Neutral Citation Number: [2012] IEHC 529

THE HIGH COURT

[2009 No. 8408 P]

BETWEEN

CYNTHIA KINSELLA

PLAINTIFF

AND

DR. GERRY RAFFERTY

DEFENDANT

JUDGMENT of O'Neill J. delivered on the 7th day of December, 2012

1. The plaintiff in this case sues the defendant for negligence and breach of duty in the carrying out by the defendant of a Total Abdominal Hysterectomy on the plaintiff on 7th April, 2008.

2. The plaintiff is a married woman born in 1960. She had been married to her husband, Austin, since 1986. They have no children. Since she left school at the age of 18, having done her Leaving Certificate, the plaintiff has always been in employment in secretarial/personal assistant-type work, and for ten years prior to 2008, she was employed by Delap Waller, a well-known firm of consulting engineers. The plaintiff was part of a pool of five secretaries but had seniority amongst these. This employment was terminated by redundancy in November 2008. The plaintiff has not worked since. The plaintiff's husband is employed in the drinks industry as a sales representative.

3. The defendant is a consultant Obstetrician and Gynaecologist in Mount Carmel Hospital in Dublin.

4. For a number of years prior to April 2008, the plaintiff suffered from very serious menorrhagia. In the year leading up to April 2008, she consulted her General Practitioner, Dr. Bill Toomey. Initially, medication was prescribed but this gave no sustained relief. Blood tests show that the plaintiff's haemoglobin was very low at 5.6, way below the normal range of 11 to 15. Although the plaintiff was able to maintain her lifestyle, and in particular, lost no time from work, she did suffer from exhaustion, the hallmark symptom of her complaint.

5. In due course, she was referred to the defendant by Dr. Toomey and first saw him on 24th September, 2007. He discussed the problem in detail with her. The plaintiff was anxious not to have a hysterectomy and so all possible avenues of treatment were considered. Medication [and Minerva] had been tried and failed. Embolisation, a fairly novel treatment, was discussed, but declined by the plaintiff and that left as the only solution, a hysterectomy. Before that was settled upon, the plaintiff was admitted to Mount Carmel Hospital for a D&C. This procedure was not considered as the solution, but rather, as a pre-hysterectomy exploration. This procedure had three outcomes. In the first instance, it demonstrated that the plaintiff's uterus was enlarged to the size of a 12 to 14-week pregnancy by the presence of fibroids, the root cause of the plaintiff's bleeding problem, and it also established that a vaginal hysterectomy was not possible. Tests carried out on the material recovered in the D&C demonstrated that there was no sinister or malign disease present, no doubt, in itself, a reassuring outcome for the plaintiff.

6. In the light of all of the foregoing, the plaintiff decided to go ahead with the hysterectomy and this was arranged to take place in Mount Carmel Hospital in early April 2008. The plaintiff, because she had no alternative to solve her bleeding problem, accommodated herself well to having a hysterectomy in spite of her original unwillingness to have it. In preparation for the operation, she lost two stone in weight.

7. The plaintiff was admitted to Mount Carmel Hospital on 6th April 2008. She was transfused blood in advance of the surgery next day. The operation was carried out by the defendant on 7th April 2008, commencing at 5.23pm, the precise point in time when the initial incision was made. The operation lasted for one hour and seven minutes. The operation note made by the defendant when the procedure was over is accepted by the defendant and all the experts who gave evidence as wanting in detail and inadequate. It does record that difficulty was encountered but does not specify what that difficulty was. In his evidence, the defendant gave a very detailed account of precisely what was done in the procedure, and as part of that, his evidence was that the difficulty referred to in the operation note occurred during the process of dissecting the bladder off the uterus in the early phase of the operation before the subtotal hysterectomy was done, namely, before the body of the uterus was removed.

8. The plaintiff had no prior complicating pathologies such as scarring from previous surgery, in particular, a C-section or Endometriosis, so that it was to be expected that the connective tissue between the bladder and the uterus would separate easily once the right plane of dissection was found. This was not how the defendant described his experience in this dissection. His evidence was that he found the dissection difficult, resulting from the distortion of the plaintiff's uterus due to the fibroids which rendered the exterior surface of the uterus where it met the bladder very uneven or lumpy. Notwithstanding the fact that there was no adhesion between these two organs, he found it difficult to find and follow a straight path of dissection, and it was necessary for him to carefully negotiate his way around the humps and hallows of the external wall of the uterus. In due course, this aspect of the operation was successfully accomplished without causing any injury to the bladder, but because of the difficulty, as described, it took somewhat longer than might have been expected. It was clear from the evidence of the defendant that he did not encounter any adherence between the uterus and the bladder as might have been the case if the plaintiff had scar tissue from previous surgery in the area, or had Endometriosis. The difficulty experienced came solely from the distortion of the anatomy of the uterus caused by the fibroids.

9. The defendant's evidence was that he completed the dissection of the bladder away from the uterus down to the cervix level. Having established his first two pedicles, namely, dissected the fallopian tubes and uterine arteries and closed these off, he then excised the body of the uterus from the cervix. The removal of the bulky uterus then opened up, visually, the field of surgery for the rest of the procedure. This involved some minor additional dissection of the bladder from the cervix and vagina described by the defendant as scoring rather than dissection. Then the third pedicle was established. After that, the defendant made an incision in the

wall of the vagina and, used two clamps to secure the ends of the vagina.

10. He then removed the cervix by circumcising it at the top of the vagina. The next step in the operation was to use sutures, to stop any bleeding where the cervix was removed and at the same time to close off the vault of the vagina. This, the defendant described, is akin to the lacing on a rugby ball with the sutures running along the top from end to end. His evidence was that he started to suture from the point furthest away from himself and sutured towards himself. At this time, his evidence was that the bladder had been safely reflected down below the top of the vagina and was held out of harm's way by a Deavers retractor which was held in position by the nurse who was assisting him.

11. As he sutured, he introduced the needle to the anterior side of the vagina so that he could see what it was entering, and specifically, that it did not encroach into the bladder. He used a continuous running suture which, at each suture, looped into the previous suture. This had the effect of preventing the line of the suture when pulled tight, puckering up like the opening of a drawstring purse, thus, not interfering with vaginal function. The continuous suture was tied or secured with a knot at both ends.

12. Because of the difficulty encountered in the dissection of the bladder off the uterus, the defendant, in his evidence, said he decided to fill up the bladder with 300mls of saline solution so that he could see and feel that the plaintiff's anatomy after the procedure was exactly as it should be. He said he did this, not because he suspected he had injured the bladder, but simply as a cautious and careful step to reassure that all was in order.

13. With the bladder full, his evidence was that he could see the entire line of the sutures and could see that it did not incorporate the bladder and he could, with his hand behind the bladder, feel that the bladder was not tethered to the vault of the vagina by a misplaced suture. He then used swabs to demonstrate that there was no bleeding.

14. Having done all that, he was satisfied that the procedure had been successfully completed and he proceeded to close up the plaintiff's abdomen, leaving the catheter that had been there during the operation in place. In his operation note, he instructed that this should be left in place until draining clear urine.

15. The nursing notes reveal that in the hours after the operation, bloodstained urine was drained. By 9.00am the next day, namely, 14 hours after the operation was completed, the catheter was draining clear urine and was removed later that morning.

16. Evidence was given by the nurses who attended the plaintiff, whose evidence was that the nursing note only disclosed bloodstained urine during that 14-hour period and not frank haematuria. Had this been present, it was said it would have been noted.

17. Post-operatively, the plaintiff recovered uneventfully and was discharged home on 12th April, 2008. She was given a booklet containing information relevant to the post-operative recovery period which she read assiduously.

