Professional Negligence Claims against Doctors: A Shift in Duty and Standard?

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General

In negligence, the existence of the duty of care may be interlaced with questions as to the breach of the appropriate standard of care. In medical negligence, determination of the duty issue is generally non-problematic, although different courts have expressed the nature of the duty owed by doctors to their patients in different ways, with variable emphasis and injunction. Thus, for example, in Hughes v Staunton & ors, Lynch J stated:

“A doctor must always act bona fide in the best interests of his patients taking all the patient’s circumstances including family circumstances into account. He must keep reasonably up to date in his sphere of practice so that he will be in a position to give a good standard of care to the patient. There can be no excuse for any want of genuine concern for the patient much less any hint of a could not care less attitude on the part of a medical practitioner.”

The importance the court ascribes to a doctor’s attitude, as reflective of the nature and discharge of the duty, is obvious in O’Doherty v Whelan, where O’Hanlon J held that the claim that the response of the defendant general practitioner to the patient’s plea for help was neither adequate nor appropriate, in particular circumstances was made out and established a cause of action in professional negligence against the defendant. Similarly, in Daniels v Heskin, Kingsmill-Moore J, in considering the “well recognized duties” a doctor owes to his patient, stated that (s)he “must display proper care and attention in treating, or in arranging suitable treatment for, his patient.”

That said, whatever about the articulation, the existence of the duty is usually clear: the class of persons to whom the duty is owed, generally patients, is almost invariably readily identifiable. Applying the Dunne principles to the question of the standard of care, it might be thought, similarly should also be non-problematic. They are, after all, relatively clear, both as to language and underlying philosophy – at least at first blush. Their judicial application, however, has been more complex than they might at first suggest. The cases are replete, of course, with examples of their straightforward application in fairly unexceptional factual situations. Issues arise, however, in respect of the inter-relationship between the first two principles and as to the provenance of the third principle. Questions

1 Prof. Neg. L.R. 244.
2 Prof. Neg. L.R. 244.
3 Prof. Neg. L. R. 440.
4 See infra.
5 [1954] IR 73.
6 See, however, Barnett v Chelsea & Kensington Hospital Management Committee [1969] All ER
7 See, infra.
also arise as to whether or not the principles should even apply at all. In addition, despite their apparent comprehensiveness, they are not exhaustive of all considerations relevant to the determination of the standard of care.

The statement and re-statement of the principles applicable in cases of medical negligence from Bolam v Friern Hospital Management Committee through O'Donovan v Cork County Council to Dunne (a minor) v National Maternity Hospital & anor and, latterly, Bolitho v City and Hackney Health Authority, have been well described. They apply expressly to matters of diagnosis and treatment, the standard applicable to alleged non-disclosure of operative risks, in this jurisdiction, being, for a considerable time, a matter of some uncertainty, although arguably less so following the decision of the High Court in Geoghegan v Harris and the later decision of the Supreme Court in Fitzpatrick v White. Insofar as Dunne is concerned, whereas it is considered as binding precedent, on careful analysis of the judgment of Finlay CJ in the Supreme Court, it is clear that it is devoid of any analysis of the limited authority relied upon (being Daniel v Heskins, O'Donovan v Cork County Council and Reeves v Carthy & O'Kelly). That said, what is set out in Dunne is almost invariably rehearsed to a greater or lesser extent in the cases that result in a written judgment of the Superior Courts. Accordingly, it forms a useful starting point for the present discussion.

**Statement or re-statement?**

The facts of Dunne (an infant) v National Maternity Hospital & anor probably need only to be briefly recited. As a matter of policy and practice, the defendants, in the case of twin labour, only monitored one foetal heart. It was asserted on the part of the defendant hospital that the practice of seeking to identify one foetal heart only had been the practice of that hospital for 15 to 20 years at the time of the trial. The practice did not seek to identify one foetal heart only, it was a specific attempt to identify the foetal heart of the first twin, because of the extreme difficulty in obtaining what might be considered a reliable result from any attempt to monitor the second twin and the impossibility, since that twin is not the presenting twin, of carrying out further investigations on it. The clinical evidence adduced by the hospital was also to the effect that an attempt to monitor two foetal hearts could be so misleading as to be a dangerous practice. Thus, this was a standard practice in what was, at the time, the largest maternity hospital in Europe and which had outcomes for twin pregnancies comparable to hospitals which adopted a different approach. Although the practice adopted was challenged as being a “general and approved” practice, there was, in addition, evidence of its having been used elsewhere too and of its having professional support on the evidence recited in the judgment of Finlay CJ. In the instant case, however, the plaintiff was severely brain damaged and his twin brother was stillborn. On the defendants’ appeal from a jury award of damages in the sum of IR£1,039,334 (including general damages in the amount of IR£467,000.00) (Finlay CJ, for a unanimous Supreme Court, Griffin and Hederman JJ concurring), one of the principal grounds of appeal related to whether the jury, on the evidence, if properly directed as to the legal principles applicable

