a duty of care, (ii) that duty was breached and (iii) such breach caused the damage. It follows that it is not in every accident that a defendant may be negligent. As such, not every accident is actionable in negligence</u>. As Lord Wright explained in Lochgelly Iron and Coal Co. Ltd. v John McMullan [1934] AC 1 at p. 25:**
>
> > **"…in strict legal analysis, "negligence" means more than heedless or careless conduct whether in omission or commission; it properly connotes the complex concept of duty, breach and damage thereby suffered by the person to whom the duty was owing."**

[109] Now, it does not follow from the mere fact that baby Hanna died as a result of shoulder dystocia that Dr. Culmer was negligent. Mrs. Hanna is requires to prove that, in the circumstances, it was negligent for Dr. Culmer to have failed to prevent it from occurring.

[110] I accept Mrs. Hanna's evidence that she expressed concerns to Dr. Culmer about her size toward the end of the pregnancy. She had gained about 100 pounds.

[111] Mr. McCartney submitted that Dr. Culmer was not negligent in his prenatal treatment of Mrs. Hanna because he went through a series of prenatal screenings in which all the results were negative. Dr. Culmer noted that she had a family history of diabetes, hypertension, twins and epilepsy. He also noted that she had a pre-existing back and neck injury and an evacuation of her uterus from a bighted ovum and he was fully aware of her medical history and found no aggravating factors which may have called for a C-section or alternative method of delivering. He was of the opinion that Mrs. Hanna was capable of delivering her first baby by way of natural birth.

[112] With respect to GDM, Mr. McCartney submitted that Mrs. Hanna bears that burden of proving that she had suffered from GDM in the third trimester of her pregnancy as it remained the Defendants' position that she did not have GDM. Mr. McCartney next submitted that, after thorough analysis of Mrs. Hanna's blood and urine test results together with Dr. Culmer's overall observation of Mrs. Hanna's physical condition throughout her pregnancy, it was his belief that Mrs. Hanna showed no signs of GDM nor was she diagnosed with the same.

[113] Mr. McCartney also argued that the Defendants maintained that appropriate prenatal surveillance was done throughout Mrs. Hanna's pregnancy since her initial visit. According to Mr. McCartney, Mrs. Hanna was referred to Doctors Hospital to do an ultrasound during her 22nd week and she was provided with prescription prenatal vitamins, regular check-ups and testing of her blood and urine throughout the pregnancy, all of which were done in accordance with standard practice. He further argued that it was Dr. Culmer's belief that a further ultrasound in the third trimester was unnecessary since Mrs. Hanna was found to have no aggravating factors.

[114] With respect to the option of elective C-section, Mrs. Hanna has not specifically pleaded that. I agree with Mr. McCartney that she is bound by her pleadings and cannot now raise it in submissions: see **Bahamas Ferries Ltd v Charlene Rahming** SCCivApp & CAIS No. 22 of 2018, per Sir Michael Barnett, JA (as he

then was) at paras 37-40.

[115] Mrs. Rolle, in her forceful submissions, relied heavily on the 3 risk factors that were identified by Dr. Stoopack as being present in Mrs. Hanna. She submitted that it was negligent for Dr. Culmer to have not been prompted to immediately test Mrs. Hanna for GDM when he himself accepted that the family history of diabetes and BMI of over 30 are considerations for GDM. Mrs. Rolle also relied on Dr. Stoopack's evidence that Mrs. Hanna, being of African American/Caribbean ethnicity, was also a risk factor. Although Dr. Culmer refused to accept that Mrs. Hanna is of that ethnicity, the Court takes judicial notice of that fact and accepted that it is another risk factor for GDM.

[116] Undoubtedly Dr. Sakharkar is very experienced with pregnant women in the public health care system in this jurisdiction but her data and treatment of pregnant women are based on her experience at a public hospital. The Court is fully cognizant of the limitations of that system. However, in this case, the relationship between Dr. Culmer and Mrs. Hanna was a private contract. Implied in that contract as per the Bahamas Medical Council Code of Professional Conduct was a representation by the Defendants that they would:

1. Always bear in mind the obligation to respect life;

2. Act in the patient's best interest when providing medical care;

3. Owe his/her patients complete loyalty and all scientific resources available to her/her. Whenever an examination or treatment is beyond the physician's ability, he/she should consult with or refer to another physician who has the necessary ability;

4. ….provide medical care only after **adequate assessment of the patient's condition through good history and appropriate clinical examination**;

5. Base their counsel on the interest of the individual patient, regardless of the constraints of the system of care. *It is recognized that in third party payer systems, the medical practitioner is often constrained to give only cheaper treatment. This is acceptable provided the treatment is appropriate*.