18. In the weeks immediately after her discharge from Mount Carmel Hospital, she spent a good deal of time in bed, resting. Up to, three to four weeks post-operatively, she continued to make progress. Then, however, she noticed that she was leaking urine through her vagina. This was not something that was mentioned in the booklet, and as it persisted, it began to cause her great distress. After a week or so, she got in contact with the hospital who advised that a urine sample be provided to test for infection. She brought this sample to her GP who had it tested and infection was confirmed and she was given an antibiotic.

19. This, however, had no effect on the continuous leakage of urine which, by now, was causing her great upset and anxiety. Apart from her worry as to the cause of this problem, the effects of it on her in terms of hygiene and odour were intolerable to her.

20. At the time of her scheduled six-week post-operative review, the plaintiff saw the defendant for the first time concerning this problem. He was suspicious as to the cause of the leak and arranged for a Cystogram to be carried out in Mount Carmel Hospital. This is an X-ray using dye to show any abnormality. This test disclosed that a Vesico Vaginal Fistula (VVF) had developed. This is an opening in the plaintiff's bladder leading to a channel into the vagina, thus permitting urine to leak directly from the bladder into and through the vagina.

21. This diagnosis did nothing to reassure the plaintiff. On the contrary, it heightened her state of anxiety and upset. Initially, the plaintiff felt that she had caused the VVF to develop by what she had done or not done since her operation. The defendant persuaded her that this was not the case and it was the evidence of the plaintiff and her husband that in their discussion with the defendant, he accepted that the problem arose because of some omission on his part. The defendant denied any such admission or omission and stressed his own upset that this rare condition had occurred, which he believed to be a rare complication of a hysterectomy, which had happened, notwithstanding that the procedure was carried out correctly.

22. Once the cause of the problem was diagnosed, the defendant immediately referred the plaintiff to Professor Tom Lynch, a consultant Urologist in Mount Carmel and St. James's Hospital.

23. He saw the plaintiff on the day that the Cystogram was performed. The plaintiff saw Professor Lynch on her own. What he told her left her speechless with upset. He informed the plaintiff that the operation necessary to repair the fistula could not be performed for three months, and in the meantime, the plaintiff would have to have a catheter put in. The purpose of this catheter was to facilitate a spontaneous closing of the fistula, although no real hope of this occurring was held out.

24. It was the plaintiff's evidence and that of her husband that the information given by Professor Lynch contradicted information given to them earlier by the defendant, to the effect that the repair could be carried out immediately.

25. When the plaintiff came out of her consultation with Professor Lynch and joined her husband who was waiting in his car in the car park, she was unable to speak. To find out what had happened, Mr. Kinsella went in to see Professor Lynch who repeated the information he had already given to the plaintiff.

26. Subsequently, the plaintiff said that in a further discussion with the defendant, he queried the delay in carrying out the repair and suggested it might be related to the availability of the Operating Theatre and he offered to give his own theatre time in the upcoming week to facilitate the repair operation.

27. The defendant denies ever saying that the repair operation could be carried out as soon as alleged by the plaintiff. He said he could not have said this because he was not a Urologist and could not anticipate what Professor Lynch would advise and do. He also denied, as had been alleged by the plaintiff and her husband, that he suggested that the fistula might have been caused by the bladder lying on a knot in the sutures he had put in.

28. Following the consultation with Professor Lynch, the plaintiff attended at St. James's Hospital where a specialist nurse fitted the catheter. It drained into a bag attached to her leg. The plaintiff found all of this extremely distressing and her grossly elevated level of distress and anxiety continued.

29. She was admitted to Mount Carmel Hospital on 6th July 2008, for the repair of the fistula. This was carried out on 7th July 2008, by Professor Lynch, assisted by the defendant. It is commoncase that the repair carried out was a complete success resulting in the complete closure of the fistula which brought an end to the leakage problem. The plaintiff recovered uneventfully from this procedure, that is, insofar as the physical aspects of the problem were concerned. However, notwithstanding this physical recovery, the occurrence of this fistula and the catheterisation of the plaintiff for two months and the surgery for the repair of the fistula had a gross impact on her mental health which did not abate. She remained in a state of hyper anxiety and distress to which, in due course, there was added a depression component, all of which have to varying degrees continued to this day.

30. In these proceedings, the plaintiff claims that all of her ills were caused by the occurrence of the VVF.

31. Relying upon the expert evidence of Dr. Peter Buchanan, Dr. Leroy Endozien, both Gynaecologists, and Mr. Patrick Smith, a Urologist, she says that the probable cause of the fistula was the misplacing of a suture into the bladder when the defendant was suturing the vault of her vagina. She claims that this occurred because the defendant had failed to adequately dissect and reflect downwards the bladder below the level of the top of the vagina and to have restricted it there by means of an appropriate retractor so as to keep the bladder safely out of harm's way when the vault of the vagina was being sutured.

32. The process whereby this misplaced stitch caused the VVF is explained by the plaintiff's experts and Mr. Smith, in particular, as causing Ischaemia in the area of the bladder captured by the errant suture which, in turn, led to the death of this bladder tissue, namely, necrosis, which in turn, resulted in a hole opening in that part of the bladder permitting urine to leak from it. Initially, the leaked urine would have pooled, forming a Urinoma. Nature then intervened by naturally creating an opening into the vagina to permit leaked urine to drain out through the vagina, thus avoiding the pooled urine escaping into the peritoneal cavity with the consequent risk of serious infection.

33. In his evidence, the defendant flatly denied misplacing a suture into the bladder. He described in detail how he performed this aspect of the procedure. He said he reflected the bladder safely out of the way and restricted it there by means of a Deaver retractor held by the nurse assisting him. His evidence was, that as he sutured the vault of the vagina, he could clearly see the needle enter the vagina on each round of the continuous suture. When he had finished suturing, he filled the bladder and satisfied himself, visually and by feeling behind the bladder, that the bladder was not tethered to the vagina by a misplaced stitch.

34. In passing, the defendant observed that if he did suture into the bladder, that "*would be a bad miss*". Implicit in this statement is an acknowledgement that such an occurrence would represent a failure to have adhered to a standard of care to be expected of a consultant Gynaecologist performing this procedure.

35. The evidence of the experts called for both the plaintiff and defendant was in agreement with the defendant on this topic, namely, if the defendant did misplace a suture into the bladder, that would only have happened if the defendant had failed to adequately remove the bladder from the area he was suturing, either by failing to have dissected the bladder down far enough off the cervix and vagina, or failing to have reflected it downwards and away and kept it there safely out of harm's way by means of a retractor. Either of these eventualities would have amounted to inadequate care by the defendant in carrying out this aspect of the procedure.

36. Thus, the outcome of this case depends on a determination of the cause of the plaintiff's VVF.

37. On this topic, the opinions of the experts called for the defendant are diametrically opposed to the opinions offered by the plaintiff's experts.

38. Each side has called in aid of their positions extracts from the available literature on this topic, namely, causation of VVFs.

39. A critical point of difference that emerged, first in the evidence of Mr. Ted McDermott, in which he was supported by the evidence of Dr. William Boyd for the defendant, was the timescale in which a VVF would develop if the cause was a misplaced suture into the bladder.

40. Mr. McDermott and Dr. Boyd were of the view that if there was a misplaced suture into the bladder, that would immediately cut off the blood supply to the area of the bladder caught in the suture. This, they said, would cause necrosis of the area of the bladder affected and this necrosis would be established in three to four days. Once this happened, the errant suture which still would have its tensile strength more or less intact, would pull through the dead bladder tissue, thus opening up the hole in the bladder.