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8 [1957] 2 All ER 118
9 [1967] IR 173
10 [1989] IR 91
11 [1997] 4 All ER 771
12 [2000] 3 IR 536
15 [1954] IR 53
16 [1967] IR 173
17 [1984] IR 348
could have made a finding of negligence arising from failure to attempt to identify a second foetal heart. In this regard, a question of law arose on the argument as to the proper meaning and interpretation of the decision in *O'Donovan* and "in particular, to the question of the appropriate directions which a court must give to a jury or, in the case of a trial by a judge alone, must follow, where questions of medical practice arise". In allowing the appeal and ordering a re-trial (on the grounds that the trial judge had mis-directed the jury as to the proper legal test to be applied in a case such as this), what Finlay CJ stated in relation to the applicable principles merits setting out *in extenso*. He stated:

"The courts have consistently recognised certain features in the general law of negligence which have particular reference to allegations of negligence made against professional persons in the carrying out of their professional duties. These particular features applicable to allegations of medical negligence have been fully set out by this court in *O'Donovan v Cork County Council* which adopted and followed the decision of the former Supreme Court in *Daniels v Heskin*. The reasoning of *O'Donovan v Cork County Council* was expressly followed by this court in *Reeves v Carthy*. It was again approved and applied to a case of professional negligence by a solicitor in *Roche v Pielow*.

There was no argument submitted to us on the hearing of this appeal which constituted any form of challenge to the correctness of the statements of principle thus laid down, although there was controversy concerning their application to the facts of this case.

The principles thus laid down related to the issues raised in this case can in this manner be summarised.

1. The true test for establishing negligence in diagnosis or treatment on the part of a medical practitioner is whether he has been proved to be guilty of such failure as no medical practitioner of equal specialist or general status and skill would be guilty of if acting with ordinary care.

2. If the allegation of negligence against a medical practitioner is based on proof that he deviated from a general and approved practice, that will not establish negligence unless it is also proved that the course he did take was one which no medical practitioner of like specialisation and skill would have followed had he been taking the ordinary care required from a person of his qualifications.

3. If a medical practitioner charged with negligence defends his conduct by establishing that he followed a practice which was general, and which was approved of by his colleagues of similar specialisation and skill, he cannot escape liability if in reply the plaintiff establishes that such practice has inherent defects which ought to be obvious to any person giving the matter due consideration.

4. An honest difference of opinion between doctors as to which is the better of two ways of treating a patient does not provide any ground for leaving a question to the jury as to whether a person who has followed one course rather than the other has been negligent.

5. It is not for a jury (or for a judge) to decide which of two alternative courses of treatment is in their (or his) opinion preferable, but their (or
his) function is merely to decide whether the course of treatment followed, on the evidence, complied with careful conduct of a medical practitioner of like specialisation and skill to that professed by the defendant.

6. If there is an issue of fact, the determination of which is necessary for the decision as to whether a particular medical practice is or is not general and approved within the meaning of these principles, that issue must in a trial held with a jury be left to the determination of the jury.

In order to make these general principles readily applicable to the facts of this case, with which I will later be dealing, it is necessary to state further conclusions not expressly referred to in the cases above mentioned. These are:

(a) ‘General and approved practice’ need not be universal but must be approved of and adhered to by a substantial number of reputable practitioners holding the relevant specialist or general qualifications.

(b) Though treatment only is referred to in some of these statements of principle, they must apply in identical fashion to questions of diagnosis.

(c) In an action against a hospital where allegations are made of negligence against the medical administrators on the basis of a claim that practices and procedures laid down by them for the carrying out of treatment or diagnosis by medical or nursing staff were defective, their conduct is to be tested in accordance with the legal principles which would apply if they had personally carried out such treatment or diagnosis in accordance with such practice or procedure.

In order fully to understand these principles and their application to any particular set of facts, it is, I believe, helpful to set out certain broad parameters which would appear to underlie their establishment.

The development of medical science and the supreme importance of that development to humanity makes it particularly undesirable and inconsistent with the common good that doctors should be obliged to carry out their professional duties under frequent threat of unsustainable legal claims.

The complete dependence of patients on the skill and care of their medical attendants and the gravity from their point of view of a failure in such care, makes it undesirable and unjustifiable to accept as a matter of law a lax or permissive standard of care for the purpose of assessing what is and is not medical negligence.

In developing the legal principles outlined and in applying them to the facts of each individual case, the courts must constantly seek to give equal regard to both of these considerations.”