[117] There is a direct conflict between the evidence of Dr. Stoopack and Dr. Sakharkar with respect to the effect of the tests that revealed sugar in Mrs. Hanna's urine. On one hand, Dr. Stoopack testified that it was very alarming and should have been conclusive or, at least, very suggestive of GDM to Dr. Culmer. On the other hand, Dr. Sakharkar's evidence was that many women have sugar in their urine and that it is no cause for concern. She stated that 50% to 60% of pregnant women in The Bahamas have spillages of sugar in their urine with no issues. I do not accept Dr. Sakharkar's generalized opinion as every pregnant woman ought to be treated differently based on her own history.

[118] It is possible that Dr. Culmer missed a diagnosis of GDM. However, **Whitehouse v Jordan** [1981] 1 All ER 287 establishes that the test for medical negligence is not whether there was a mistake in diagnosis. Whether it amounts to negligence is a question of whether the doctor acted as a reasonable and competent medical practitioner in the circumstances.

[119] I agree with Mrs. Rolle that the existence of the three risk factors ought to have caused Dr. Culmer, at the very least, to suspect GDM and order that Mrs. Hanna be screened for GDM. I am also cognizant that the OGTT test that Dr. Stoopack alluded to that should have been done, may not have been readily or practically available in The Bahamas back in 2012 but Dr. Sakharkar herself agreed that it is the best test to be done. Mrs. Hanna was a paying patient and was not relying on the public system so, at the very least, she ought to have been referred and be diagnosed for GDM. For Dr. Culmer to jocularly state that she was carrying twins suggest that he saw that she was gaining a lot of weight although I do agree with him that her stomach was expected to get bigger but he should have probe this issue further. His failure to do so, in my opinion, suggests that he was negligent and fell below the standard of care of an ordinary competent doctor holding himself out to possess the skill and competence of an OB/GYN and not a missed diagnosis. He is an experienced practitioner and has been practicing his profession for many years.

[120] Now, Mrs. Rolle argued that the failure of Dr. Culmer to do an ultrasound in the third trimester was critical and, as a reasonable OB/GYN, he should have ordered another ultrasound to be done. She asserted that his failure to do so was yet another reason why he failed to diagnose GDM, as it would have revealed the size of baby Hanna and his approximate weight.

[121] Dr. Culmer explained that an ultrasound would have made no difference as the true weight of baby Hanna could only be determined at birth. This is true. However, an ultrasound nearing delivery would have revealed the size of baby Hanna. But, Dr. Culmer stated that the size of the baby would not warrant a discussion of a C-section with Mrs. Hanna as he believed that Mrs. Hanna was capable of having a natural birth based on her overall health. He did not expound how he arrived at that belief. Dr. Sakharkar's evidence was consistent with Dr. Culmer which I also, do not accept.

[122] In my opinion, Dr. Culmer should have ordered that Mrs. Hanna do an ultrasound for fetal macrosomia. I do not believe him that he did ultrasounds in his office. In any event, as he did on the first occasion, he should have sent her to Doctors Hospital to have another ultrasound when she was nearing her delivery date. While it is true that an ultrasound would not conclusively tell a doctor the weight of the baby because that could only be achieved at birth by weighing, it certainly would have revealed baby Hanna's size and give a guesstimate of his weight. It may have also altered Dr. Culmer's opinion as to whether Mrs. Hanna was capable or not of delivery a baby by natural birth since the ultrasound would have given some indication of fetal macrosomia.

Conclusion

[123] In my judgment, Mrs. Hanna has adduced plausible evidence that Dr. Culmer fell below the standard accepted by a body of medical opinion in not delivering baby Hanna alive. When baby Hanna's head was crowned, Dr. Culmer knew that shoulder dystocia had occurred hence the reason why he resorted to shoulder rotation. But, when shoulder rotation did not work, he should have attempted the

miscellany of other maneuvers which are available knowing that time was of the essence.

[124] In addition, with a BMI of 32, a history of diabetes in her family and her African-American/Caribbean ethnicity, Mrs. Hanna's overall health suggested that she should have been tested for diabetes early in the pregnancy. She was not tested for GDM until 32.3 weeks gestational age after a random blood glucose measurement which returned elevated at 111. The 2-hour OGTT returned abnormal with an elevated fasting blood sugar of 104, the threshold in the US being 92 and in Britain 100. By all accounts, it was elevated so Mrs. Hanna had unrecognized GDM. Further, an ultrasound should have been ordered in the third trimester of her pregnancy.

[125] For all of the reasons stated above, I find that the Defendants breached the duty of care which they owed to Mrs. Hanna in both the prenatal and delivery of baby Hanna. Mrs. Hanna is therefore entitled to damages.

Damages

[126] The next issue which arises is quantum of damages. I will make an order that such damages be assessed by the Registrar.

Costs

[127] Mrs. Hanna is the successful party in this action and, as such, she is entitled to her costs to be taxed if not agreed.

Dated this 19th day of January 2023

Indra H. Charles
Senior Justice