41. Both Mr. McDermott and Dr. Boyd were strongly of the view, if this was the cause of the plaintiff's fistula, that she would have experienced urine leakage through the vagina three to four days after her operation and not three to four weeks later. Thus, they concluded that the occurrence of leakage three to four weeks after the operation, as reported by the plaintiff, out ruled a misplaced suture into the bladder as a cause of the fistula.

42. In this respect, they contended, in particular Dr. Boyd, that the literature demonstrated that where the cause of fistula was traumatic, as in the case of a misplaced suture, *inter alia*, leakage of urine occurred within the first week post-operatively. Where leakage occurred later, usually three to four weeks post-operatively, the literature suggested that the cause was usually the development of a natural pathology such as infection resulting in abscess at the site of the fistula.

43. For the plaintiff, Mr. Smith gave evidence to the effect that whilst the ischemic/necrotic process began in the first three to four days post-operatively, it would have taken considerably longer for the necrosis of the affected tissue to progress to a full thickness injury which was what was necessary to permit urine to leak from the bladder. In addition, whilst the misplaced suture was the cause of the ischemic/necrotic process, it also had the effect of holding the knuckle of bladder tissue caught in the suture together for a considerable period, thus preventing a full thickness opening developing. Eventually, the natural decline in the tensile strength of the suture, in combination with the progress to full thickness necrosis, would allow the hole in the bladder to open up.

44. Mr. Smith was of opinion that this process was wholly consistent with the timescale of three to four weeks in which the plaintiff's leakage problem emerged. He, too, pointed to various extracts from the literature supporting his contention.

45. At the outset of a consideration of the evidence on this fraught topic, it is to be noted that all the experts agreed that the

probable process leading to the development of the plaintiff's fistula was ischemia causing the necrosis of the affected bladder tissue. Also agreed by all the experts was the fact that a VVF could not occur spontaneously or naturally as part of the healing process post-hysterectomy. They agreed that there had to be a precipitating or causal event which set in train the ischemic/necrotic process that opened up the VVF.

46. Several potential causes were considered by the five expert witnesses in the course of their evidence.

47. One of these was bruising or injury caused to the bladder by the retractors used in the operation. This got no support, as a cause, from any of the experts for two reasons. The first was the manner in which the two retractors, namely, the Bonneys and Deaver retractors were used during the procedure, and secondly, the rich vascularity of the bladder which made it very unlikely that in the event of bruising of the bladder by these instruments that this would cause ischemia leading to necrosis of the affected tissue.

48. A second potential cause arose from the evidence of Mr. McDermott, the Urologist, called for the defendant. His evidence in this regard was to the effect that the VVF could have been caused by erosion of the bladder wall resulting from contact between the knot at the end of the continuous suture, which would have stood somewhat proud of the surrounding tissue, resulting in friction leading to erosion of the bladder wall in the area affected. In this regard, Mr. McDermott instanced the phenomenon of internal sutures emerging through external skin as an example of how a suture can erode through adjoining tissue.

49. None of the other experts agreed with Mr. McDermott in this respect and Mr. Smith and Dr. Buchan flatly rejected this explanation on the basis that all surgery in the abdomen, and particular, Caesarean sections have sutures that stand proud and come up against the bladder in the post-operative period until the sutures are naturally absorbed. These two witnesses said that these sutures were never known to erode through the bladder wall: they had never encountered this in their professional experience and had never heard of it, nor had it ever been mentioned in the literature. They recognised the phenomenon of internal sutures emerging through skin, but distinguished this as an instance of the natural rejection of a foreign body rather than any process of erosion.

50. It is interesting that this erosion explanation was presaged in a discussion which the plaintiff and her husband alleged took place between them and the defendant when the fistula was initially diagnosed. They said the defendant mentioned the bladder lying on the knotting as an explanation of the cause of the fistula. The defendant denied saying this. However, in her letter of complaint to Mount Carmel Hospital of 4th August 2008, the plaintiff mentions this. It would seem to me to be highly unlikely that the plaintiff at that time could have had any such knowledge unless it had been mentioned to her by a medical adviser. I am satisfied that the defendant did raise this with the plaintiff and her husband at that time, but not as the plaintiff interpreted it, as an admission of fault, but rather, as a speculative consideration of what caused the fistula.

51. Be that as it may, Mr. McDermott's evidence in this regard does not afford a convincing explanation of how the fistula occurred.

52. I am impressed by the evidence of Mr. Smith and Dr. Buchan in this regard and have come to the conclusion that it is highly unlikely that the fistula was caused by erosion contact between the bladder and the suture in question. If this was to be considered a potential explanation of the occurrence of the plaintiff's fistula, it would seem to me that it is the kind of event which, in the overall context of abdominal surgery adjacent to the bladder, would occur on a regular, if rare, basis, and one would have thought would be well-known to medical practitioners with expertise in this field and would be mentioned in the literature. The absence of any reference to it in the literature persuades me, that in the search for an explanation of the plaintiff's fistula, the erosion theory should be rejected. The fact that the contact would have occurred at a part of the bladder low down where it is relatively fixed and rigid and where little friction from movement would arise, reinforces my conclusion in this regard.

53. The next cause suggested for this fistula is the development of infection, perhaps leading to an abscess where the fistula developed. Such an infection could have arisen from the development of a haematoma or accumulation of blood in or about the vault of the vagina. The presence of inflammation in this area could contribute to this process.

54. Because the vagina is rich in bacteria, infection can predictably develop where the vagina is closed off after a hysterectomy if the bleeding is not adequately controlled when the vault of the vagina is closed. Hence, the importance of suturing to close off bleeding after the removal of the cervix and the closing the vault of the vagina. The fact that this area is so low in the abdomen allows any bleeding to accumulate here, thus creating the risk of haematoma and consequent risk of infection because of the proximity to the vagina and its rich supply of bacteria.

55. The defendant, in his evidence, was adamant that when he closed the vault of the vagina, apart from visualising the line of the suture, he checked for bleeding by using a swab and ascertained that there was no bleeding from where he had sutured. The evidence of the plaintiff's experts, with which it seemed Dr. Boyd agreed, was that if an infection of this kind occurred leading to, perhaps, an abscess, the plaintiff would have presented probably with a high temperature, purulent discharge from the vagina and flu-like symptoms. It is quite clear that the plaintiff did not suffer any of these symptoms at the relevant time. When the leakage problem started, about three weeks after the hysterectomy, the plaintiff was found to have had a Urinary Tract Infection, which was treated by antibiotics. This infection seems to have been of a wholly different character and degree to the abscess-type event postulated by the experts in this regard, and none of the experts advanced this UTI as a cause of the fistula, or as associated with its cause.

56. In the course of his evidence, Dr. Buchan did describe a process whereby bacteria from the vagina could, if there was a misplaced stitch into the vagina, invade into the bladder, but this bacteria, whilst infecting tissue and contributing to its degeneration and necrosis, would act or operate at a sub clinical level not causing any illness but might speed up the process of necrosis. Without a misplaced stitch or some other form of insult or invasion which connected the vagina to the bladder, the normal bacteria in the vagina would not affect the bladder. Similarly, inflammation associated with the healing process where the vault of the vagina was sutured could not affect the bladder unless some invasion of the bladder had taken place which connected these two organs together, such as a misplaced suture.

57. Although the development of significant infection with abscess resulting from haematoma in the area in question could have led to a fistula, in the absence of any symptoms of illness in the plaintiff at the relevant time, in my view, this is an unlikely explanation of the plaintiff's fistula, and on the balance of probability, I would reject it as a cause.