_Dunne_ is the case that sets out the principles to be applied in all subsequent cases involving allegations of medical negligence. However, it might be considered remarkable that, although it is a case of central importance in professional negligence, as already noted, it is

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24 Sometimes characterised as ‘a responsible body of medical men’ or ‘a competent reasonable body of opinion’ (see: _Bolam v Friern Hospital Management Committee_ [1957] 2 All ER 118 at 122, [1957] 1 WLR 583 at 587-588), or a ‘respectable body of professional opinion’ (see: _Maynard v West Midlands Regional Health Authority_ [1985] 1 All ER 635 at 639, [1984] 1 WLR 634 at 639, per Lord Scarman).

25 In relation to these broad parameters outlined by Finlay CJ as underlining the establishment of the principles enunciated, see, _infra_.

26 [1989] IR 91 at 108-110. The principles, as set out, were expressed to apply not alone to treatment but also to diagnosis, but the appropriate standard to be applied in cases of disclosure (and, thus, consent) was not considered.
frankly devoid of any analysis of the limited authority that is relied upon. No authority other than Daniels, O’Donovan and Reeves (and to a peripheral extent, Roche v Peilow) is even mentioned in this regard. In addition, the assertion that “[t]he courts have consistently recognised certain features in the general law of negligence which have particular reference to allegations of negligence made against professional persons in the carrying out of their professional duties” while generally true does not fully articulate the more general propositions set out in Daniels or, indeed, in O’Donovan, and is wholly unattributed.  

Whatever about that general proposition, however, the “particular features” applicable to cases of medical negligence, although considered by the Supreme Court in O’Donovan, it is not the case that they were “fully” set out. Similarly, the assertion that the reasoning of O’Donovan was “expressly” followed in Reeves, overstates the significance of that decision. The decision in Reeves - in which Hederman J agreed with O’Higgins CJ and Griffin J gave a separate judgment and both of whom agreed with Finlay CJ in Dunne - again, is really only concerned with what occurs where there is deviation from a “general and approved” practice.

Secondly, it might be noted that, in Dunne, Finlay CJ noted that no challenge to the correctness of the statements of principle laid down in the earlier cases was made (although there was controversy concerning their application to the facts of the case). This, too, is probably unremarkable, given one of the central conclusions on appeal – which again related to the question of the existence of, or deviation from, a “general and approved” practice.

Thirdly, not alone from this passage, but also when considering whether or not the trial judge’s charge to the jury had been deficient, it seems clear that Finlay CJ considered that he was merely re-stating the principles which had already been laid down in O’Donovan. Thus, he was not seeking to add anything further to what O’Donovan stated. That was the ostensible touchstone.

On his analysis of the evidence in relation to the monitoring of the foetal heartbeat, Finlay CJ considered that part of the plaintiff’s case was that the defendants each deviated “from a practice generally adopted and approved by both the medical administrators of maternity hospitals and by consultant obstetricians”. It was also equally clear to him that part of the defendants’ case was that in seeking to identify one foetal heart only they were following a practice which was “general and approved” within the meaning of that expression as he had interpreted it and that there was evidence to go to the jury in relation to each contention.

He then continued:

> “Having regard to these conclusions [i.e. that there was evidence to go to the jury], I am satisfied that if the jury found that the defendants had deviated from a general and approved practice then, having regard to the

27 Geoghegan J in Patton v Griffin & anor. [2004] IESC 46 noted that “[t]he principles established from the unchallenged case law at that time . . . .” were set out in Dunne.

28 Although O’Donovan did adopt the decision of the former Supreme Court in Daniels, it was limited to consideration of – and essentially followed really only in relation to - the question of an “honest difference of opinion” between doctors. It did not consider such differences in approach as there were between the different judgments. Lavery J, in that case, cited Hunter but there are dicta in his judgment not wholly consistent with it. Walsh J, for the majority, although it had been cited by Lavery J, did not refer to Hunter at all.

29 Reeves was limited to part only of what O’Donovan actually said.

30 In this case, in relation to the monitoring of the foetal heartbeat in a twin labour without apparent complication.

opinions expressed by [expert witnesses for the plaintiff] it would have been open to the jury if it accepted those opinions, to hold that the course being
taken by the defendants was one which no hospital and/or consultant obstetrician of ordinary skill would, acting with due care, have followed.