58. This brings me to the cause suggested by the plaintiff's experts, namely, a misplaced suture into the bladder. The plaintiff's three expert witnesses all said that this was the most probable or likely cause of the fistula for essentially three reasons, namely, the location of the fistula, the size of it and the timescale over which it developed.

59. As to the first of these, namely, the location of the fistula, all the experts agreed that the fistula was located very close to the last securing knotted stitch placed by the defendant when completing the suturing of the vault of the vagina, and it was the

evidence of the plaintiff's experts that, in their opinion, it was this final suture that caught or snagged the bladder in the adjacent area.

60. The size of the fistula was measured at 1cm by Professor Tom Lynch when he carried out the repair. The evidence of the plaintiff's experts was that this size was entirely consistent with a knuckle of bladder tissue being caught in a misplaced suture and was inconsistent with a more diffuse injury to the bladder that might have been caused by other potential insults. In this regard, it is worth noting that none of the expert witnesses was of the view that this fistula was caused by a perforation of the bladder during the dissection process. Mr. Boyd did suggest ischaemia caused by an unspecified dissection injury in the vicinity of the site of the fistula. None of the other experts supported this proposition, and I reject it, as a probable cause of the fistula.

61. The evidence of the plaintiff's experts as to the significance of the size of the fistula was not contradicted or challenged by the defendant's experts.

62. The real controversy between the plaintiff's expert witnesses and the defendant's was in relation to the period of time over which this fistula developed. As mentioned earlier, the plaintiff first noticed leakage of urine through her vagina approximately three to four weeks after the hysterectomy. Mr. McDermott and Dr. Boyd, for the defendant, were emphatic that where a traumatic event, such as a misplaced suture occurred, this would lead to the development of ischaemia and necrosis within three to four days so that the suture would pull through this dead tissue leading to the development of a hole in the bladder, thereby causing the leakage of urine within three to four days, or at most, a week. In this regard, they prayed in aid of their proposition, various extracts from the medical literature which I will deal with later.

63. The plaintiff's experts, and in particular, Mr. Smith, were adamantly of the view that the ischemic/necrotic process could take several weeks to result in a leakage of urine. Mr. Smith's evidence was to the effect that the ischemic/necrotic process would be established in the three to four-day period envisaged by the defendant's experts, but would take considerably longer to get to a full thickness injury which was necessary in order to give rise to leakage. In this regard, he said that the suture which was the cause of the problem initially, by holding the tissue together, prevented the development of a leak for some considerable time. Dr. Buchan was of the view that the final stitch in the line would have incorporated a considerable volume of tissue thereby diminishing the tightness of its hold on any particular part of that tissue, thus contributing to the survival of that tissue for some time. Dr. Buchan acknowledged that many fistulas caused by a misplaced suture in the bladder would result in leakage within a week of the hysterectomy, but also many such fistulas took much longer to reach the leakage stage, three weeks being well within the recognised timescale for these eventualities. The plaintiff's experts, but in particular, Dr. Endozien, relied upon the literature to support the contention that the development of a fistula resulting from a misplaced suture into the bladder could take up to six weeks to develop and the three to four-week period in which the plaintiff's symptoms of leakage developed was well within that timescale.

64. Critical to evaluating the conflicting opinions of the various experts on this topic is an assessment of the state of the literature on this subject. The following passage occurs on page 1 of an article entitled '*Vesicovaginal, Urethrovaginal and Ureterovaginal Fistulas'*, the authors being Alan D. Garely M.D. and William J. Mann Jnr. M.D.:

> *"Despite the best efforts of the surgeon, injury to the urinary tract may still occur as part of the healing process in pelvic surgery. Tissue necrosis follows tissue ischemia, attributable to external pressure (crush or clamping), kinking of urinary tract tissue (proximity to a ligated pedicle) or marked inflammation with tissue fibrosis (5). Direct injury to the urinary tract by laceration or puncture usually results in immediate urine leakage, while delayed injury from retroperitoneal fibrosis, tissue pressure, or partial obstruction may not result in fistula formation and urine leakage for several days or weeks . . ."*

65. In an article entitled '*Incontinence: Vesicle and Urethral Fistulas'* by Richard E. Symmonds M.D. of the Mayo Clinic, Rochester, Minnesota, the following is said:

> *"When do the fistulas first become apparent after operation? This question was seen to have some etiological implications. Historically, in the patients referred to the author, the fistulas have appeared most commonly during the first ten post-operative days, many within the first 24 to 48 hours. One would generally think that these early appearing fistulas must be due to actual bladder or urethral perforations that were not recognised at operation. In an almost equal number of patients, the fistulas first developed 10 to 30 days after hysterectomy; these late appearing fistulas may well be the result of a different degree of trauma, for example, demuscularisation, devascularisation, haematoma, compression with infection and necrosis, or perhaps, a misplaced suture that has gradually eroded through the bladder wall . . ."*

66. In a textbook known as Bailliere's '*Clinical Obstetrics and Gynaecology International Practice and Research*' Vol. 1. No. 2, June 1987, under sub-heading '*Gynaecological Surgery'*, the following is said in Chapter12 under the title '*Vesicle Vaginal Fistulae*' written by Karl. C. Podratz, Richard E. Symmonds and John B. Vagan commencing at p. 415:

> *"The spatial separation between the therapeutic event and the notation of continual wetness will ordinarily portend the aetological factors. Therefore, the authors have sub-categorised fistulae according to the timeframes separating treatment and clinical manifestations. 'Early fistulae' become clinically evidenced within seven to ten days after surgery; a significant percentage surface within 28-48 hours after the procedure. These presumably represent unrecognised intra-operative trauma, such as an inadvertent incision, perforation, or partial transaction of the bladder and/or ureter. Retrospectively, such patients frequently have subtle associated sequelae, including mild temperature elevations, minimally elevated creatinine (approximately 0.5mg/dl above upper limits of normal), delayed ileus and/or mild flank or pelvic discomfort. 'Intermediate fistula', which become manifest between ten days and approximately six weeks post-operatively, are thought to reflect vascular compromise and necrosis between aberrant suture placement or devascularisation or necrosis resulting from pressure or from haematoma formation and/or infection. . ."*

67. In Chapter 41 of a textbook known as Te Linde's *'Operative Gynaecology'* 8th Ed., under the heading *'Vesicle Vaginal and Urethral Vaginal Fistulas'* by John D. Thompson, the following is at p. 1178:

> *"Some vesicle vaginal fistulas are caused by placement of sutures through the bladder base when the vaginal vault is sutured. This is usually the result of inadequate mobilisation of the bladder inferiorally and laterally away from the upper vagina or of inadequate exposure and retraction. In this instance, which is usually unrecognised, gradual necrosis of the bladder wall leads to the development of a vesico vaginal fistula, most commonly within the first week after surgery when the patient notices incontinence of urine through the vagina . . ."*

68. For the defendant, heavy reliance was placed on various extracts from the literature to the effect that even with the best possible care in the carrying out of a hysterectomy, fistulas can occur. In particular, emphasis was placed on the fact that where fistulas do occur, 50% of these, or perhaps 70% are in cases of uncomplicated hysterectomies. The expert evidence overwhelmingly supported the proposition that where there was a prior complicating pathology such as scarring from the earlier surgery or Endometriosis, fistulas could occur, even with the best care, due to the difficulty in dissecting the bladder away from the uterus in these situations. Where no such complications existed, as a general proposition, the expert evidence in the case supported the proposition that fistulas will not occur unless there was a want of due care in the performance of the procedure.

69. It is clear that the literature does not deal expressly with the incidence of fistula caused by inadequate care in the carrying out of the procedure. Thus, whilst 50% or so of fistulas occur in uncomplicated hysterectomies, it is not possible from the literature to discern how many or what proportion of fistulae are caused by inadequate care, and whilst it could be said that these would be more likely to occur in the 50% of uncomplicated hysterectomies, it may very well be that some of the fistulae that occur in complicated hysterectomies may also be due to inadequate care. In reality, because there is no express mention of cases of inadequate care, these are buried in the overall statistics.

70. One study titled '*Iatrogenic Bladder Injury during Hysterectomy'*, the authors being Edward A. Graber M.D. F.A.C.O.G., and James J. O'Rourke M.D. and Thomas McElrath M.D., contained a breakdown of the stage of the operation when the injury leading to fistula occurred. Thus, in this study, out of 819 cases reviewed, there were sixteen cases of injury to the bladder. Of these, eleven were diagnosed during the hysterectomy and repaired at once. All five of the bladder injuries undiagnosed at operation resulted in Vesicle Vaginal fistulae. The cause of two of the sixteen was attributed to the bladder probably being sutured during the closing of the vaginal vault and these two were amongst the five not diagnosed during the hysterectomy.

71. Insofar as the literature is concerned, it would appear to me that a misplaced suture into the bladder when closing the vaginal vault appears to be a well recognised cause of Vesicle Vaginal fistula. It is to be observed, of course, that the occurrence of a Vesicle Vaginal fistula is, nonetheless, a rare occurrence.

72. The defendant relied heavily on the foregoing passage from the Thompson article, whereas the plaintiff placed reliance on the Podratz article. It would seem to me that insofar as the literature goes, it is more persuasive of the plaintiff's proposition rather than the defendant's for the simple reason that in the Podratz article, there is an express consideration of different kinds of fistulae and the development times associated with them, whereas in the Thompson article, much less is said and in much more general terms. The extract from the other article emanating from the Mayo Clinic appears to be in agreement with the Podratz article but the author of the Mayo Clinic article, Mr. Symmonds, appears also to be a joint author of the Podratz article. It is, of course, to be noted that in the Thompson article, what is stated is, "*. . . leads to the development of a vasico-vaginal fistula, most commonly within the first week, after surgery . . .*" which implies that the fistulas can emerge later in some cases. Thus, there may not be any conflict between the two articles.

73. The explanation as to how a fistula develops from a misplaced suture into the bladder, given, in particular, by Mr. Smith in his evidence and supported by Dr. Buchan, is convincing as far as I am concerned. This, of course, does not exclude the scenario envisaged by Mr. McDermott and Dr. Boyd, namely, that in many cases, the suture will pull through the necrotic tissue creating the fistula within the first week. But I have come to the conclusion, as a matter of probability, that many of these fistulas can take several weeks to develop and that conclusion seems to me to be amply supported in the literature referred to in the evidence and quoted above.

74. All this persuades me that I should accept the evidence of the plaintiff's experts to the effect that the most probable cause of the plaintiff's fistula was a misplaced suture incorporating a knuckle of tissue of the plaintiff's bladder and that this occurred, in all probability, in the final round of the suture placed by the defendant in the vault of the vagina which was then knotted.

75. Before leaving this topic, I would like to address an opinion expressed by Mr. McDermott to the effect that he did not think that a misplaced suture could be the cause of the plaintiff's fistula because the blood supply to the affected area was so good that it was very unlikely that a suture could interfere with the blood supply to the extent of causing ischaemia and necrosis. All of the plaintiff's experts vehemently disagreed with Mr. McDermott on this, on the basis that no matter how good a supply of blood was it could be cut off by a ligature such as a suture. I am inclined to the view that their opinions on this topic are persuasive and I would be of the view are probably correct.

76. A good deal of expert evidence was directed at the presence of bloodstained urine, draining through the catheter that was left in place after the hysterectomy. I am satisfied from the evidence of the nurses who attended the plaintiff after the surgery that the catheter drained bloodstained urine, rather than frank haematuria, and that 14 hours after the conclusion of the hysterectomy, the plaintiff was draining clear urine and the catheter was removed soon thereafter. Dr. Endozien, in his evidence, said that the presence of blood in the urine three hours post-surgery was *prima facie* indicative of injury to the bladder. None of the other experts supported that evidence. There appeared to be a consensus amongst the rest of the experts to the effect that in 30% of hysterectomies, approximately, bloodstained urine is drained post-operatively, and if it clears within 24 hours, it is not a matter for concern and does not indicate injury to the bladder.

77. I am satisfied that the presence of bloodstained urine for 14 hours after the plaintiff's surgery is a neutral factor in the case and does not tilt the balance in favour of any conclusion on the question of what caused the plaintiff's VVF.

78. Dr. Boyd, while not outruling entirely a misplaced suture as the cause of the plaintiff's fistula, his evidence was to the effect that it was the least likely cause, but that in reality, no one could say what the cause was; it was, in effect, unknown. Whilst I would have some sympathy with this point of view to the extent that it is obviously impossible to determine scientifically with certainty what did cause the plaintiff's fistula, nonetheless, a consideration of all the known facts can lead in retrospect to a conclusion as to the cause on the balance of probabilities. Having done that, I am satisfied, as stated already, that the probable cause of the plaintiff's fistula was a misplaced suture into the bladder.

79. Necessarily, in reaching this conclusion, I have not accepted the evidence of the defendant to the effect that he did not misplace a suture into the bladder.

80. In his operative note, the defendant does record that difficulty was encountered without specifying what that difficulty was. In his evidence, he explained that the difficulty in question was in dissecting the bladder off the uterus because of the uneven or bumpy exterior surface of the uterus due to the fibroids. The defendant's evidence was that he completed the dissection of the bladder off the uterus before removing the body of the uterus, and having done that, all that was required by way of further dissection of the bladder off the cervix and vagina was some light scoring. In this respect, he was criticised, in particular, by Dr. Buchan, who was of

the view that attempting to dissect the bladder off the uterus all the way down before the body of the uterus was removed was a dangerous procedure because the uterus obscured visibility and impeded access into the lower regions of connection between the bladder and cervix and vagina. Dr. Buchan's evidence was to the effect that there would be no point in doing a subtotal hysterectomy if one could safely dissect the bladder off the uterus all the way down, in which case the uterus and cervix could be removed at the same time. Dr. Buchan further took issue with the defendant's evidence to the effect that only "*scoring*" was required to remove such connective issue as remained between the bladder, cervix and vagina, and in particular, his evidence was that at the lateral aspects, proper or full dissection was required to safely remove the bladder away from the angles of the vagina and the ureters. Insofar as the defendant merely scored in these areas, Dr. Buchan implied or inferred the defendant may not have properly or adequately dissected the bladder off the cervix and/or vagina in these lateral aspects, where, in fact, the fistula occurred, and thus may have left the bladder too close to the operative field with a consequent risk of being caught in the suturing of the vault of the vagina.

81. It is clear that the bladder was permitted by the defendant to remain much too close to the field of operation at the time the defendant was suturing the vault of the vagina. Whether this was because of inadequate dissection of the bladder off the uterus or whether if the dissection was adequate, the defendant failed to adequately reflect the bladder downwards and to keep it out of harm's way by means of a properly placed Deaver retractor is impossible to say. However, the fact that the bladder was snagged by a misplaced suture means that either one or other of the foregoing eventualities occurred.

82. I am satisfied that this was due to inadequate care by the defendant in the carrying out of this procedure and all of the expert evidence appears to me to support that conclusion.