If, on the other hand, the jury were to find that the defendants had followed a "general and approved practice" they could still have found that they were negligent if, having accepted the opinions of [expert witnesses for the plaintiff], they concluded from them that the practice was one which had inherent defects which ought to have been obvious to any maternity hospital, medical administrator or to any consultant obstetrician giving the matter due consideration.32

He was, accordingly, satisfied that on the evidence the jury could, if properly directed, have found both defendants negligent arising from their failure to attempt to identify a second foetal heart. The inadequacy in the charge to the jury consisted in the trial judge’s failure expressly to point out two matters which Finlay CJ articulated as follows:

"1. That if they concluded that there was a general and approved practice of monitoring two foetal hearts from which the defendants deviated, that they should not find that the defendants were negligent unless they also concluded that no hospital medical administrator or no consultant obstetrician would have so deviated if he were taking the appropriate ordinary care.

2. That if they concluded that the monitoring of one foetal heart was a "general and approved practice" that they could not find the defendants were negligent unless they also concluded that it was a practice which had inherent defects which should have been obvious on due consideration to a hospital medical administrator or to a consultant obstetrician."

For Finlay CJ, the omission in the charge was not "merely a failure to use a particular phrase or set of words but is a failure specifically to draw to the attention of the jury the legal principles applicable to the determination of cases of medical negligence and the standards by which they must judge them".34

The principles are well-known, if applied (insofar as the first and second principles are concerned) in a manner, the underlying logic of which may be difficult to determine. However, there are two cases within the past 18 months or so which significantly call into question the general applicability of the principles, and how the duty of care is to be assessed. Both involve birth injuries to women, and are discussed next.

**Obstetric Interventions: Symphysiotomy** – an old procedure with many survivors

Symphysiotomy, a procedure in which the symphysis pubis (or the joint between the front of a woman’s pubic bones) is split, to widen the pelvis to facilitate delivery of a baby’s head, was at the centre of a series of cases *sub nom* Kearney v McQuillan. The question of liability for symphysiotomy in certain cases (so-called, “on the way out”, i.e. after prior caesarean section) was finally settled by the Supreme Court in *Kearney v McQuillan*,35 the first of these actions to proceed to trial, where McMenamin J gave judgment for a unanimous Supreme

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33 [1989] IR 91 at 117.
34 [1989] IR 91 at 117.
35 [2012] IESC 43
Court (Denham CJ, Hardiman, Fennelly, Clarke & MacMenamin JJ). So, too, was the tariff for quantum. In addition, it also appears to settle the liability issue in a range of other cases, not those merely "on the way out". The odyssey involved warrants setting out in summary form, as follows.

The plaintiff underwent a symphysiotomy in 1969, just after the birth of her first, and only, child by caesarean section. She was 18 years old at the time. Proceedings did not issue until May 2004, some 35 years later. Her case was that she was unaware of what had occurred to her until 2002 when she heard a radio broadcast on the subject, and realised, from the symptoms described and her symptoms, that her obstetrician must have carried out such a procedure on her. Her claim was dismissed, on the ground of delay, in 2006 (Kearney v McQuillan & anor). The Supreme Court allowed the plaintiff's appeal, in March 2010 (Kearney v McQuillan & anor.) on one narrow ground: that the procedure was unjustified and improper, even having regard to the conditions, circumstances and standards prevailing in this country at the relevant time. In other words, the second Dunne principle applied. In such circumstances, the court considered that there was no enduring prejudice because of the death of the operator or non-availability of other witnesses at the trial, which then proceeded before Ryan J (Kearney v McQuillan).

Evidence adduced by the defendant, at trial, was to the effect that the only possible justification for symphysiotomy was "absolute disproportion", i.e. that the baby's head was too large to pass through the mother's pelvis. In this case, it was performed "on the way out". Ryan J observed that the plaintiff's medical records did not evidence any justification for the procedure; critically, he found that there was no indication of obstruction or pelvic deformity, the caesarean section had, in fact, been carried out because of failure to progress and persistent occipito-posterior (POP) position, there was no evidence of disproportion and not the slightest indication to suggest absolute disproportion, even on the defendant's expert evidence. He held that the operator had embarked on an elective procedure: by the time of the symphysiotomy, the baby had already been delivered and, thus, there could be no justification for it to facilitate the birth. In the absence of absolute disproportion there was no indication that it was justified at all. Furthermore, he found that there was no evidence to indicate that the plaintiff, in future pregnancies, might have encountered disproportion and POP was unlikely in a second or subsequent pregnancy. By way of observation, it might be noted that this last point does not appear to be of any particular relevance, in the circumstances, unless to ground the finding that, accordingly, there was no basis for inferring that future caesarean sections might be necessary or that the plaintiff would not go to full normal delivery in later pregnancies. In any event, the plaintiff's pelvic x-rays were normal. There was, therefore, no objective medical basis for what was done. Ryan J was also satisfied that relative disproportion would be an insufficient basis, for the procedure, in this case. This later observation, although obiter, it might be noted, as already indicated, significantly expands the scope of liability.

Thus, at first instance, being satisfied that the procedure was, in the circumstances, unnecessary, Ryan J awarded general damages in the amount of €450,000. The defendant appealed both liability and quantum.

A unanimous Supreme Court agreed that there was no evidence sufficient to justify symphysiotomy in this case and that it was proper to conclude that no other practitioner of

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36 [2006] IEHC 186, Dunne J
38 [2012] IEHC 127
equal specialist knowledge or of equal status or skill would have carried out the procedure in
the circumstances, if taking ordinary care. Insofar as there was a general and approved
practice, in that regard, which, the defendant maintained, provided a sufficient defence to
what had occurred, McMenamin J (for the Court) was not satisfied that the evidence
established “that the practice of symphysiotomy was sufficiently general by 1969, or
generally approved by colleagues of a similar specialisation and skill to warrant this
operation.” On the evidence, as recited in the judgments, however, this is uncertain. Be that
as it may, he continued: “The position was, rather, that there were adherents of a school of
thought which considered it justifiable in certain circumstances.” But that acknowledges the
existence of a general and approved practice, albeit in “certain circumstances”. The question
of whether or not there was a general and approved practice was, perhaps, academic (if
even that) having regard to the primary findings made in the High Court and endorsed on
appeal. On the facts established, there was no clinical indication for the procedure;
accordingly, the assertion that it was “deeply and fundamentally flawed in a way which
should have been obvious to any doctor of similar skill or specialisation”, which seems to
import the third Dunne principle is otiose. It is far from clear that this was the “second
aspect” of the defence.

The Court acknowledged that “the threshold of proof set for the defendant was relatively
low”, an observation that applies in all cases alleging medical negligence. Even at that,
however, it was not met and the plaintiff was entitled to succeed on liability.

As to quantum, general damages in the amount of €450,000 (€300,000 for pain and
suffering to date and €150,000 into the future), the Court considered the decisions of the
Supreme Court in MM v SN (damages), 39 and Sinnott v Quinnsworth, 40 and the decisions of
the High Court in Yang Yun v MIBI & anor 41 and JR v Minister for Health & Children. 42
McMenamin J stated:

“It is important in this context to recollect, particularly at this time, those
criteria of social conditions and common good. These are not just empty
words. The resources of society are finite. Each award of damages for
personal injuries in the courts may be reflected in increased insurance costs,
taxation, or, perhaps, a reduction in some social service. We are living in a
time where ordinary people often find it difficult to make ends meet. The
weight to be given to each of these factors must always be a consideration in
the balance.”

He then continued:

“Against this, one must consider the human situation of a young 18 year old
mother who entrusted her own care, and that of her child, to [her
obstetrician]. The Constitution identifies rights which are to be protected and
vindicated because they belong to each human person because of their very
humanity. Among the values which have been recognised by the Courts are
human dignity, bodily integrity, and autonomy, that is the capacity to make
informed decisions affecting one’s own health. The duty to protect those
rights is not confined to the Courts. Each health professional is, and was
always, under a similar duty. Although the finding of the Court is founded in

39 [2005] 4 IR 461
40 [1984] ILRM 523
41 [2009] IEHC 318 (Quirke J)
42 (unreported, High Court (Irvine J) 24/02/11
negligence, what happened here was a betrayal of trust; it was an invasion and violation of the rights just identified; it was the gravest kind of negligence. The determinations of both the High Court and this Court on the liability issue, on the facts of this particular case, are a vindication of Mrs. Kearney’s decision to pursue matters. As even the comparisons between Mrs. Kearney’s case and others in the hospital show, however, the circumstances of each case before the courts may differ, even if there are apparent similarities between cases on a superficial analysis.”

The potential import and weight of this statement merit some examination. In the reference to Constitutional rights, is the Supreme Court impliedly asserting that the remedy to be afforded, in a case such as this, is in part, attributable to their violation? If so, this is difficult to reconcile with a long line of authority cautioning against the constitutionalisation of tort (see, for example, *Hanrahan v Merck, Sharp & Dohme (Ireland) Ltd.* 43 In addition, there appears to be some philosophical inconsistency in the characterisation of the constitutional “values” (non-exhaustively) identified. What is constitutionally required is respect for human dignity and individual autonomy. Unlike, a bodily integrity, they are not, of themselves, rights, as properly understood (although see, for example, *In the matter of A Ward of Court (withholding medical treatment) (No. 2)* 44). Capacity to make decisions about one’s own health, of course, may be circumscribed, in a variety of circumstances, but it is bound up with the exercise of constitutional rights identified in Article 40.3 (the precise right being of somewhat academic relevance, but not confined to bodily integrity (in this context, too, see *In the matter of A Ward of Court (withholding medical treatment) (No. 2)* 45) and, looked at from a more general philosophical perspective, predicated on respect for human dignity and respect for individual autonomy. They are not, however, the same thing.