83. This brings me to a consideration of the defendant's explanation of why he carried out the bladder check noted in the operative note. Initially, it was assumed by several of the experts that this was merely a visual check. However, in his instructions to the defendant's experts, the defendant explained that he had filled the bladder with 300mls of saline solution and satisfied himself that there were no leaks. In the context of the difficulties in dissection he described in his evidence, doing this form of bladder check obviously made sense and would have been a wise precaution.

84. Late in the day, having obtained expert opinions from Dr. Buchan and Dr. Endozien in the autumn of 2011, in further particulars delivered in February 2012, the plaintiff ascribed the cause of the fistula to a misplaced suture into the bladder, when the vault of the vagina was being sutured.

85. In his evidence in this trial, the defendant described the carrying out of this check, namely, the filling of the bladder with 300mls of saline solution, but he explained that he did this not because he had any fear or apprehension or suspicion that he had injured the bladder during the procedure, but as a precaution to satisfy himself that at the end of the procedure, everything was in its anatomically correct position and that there was no tethering between the bladder and adjacent tissue. He said he mobilised the filled bladder with his hand so that he could see behind it and visualise the line of his suture and saw it in its entirety and that it was as it should be. He said that by using his hand behind the bladder, he could feel that it was not tethered to the angle of the vagina by a misplaced suture.

86. The difficulty which I have with this explanation given in evidence by the defendant is that it does not appear to make a great deal of sense. Firstly, insofar as carrying out a visual inspection of the suture line is concerned, it is very hard to see or understand how filling the bladder thereby creating an obvious obstruction to visibility would be a sensible way to visualise the entirety or any part of the suture line in the vault of the vagina. Secondly, and the great weight of the expert evidence was in agreement on this, attempting to ascertain whether or not the bladder was tethered by a misplaced stitch by filling it, mobilising it and feeling behind it with a hand would be wholly ineffective to discern any such tethering because the tethering created by a misplaced suture in the location where the plaintiff's fistula occurred, namely, very low down in the rigid structure of the bladder, would not be revealed by the kind of hand manoeuvre which the defendant described. All of the experts agreed that if there was a suspicion of tethering by a misplaced suture, the only reliable way to diagnose this would be by way of Cystoscopy, which should have been done if the defendant had an apprehension that he might have misplaced a suture in to the bladder.

87. I find myself unable to accept the defendant's explanation in this regard and the fact that there was a significant shift in this latter explanation from the original explanation apparently advanced by the defendant for carrying out this bladder check leads me to conclude that the defendant's evidence in this regard is unconvincing.

88. In the course of his evidence, Dr. Boyd described a procedure which he said was standard practice and that he would be surprised if the defendant had not adhered to it, which was that at each end of the suture line, a length of suture would be left which, when the suture line was completed, could be used to lift upwards the vault of the vagina so as to enable a clear visual inspection of the suture line to determine that there was no bleeding and the integrity of the suture line was intact. Notwithstanding the fact that the defendant gave evidence of exquisite detail in the carrying out of every phase of the procedure, he made no mention of adhering to what Dr. Boyd described as this standard practice. I can only infer from this that he did not adhere to this practice, and whilst, undoubtedly, the swabbing which he did was an adequate alternative method of satisfying himself that there was no ongoing bleeding, his evidence did not disclose any alternative adequate method of establishing the integrity of the suture line, and his explanation of the bladder check clearly failed in this regard.

89. Having concluded that the probable cause of the plaintiff's fistula was a misplaced suture into the bladder, having considered the literature on this topic, having carefully considered the expert testimony of all of the expert witnesses in the case and having considered the defendant's evidence, I have come to the conclusion that the plaintiff's fistula was caused by a failure on the part of the defendant to carry out this procedure with the degree of care to be expected from a consultant gynaecologist.

Damages

90. It is quite clear, indeed it is commoncase, that the repair of the plaintiff's fistula carried out by Professor Lynch with the assistance of the defendant in July 2008 was a complete success insofar as the fistula was closed and all leakage stopped. In other words, this procedure resulted in a complete recovery by the plaintiff from the physical injury and sequelae resulting from the occurrence of the fistula in the hysterectomy.

91. This favourable result, however, did not appear to produce any improvement in the plaintiff's state of anxiety and distress that had been there since the fistula became apparent about three weeks after the hysterectomy. It is quite clear that the plaintiff developed a severe anxiety disorder with a depressive component. The plaintiff was initially treated for this by her General Practitioner, Dr. Bill Toomey. He referred her in due course to a consultant psychiatrist in Tallaght Hospital, Dr. Denis Murphy. Later, the plaintiff was referred to Dr. Abie Lane, a consultant psychiatrist, who runs the Dublin Stress Clinic in St. John of God Hospital. The plaintiff was later examined by Dr. John Tobin, a consultant psychiatrist, who examined the plaintiff and gave expert evidence on behalf of the defendant.

92. All of the doctors were in agreement that the plaintiff, as a result of the experience of the fistula followed by her catheterisation and subsequent surgical repair, suffered a well recognised anxiety disorder which all of them agreed was severe. Dr. Abie Lane described it as a generalised anxiety disorder, Dr. Tobin called it a anxiety/depressive disorder.

93. Dr. Abie Lane, a consultant psychiatrist called as an expert witness for the plaintiff, described this condition in her evidence on Day 8 of the trial at p. 125 of the transcript as follows:

"MR. JUSTICE O'NEILL: This is what you describe as a generalised anxiety disorder?

> *A. Yes. These are notoriously difficult to treat and manage. And most people, even if they do return to some level of functioning, will still have residual symptoms. In this particular case, where residual symptoms likely to be reactivated at any time, health becomes an issue. People with this disorder are often chronically disabled. They tend to use a lot of health services. They have very frequent inputs from general practice/psychology in terms of the managing of this, and that's even if you have a patient who doesn't have the fear of attending. So, they're difficult illness to manage and more than 50%, in fact some would say you'd be looking probably up at around 70% don't return to function.*
>
> *MR. JUSTICE O'NEILL: Does that mean that regardless of what the initial trigger was that springs somebody into this anxiety complex, even though that may disappear into the mists of time, all this continues?*
>
> *A. Yes, all this continues. It's a very chronic disabling condition. It has people on red alert all the time, on edge, anxious, extremely uncomfortable in themselves all day, every day, and often the trigger that flicks the switch is long gone. I suppose in Mrs. Kinsella's case the initial trigger, in my view, was the incident after the first surgery. But the other difficulty with these illnesses is that the anxiety tends to spread. So, initially it starts with the hospital and surgery and then it could be going out in public, it could be travelling on a plane, it could be travelling in a car. So, it tends to spread. And what people tend to do is to try to narrow down their lifestyle so that the less they do or the quieter they become or the less interaction they have then the less anxiety-provoking it all is. In terms of, I suppose, a psychiatric illness, it would be down the list of what we would call - you know, there are various major and minor psychiatric illnesses. But these illnesses, while regarded as minor in many classification systems, often have quite a profound effect on people's ability to manage in the longer term."*

94. Dr. John Tobin, a psychiatrist called as an expert witness for the defendant, when asked by me whether he agreed or not with Dr. Lane's description, said the following on Day 17, p. 82, Question 341, line 1:

> *"A. The severe end, the severe end of what she is talking about and how it spreads, she is totally correct in that. I would have no quibble. That is why questions in my report, we ask about social isolation, do people go out? Do they withdraw into themselves? That is why those issues become very pertinent, because it is a sign that it is actually spreading beyond the actual initial event.*
>
> *MR. JUSTICE O'NEILL: Yes, so you shrink?*
>
> *A. Pardon?*
>
> *MR. JUSTICE O'NEILL: You shrink.*
>
> *A. You shrink back into yourself. A huge amount of this is actually self-esteem. Your self-esteem collapses.*
>
> *MR. JUSTICE O'NEILL: Yes.*
>
> *Q. MR. NOONAN: I take it that would explain why somebody, well, not somebody, Mrs. Kinsella herself, is always apologising for herself in these type of scenarios?*
>
> *A. Yes."*