Be that as it may, the assertion that health professionals are, and always were, under a duty to protect patients’ constitutional rights merits noting. Accordingly, it now appears, mere respect for such rights is not (and never was) sufficient. That being so, what are the parameters of the duty? Are they co-extensive with those of the courts? Is the remedy for failing to protect them *sui generis* or still rooted in tort principles? How is this to be distinguished from negligence *simpliciter*?

That said, why what occurred in this case, was characterised as the “gravest kind” of negligence is not clear from the next following passage. What is negligence of the “gravest kind”? Does it differ from gross negligence, and, if so, in what way? Or is it a new species and, if so, what are its defining characteristics? How can it be identified? Is “betrayal of trust” an essential component? In many professional negligence actions, there is a betrayal of trust, in the ordinary sense of that expression. But, is more required here? Must there be, in fact, some deliberate, intentional or reckless act? It must be recalled that this case was allowed to proceed on a very narrow negligence ground only, trespass having been initially relied upon but, in the reformulated claim following the Supreme Court appeal in 2010, abandoned. Whatever about limitation questions that might have arisen, in that regard, the implicit acceptance that there was no consent whatsoever for the symphysiotomy (irrespective of the standards of the time which were not considered – in this context, the comments of both Lavery J and Kingsmill-Moore J in *Daniels v Heskin* 46 merit consideration) would, on ordinary principles, justify a finding of liability in trespass. Is it this that

43 [1988] 1 I.L.R.M. 629
44 [1996] 2 IR 100 per Denham J (as she then was) at 163
45 [1996] 2 IR 100 at 126 (per Hamilton CJ), at 130 per O’Flaherty J and at 163-4 (per Denham J, as she then was).
46 [1954] IR 73
constitutes the “betrayal of trust”? Insofar as there was “an invasion and violation of [constitutional] rights” is this, too, or in the alternative, a necessary component and, if so, must it be deliberate and conscious, as in other cases? Even if there is such a violation, can that alter the remedy – or the head of claim – where the tort law appears to afford sufficient remedy, having regard to Supreme Court decisions on point? These issues, in what might otherwise be considered to be a straightforward professional negligence case, raise questions for broader consideration; but it is difficult to discern why it was considered necessary to raise them, in the first instance. Regarding them as a herald of a more expansive approach to professional negligence actions is, however, probably unwarranted, having regard to the reluctance of our superior courts to expand the frontiers or parameters of liability in tort since the decision of the Supreme Court in *Glencar & anor. v Mayo County Council*, and the anti-plaintiff thrust of the Personal Injuries Assessment Board Acts 2003 and 2007 and the Civil Liability and Courts Act 2004. How these matters will be addressed by our courts, in the future, remains to be seen.

Finally, the provenance of the last sentence in this passage is somewhat unclear, other than as a generic statement.

Another view is that the whole passage reflects the vindicatory nature of tort proceedings (see, for example, *Grant v Roche Products*) but, if so, its insertion into a consideration of quantification of damages might be considered puzzling, an assessment that might also be said to apply to the foregoing comments.

McMenamin J concluded (at paras 33 - 34):

“What was done to her was entirely unjustified and unwarranted. It was wrong even by the standards of time. While the liability must be assessed by those standards; the damages issue, that is, the effect on [the plaintiff], may be seen with the benefit of hindsight.

It is very difficult now to understand the thinking where some obstetricians considered it appropriate to embark on this highly invasive and painful procedure so as to avoid the possibility of successive caesarean sections which might perhaps result in a patient opting for sterilisation. By today’s standards the reasoning behind such an approach can only be seen as almost unfathomable. But even by reference to the standards then current, the procedure . . . [carried] out . . . had no justification whatever”.

The defendant did not lead any evidence on damage. The plaintiff’s evidence was that, in addition to various ongoing physical effects, she suffered an acute stress disorder arising from her discovery, in 2002, of what had been done to her. Despite those ongoing physical effects – which were not minor in nature – she had managed to work on an ongoing basis for the previous 25 years. McMenamin J considering the requirement to balance the psychiatric evidence against the objectively discernible facts regarding the plaintiff’s own life did not think (at para 42) that the High Court had “sufficiently weighed the mitigating factors on the damages issue”. Nor did he consider that dividing the award into past and future pain and suffering (although often appropriate) was appropriate on the facts of the case. A very substantial period separated the events complained of and trial and, accordingly, the Court had the advantage of an “entire perspective of the nature and

48 See, for example, the comments of Kearns J in *O’Donnell v. McEntee & anor* [2009] IEHC 563 and *Lackey v Kavanagh* [2012] IEHC 276 (at para 20).
duration of the plaintiff’s injuries and their effects over a total period of 33 years”. While not underestimating the very serious nature of the injuries the plaintiff had suffered, and their effects, McMenamin J was of the view that they fell short of those in catastrophic injury cases and substituted an award of general damages in the amount of €325,000.

So much, accordingly, for the duty question. What about the standard of care? Dunne is not the last word, and medicine has moved on since February 1982, when the events complained of occurred. Ought not the law, accordingly, take those developments into account? This arose for consideration in the next following case, a decision of Charleton J.

Birth Injury: Mother’s Claim

By way of preliminary comment, it might not be considered usual for regard to be had to the PIAB Book of Quantum in assessing damages for injuries in a medical negligence action, given that the injuries are generally at the more serious end of the scale, and often complex. However, in *HM v HSE* Charleton J did have regard to it, in a distressing birth injury case, again with an endorsement redolent of what he stated in *O’Brien v Derwin & anor.*

Here, the plaintiff suffered a third degree perineal tear during the course of an instrumental delivery – with forceps – of her first child, because of foetal distress. Negligence was alleged in the management of the labour, its augmentation with oxytocin, the angle at which an episiotomy was made, the occurrence of the tear and the diagnosis and repair of the anal sphincter injury.

Charleton J made a number of initial observations as to the standard of care which merit noting, in passing, before proceeding to deal with the outcome. The first observation is generic, but stresses institutional liability – in a manner somewhat different from *Dunne* (on which he expressly relied) – and which assumed particular importance in the case. He noted that the plaintiff was

> “entitled to a standard of care commensurate with a careful and competent system of the medical management of childbirth . . . a standard of care commensurate with that which could be given by a careful and competent midwife and a careful and competent obstetrician and gynaecologist. The hospital system within which these medical people operated is also required to be such that it supports the competence and level of professional expertise that attends a busy maternity unit. Those professionals attending women in childbirth are entitled to the support which proper hospital administration provides to the professionals working within that system.”

The second is of some importance, clear judicial approbation of professional guidelines and (almost reflexive) incorporation into the assessment of what the appropriate standard of care, virtually a declaration of equipollence. In this case, the particular guidelines in question were those of the RCOG on the management of third and fourth degree perineal tears. As to institutional liability, in this regard, Charleton J stated:

> “Ordinary care by a hospital which has a maternity unit would require, in my view, a meeting proximate to the issue of the guidelines and a presentation

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50 [2011] IEHC 339
51 [2009] IEHC 2
and explanation. The issues set out in the guidelines are of critical importance to the avoidance of anal injury. The incidence of this problem places it as highly important. This important document should have been made available by the hospital to its staff at registrar, senior registrar and consultant level. In the alternative the guidelines might have been circulated by the hospital, over a computer system or manually by envelope.

In the instant case, this was not done. He continued:

“Circulating guidelines on a statistically commonly occurring injury to women to doctors involved in childbirth in a maternity unit is ordinary care in the management of such a unit. These guidelines were brought into common practice by the hospital in the calendar year following this incident. There was no reason given in evidence as to why there should have been such a delay. In my view, these guidelines are perfectly clear . . . .”

As to liability more generally, he stated:

“Whereas it has been argued that guidelines have the status of advice, I am convinced from all of the evidence I have heard that the implementation of these guidelines is essential in order to avoid the distressing condition that may result in the event that women are left improperly diagnosed and treated after an anal tear. I do not accept that the guidelines were so new or so radical that they required a period of analysis, or trial, before acceptance. Even had they so required, my view is that the very important guidelines which emerged in July 2001 should have been in place by at least the time of the delivery by the plaintiff of her son on the 1st October 2001.”

This should be regarded as a herald, at least insofar as evidence-based professional guidance is concerned.

As to the facts, having regard to the conflicting opinion evidence, Charlton J was not convinced as a probability that the earlier stopping of oxytocin augmentation of the plaintiff’s labour (which, it was alleged, led to the necessity for instrumental delivery and, hence the perineal tear) would have made a substantial difference. He considered it probable that at a later stage in the labour instrumental delivery would have been necessary in any event.

Although it was alleged that the episiotomy was performed before the forceps were applied – which may have increased the likelihood of damage and so clearly departs from standard practice that it would provide some evidence of want of care – it was not accepted by Charlton J, on the evidence.