95. Having listened to the evidence of the plaintiff and to that of her husband, I consider Dr. Lane's description of the plaintiff's condition as extremely apt. In addition, in listening to the plaintiff give her evidence over the two days that she was in the witness box, I was struck by the remarkable hesitancy with which she gave her evidence. It was quite clear that she is a person of considerable intelligence who clearly understood the questions that were being put to her but she clearly had great difficulty in delivering answers to those questions in a normal, fluent fashion. I am quite satisfied that the plaintiff was an honest witness and that the hesitancy in the giving of her answers was in no way the result of any reluctance to be forthcoming with the truth or any desire to control or manage her evidence in a calculating way. The explanation given to me by all of the doctors on this aspect of the plaintiff's behaviour was that this was due entirely to her high state of anxiety. It is obvious that the anxiety disorder which afflicts the plaintiff does so to a severe degree, and indeed all of the doctors were in agreement on that.

96. The consequence of this disorder is, as was described by Dr. Lane, to cause the plaintiff to shrink from normal life. She has been, since this disorder came upon her, incapable of coping with the stresses of a working environment. Normal social interactions likewise cause her high levels of stress, and because of that, she has effectively withdrawn from the social life she had before all of this happened. Her interactions with a variety of professional persons with whom she has had to deal for the purposes of this case have been a source of great stress and anxiety to her, as is evident from the evidence of witnesses such as Ms. Brenda Keenan and Mr. Roger Leonard and others, in particular, her General Practitioner, Dr. Bill Toomey.

97. Thus, what started out as an anxiety related to her unfortunate surgical experience following this hysterectomy has, as Dr. Lane described, spread out into all aspects of her life. In response, she has, in effect, reduced her range of activity to the minimum and lives what would appear to be an isolated life. Clearly, this is not a happy situation for her, but it is probably the type of life which causes her least stress and anxiety.

98. The question which necessarily arises in all of this, and which was debated at considerable length amongst the expert psychiatric witnesses, was the prospect or possibility of rehabilitating the plaintiff's life, both in terms of work and normal social living.

99. All of the psychiatric experts agreed that there was no prospect of the plaintiff's condition being remedied unless she could undergo an effective therapeutic process which would probably be fairly prolonged. This would consist of the taking of anti-anxiety and depression medication and also probably active intervention in the form of cognitive behavioural therapy.

100. Even with adherence to such a programme, for perhaps up to 24 months, the evidence of Dr. Lane was that in at least 50% of cases, perhaps up to 70%, no improvement resulted and there was no return to normal functioning. Dr. Tobin, whilst disagreeing with the higher figure of 70% as being too pessimistic, nonetheless agreed that in cases of severe anxiety disorder, the failure rate in treatment was of the order of 50%. All of the psychiatric experts agreed that the longer the condition persisted the harder it was to treat and the likely outcome correspondingly poorer. All agreed the plaintiff's condition was and had been for some time in that chronic state.

101. Some controversy surrounded the initial treatment undertaken by the plaintiff late in 2008, when she was prescribed a drug called Cipramil. She was prescribed this drug, first, before she went back to work in October 2008, but postponed starting it at that time because of her return to work. She coped badly at work in the sense that her concentration was poor and her work was frequently called in question by her superiors because of mistakes. Because of the stress of all this, she went out of work again on 4th November 2008, and after that, commenced taking this drug. She attended her GP, Dr. Toomey, in January and again in February 2009, and she reported to him some improvement on this drug and he noted himself some improvement at that time.

102. However, her evidence and, in particular, the evidence of her husband, was that she found it extremely difficult to tolerate this drug. Her description, and more particularly, that of her husband, was that whilst she was on it, she was a "*zombie*" or was constantly "*out of it*". Her husband described a variety of minor domestic mishaps resulting from her absent mindedness or forgetfulness or lack of concentration while she was on this drug. Eventually, she could tolerate it no longer and gave it up about March 2009.

103. Whilst the plaintiff did report to Dr. Toomey some improvement while on this medication, I am satisfied from her evidence, and particularly from the evidence of her husband, that by March 2009, when one would have expected this medication to be producing a tangible benefit in terms of the plaintiff's overall wellbeing, the reverse was the case, and the plaintiff found herself no longer able to tolerate it. I think it is probable that in her reporting to Dr. Toomey, her general demeanour of diffidence and apology for her condition may have induced her to present to him a more optimistic picture than was justified.

104. All of the psychiatric experts were asked to consider the reasons why the plaintiff gave up this medication. This arose from the fact that in a second report, Dr. Tobin expressed the opinion that if the plaintiff was compliant with this type of medication regime, she was likely to begin to improve after three weeks or so, to be significantly improved after about two months and to be ready to resume employment after about three months.

105. Dr. Lane thought this scenario far too optimistic. Both Dr. Lane and, in particular, Dr. Murphy who saw her on several occasions, was of opinion that the precipitating factor causing her to give up the medication was not any wish on the part of the plaintiff to get by without the medication, nor any personal bias against this type of medication, but rather, her state of mind induced by her anxiety condition in the first place. Dr. Lane further explained that the type of medication the plaintiff was on had in it a component which tended, in the initial phase, to increase anxiety, and whilst Dr. Tobin agreed with this, he was of opinion that this could have been counteracted by offering a tranquilising-type drug at the same time until the initial phase was overcome.

106. It is unlikely that the plaintiff's problem with this drug was any initial adverse reaction to an anxiety component in the drug. She persisted with the medication for approximately four to five months, which should have taken her beyond this initial phase, but by that time, she found the effect of it on her intolerable. I have no doubt that given that this medication did not alleviate her anxiety state, it was probable that the continuance of this kind of medication had an exacerbating effect on her anxiety state, in the sense that if the medication was not making her any better and if she felt in many ways worse on the medication, it was inevitable that the continued taking of the medication, or of an alternative substitute for it, was likely to heighten her anxiety state.

107. Accordingly, when she saw Dr. Lane who suggested an alternative medication and when the dosage levels were mentioned, which appeared high to the plaintiff but in fact were not, her reaction was, understandably, resistance, no doubt driven by her underlying state of hyper-anxiety. What this suggests is that it is going to be very difficult to establish the plaintiff, having regard to her chronic state of high anxiety, on a regime of medication that she will, in the first instance, be able to accept, and secondly, tolerate to the point of achieving some benefit.

108. There is then, the rather chilling evidence of Dr. Lane, with which Dr. Tobin agreed, that in any event, in 50% of cases of severe anxiety, even with total compliance by a motivated patient, the treatment fails.

109. All of this suggests to me that as a matter of probability, it is unlikely that the plaintiff's condition will be amenable to any therapeutic process as has been described by the psychiatric experts and it likely that the plaintiff will continue as she is unless for some reason which cannot be foreseen, a spontaneous or natural recovery takes place.

110. The defendant placed considerable reliance on a complaint of bullying made by the plaintiff against a fellow employee. This complaint was made formally in writing shortly before the plaintiff went out sick in April 2008 in order to have the hysterectomy. In it, the plaintiff referred to long-term bullying. It was suggested by the defendant in cross-examination of various witnesses, that this problem was a likely cause or contributory factor in the development of the plaintiff's anxiety disorder and her inability to work since November 2008.