On the basis that the risk of anal sphincter injury is minimised by a mediolateral episiotomy at an angle of 45° to the midline, its being alleged that the angle was too acute, in the instant case, he stated:

“It is highly likely that the episiotomy . . . . was effected with the intention of achieving a 45° angle to the midline. In approaching this task, at a time when a baby requires to be rescued, and in circumstances where the perineum is distended, some measure of appreciation is required. The standard required is that which is appropriate in the circumstances.”
However, on the evidence he was not satisfied that he could find in favour of the plaintiff in respect of this allegation. Insofar as the repair of the injury, once it had occurred, was concerned, Charlton J noted the evidence that proper repair was important and stated: “I do not regard this as being novel science but as ordinary sense”. He was satisfied that the treating gynaecologist – a member of the Royal College of Obstetricians and Gynaecologists – did what the hospital required her do at that time. However, the issue was whether or not that was the correct approach. Concluding that the plaintiff had suffered a type 3B perineal tear, and not a relatively minor tear as described at the time, Charlton J observed that the issue of misdescription (or, perhaps more correctly, misdiagnosis) was “not necessarily determinative of liability”. As to liability, which he considered to be institutional, he said:

“The attending doctor described the injury that she thought she saw in accordance with the current hospital procedures. If the plaintiff had been treated under correct hospital procedures, in place through appropriate measures from 2002, I am convinced the description would have been more reliable and the repair under general or regional anaesthetic much more suitable . . .

What is clearly established in the evidence is that the hospital should have had in place procedures whereby the guidelines would be followed in appropriate cases. This is clearly one of the appropriate cases. Had the hospital appropriate procedures or had it disseminated appropriate information, the plaintiff would and should have been immediately brought to theatre and an assistant would have been sought. Proper lighting would then have been available. In addition it is clearly established on the evidence that general or regional anaesthesia was necessary. The emphasis in the evidence on the fact that anaesthesia had already been provided for the purposes of childbirth, and the cutting of the episiotomy scar, is a complete irrelevancy. The purpose of regional or general anaesthesia is to relax the muscle so that the torn ends of the anal sphincter may be identified, brought together, and repaired. Regrettably, this was not done. The result is that the anal sphincter of the plaintiff is compromised. The responsibility, in that regard, attaches to the defendant hospital in the management and organisation of a busy maternity unit. Ordinary care demands that such a unit be kept reasonably up to date in important thinking in medical science. Since these guidelines were extremely important, involving a commonly occurring injury, and making practical and difficult to dispute suggestions, they should have been implemented. At the very least the hospital should have ensured that they were discussed between the hospital staff or the subject of a circular by electronic or paper means. Instead, the entirety of the evidence convinces me that the hospital did not expect to deal with anal injuries in this way and had no procedures in place in its busy maternity unit to which [the doctor] could reasonably have been expected to turn. That is a fault in hospital management and not in the individual doctor. In 2002, however, as I understand it, the guidelines were implemented. Had the guidelines been implemented in 2001, the year prior to that, it is clear on the evidence that a better outcome, with a probability of no compromise to the anus, would have been established. It is also clear that as soon as the guidelines were implemented by the hospital that [the doctor] would have followed them.”

Causation, on the evidence, was, accordingly, non-problematic. He considered that sphincter injury exceeded 15%: endoanal ultrasound demonstrated no involvement of the internal
anal sphincter, a defect in the mid-anal canal region, no ascertainable defect in the puborectalis and a defect in the low anal canal, its being established on the evidence as probable that the defect in the anus was such as to be capable of causing the plaintiff's symptoms. Charlton J did not accept, on the evidence, that the cause of the plaintiff's problems was pudendal nerve neuropathy, an unfortunate, non-negligently caused consequence of some deliveries, with a prolonged second stage and instrumentation: he was satisfied that relevant nerve conduction studies were not “not sufficiently definitive” in the context of the other evidence (of recovery of sphincter tone with physiotherapy). Nor was he satisfied, on his assessment of the plaintiff's evidence, that she was statute barred.

As to damages, special damages of €2,400 were proved. In addition, he allowed €5,000 for future psychotherapeutic intervention, which he was satisfied was a reasonable sum and on the evidence was necessary. He continued:

"I have had regard to the Personal Injuries Assessments Board Book of Quantum. The High Court always finds this work to be useful in the sense that it gives a foundation set in 2004 as to the measure of compensation for particular injuries. With rapid deflation since September 2008, these figures have again returned to keen relevance. For temporary bowel issues, figures are given as between €40,900 and €50,300. For serious and permanent bowel conditions, the latter contemplating a permanent, as opposed to a reversible, colostomy, the figures mentioned are between €51,500 and €113,000. It seems to me that the plaintiff is toward the middle end of that range. Psychosexual problems have also to be taken into account. I am convinced, however, that with the allowance for psychotherapy these will improve considerably."

General damages of €40,000 to date and €40,000 into the future were awarded.

Whatever about the facts of the case, the approach to the determination of the standard of care – importing aspects of ordinary and professional negligence principles – should, it might reasonably be asserted, not be discounted, having regard to the embedding of evidence based practice – as distinct from opinion evidence – in clinical care.