111. The complaints made by the plaintiff were, that in the weeks preceding her departure from work to have her surgery, this other employee would not make allowance for the fact that the plaintiff, due to her condition, could not tolerate bending or stooping and therefore could not do filing, which would have been a very small part of her duties in any event. In addition, she complained that this fellow employee had made what may be described as sarcastic but unkind remarks concerning the plaintiff's position in the firm and the security of it because of her health condition.

112. Some years earlier, in 2004 to 2005, a similar situation of tension arose between the plaintiff and the same employee. This, however, was resolved amicably and they continued to work together, and indeed, frequently had lunch together.

113. The complaints made concerning the events occurring just before the plaintiff went out sick in April 2008, were investigated by the employer. Much of the content of the plaintiff's complaint does not appear to have been denied by the other party, but it was said that the offending remarks were made in jest, with no harm, intended.

114. The evidence establishes that a reconciliation was again brought about between the plaintiff and this other employee before the plaintiff returned to work in October 2008. At that time, the plaintiff was very anxious to get back to work, and indeed, went back to work well in advance of the time advised by her doctor.

115. Whilst the plaintiff may have used the term "*bullying*" or "long-term bullying" to categorise her complaints, it would seem to me that if the conduct complained of could at all be objectively considered as bullying, it was very definitely at the light end of the spectrum. In reality, it would seem to me that what occurred was more in the nature of an episode of interpersonal tension occurring at a time when the plaintiff was unusually vulnerable. In any event, a reconciliation occurred in a speedy fashion.

116. I am quite satisfied that this episode had no bearing whatsoever on the development of the plaintiff's anxiety disorder. It was a minor incident with which the plaintiff coped easily, as evidenced by her early return to work, which was obviously not inhibited or delayed by the effects of the incident. Manifestly, post-November 2008, this incident would not, indeed could not, have impacted directly on the plaintiff's return to work in a workplace not involving the other party to the complaint made.

117. I am satisfied that the plaintiff's severe anxiety disorder was caused by the occurrence of the vesicovaginal fistula, which in turn was caused by the negligence of the defendant, and it is probable that the plaintiff will continue to be afflicted with this severe anxiety disorder for the foreseeable future.

118. As a consequence of this, the plaintiff's life will continue to be grossly restricted and it is highly improbable that in the foreseeable future she will be able to return to paid employment in any form.

119. In this respect, I am quite satisfied that the plaintiff lacks the capacity and will continue to lack the capacity for the foreseeable future to embark upon any kind of rehabilitative or re-skilling courses which would facilitate a re-entry into the workforce. Both the stress of the personal interactions that these courses would involve and her inability to sustain concentration mean that she would have no real chance of completing any such courses. In her present condition, I am quite satisfied she would have absolutely no chance of securing temporary or permanent employment or of being capable of holding down a job if, perchance, she somehow managed to get one.

120. I am also satisfied that it is highly improbable that she would be capable of getting or sustaining secretarial-type work on a self-employed basis. The necessary self-promotion and social interactions that would be required to generate this type of enterprise would, in my opinion, be wholly beyond the plaintiff's current capacity and for the foreseeable future that will not change.

121. The plaintiff has to be compensated by way of general damages for her pain and suffering to date and into the future and she is also entitled to damages in respect of the loss of her earning capacity until normal retirement age.

122. Insofar as her pain and suffering to date is concerned, what she has to be compensated for is the occurrence of the fistula itself and the physical consequences of it, including the necessary surgery to repair the fistula, and all of the physical consequences flowing from these, together with the severe anxiety disorder which was caused by the foregoing.

123. In my opinion, the appropriate sum to compensate the plaintiff for her pain and suffering to date is the sum of €100,000.

124. As I have mentioned earlier, it is likely the plaintiff will continue to suffer from this anxiety disorder for the foreseeable future and this is going to cause her a great deal of distress, anxiety and unhappiness and a gross loss of the amenities of life. Having regard to her age and all of her personal circumstances, and in this regard, I bear in mind the fact that she has, in all of her troubles, the unstinting support of her husband, Austin, which, to a very significant extent has to date and will continue in the future, to cushion her and protect her from the more isolating consequences of her disorder.

125. I have come to the conclusion that the appropriate sum to compensate her by way of general damages for pain and suffering into the future is also the sum of €100,000.

126. Finally, this brings me to the loss of earnings or loss of earning capacity claim.

127. Prior to the plaintiff's surgery in April 2008, the plaintiff had an excellent work record. After she left school in 1978, she did a secretarial course and from then until November 2008, was constantly in employment. Over that time, she had only three employers and her work history thus presents a picture of considerable stability. For the ten years prior to November 2008, she worked for Delap & Waller, as mentioned above, in a secretarial/personal assistant capacity and was earning approximately €39,000 *per* annum including bonuses.

128. I am quite satisfied on the evidence that the plaintiff was a diligent, competent and valued employee. I am satisfied that upon her return to work in October 2008, her capacity for her work was greatly degraded because of her anxiety disorder and I accept her evidence that in that short period back at work, she was frequently in difficulty because of mistakes in her work.

129. However, it is clear that the reason for her redundancy in November 2008 was not her inability to work, but rather the downturn in the construction industry which led her employers to downsize their operation, and the plaintiff does not make the case that she was made redundant because of the anxiety disorder which, by then, was grossly afflicting her.

130. I am satisfied that if the plaintiff had not suffered this anxiety disorder, having been made redundant in November 2008, she would in all probability have sought alternative employment, and if necessary for that purpose, would have undertaken upskilling courses. Because of the state of the economy then, and indeed now, it would not have been easy for anyone of the plaintiff's age, made redundant in November 2008, to get new employment. I am satisfied, therefore, that the plaintiff, regardless of her anxiety disorder, would have faced a prolonged period of unemployment post-November 2008, but I am also equally satisfied that in due course she would have made her way back into fulltime employment.

131. I would be inclined to the view that this would probably have taken her two to three years to accomplish and may indeed have required upskilling courses, but she was a person who had always been employed, clearly enjoyed work, and no doubt the earnings it generated. Thus, I am satisfied that as a matter of probability, she would have regained her position in the workforce, probably in the area of secretarial services or personal assistant-type work. Initially, she would probably have regained her foothold perhaps by doing temporary work through an agency or perhaps by providing secretarial services on a self-employed basis. I am satisfied in due course she would have made her way back to fulltime employment.

132. In all of these circumstances, it is obviously not possible to be in any way precise in the calculation of what the loss to the plaintiff as a result of what has been the destruction of her capacity for work, either since being made redundant in November 2008 to date, or from now until normal retirement at the age of approximately 65 years.

133. I have the benefit of actuarial report prepared by Mr. Byrne, but the figures there provided can only be used as a guide. He

estimates the future loss of earnings of the plaintiff at approximately €350,000. A number of factors would combine to reduce this. The first of these is that the earnings level which the plaintiff might expect to have on return to work would probably be considerably less than she had when working for Delap & Waller. In this regard, I think it is likely that on return to fulltime work, her earnings would probably be in the region of about €30,000 per annum. In addition, there must be a discounting in respect of other vicissitudes of life that might intervene to impair or shorten her working life, as required by the decision of the Supreme Court in the case of *Reddy v. Bates*.

134. Taking all things into account, it would seem to me that the most appropriate way to compensate the plaintiff for the loss of her earning capacity is to award her a global sum in respect of her past loss of earnings and future loss of earnings to include also any consequential loss of pension entitlement resulting from her inability to continue making contributions to a defined contribution scheme as she had been doing whilst employed in Delap & Waller.

135. My conclusion in this regard is that the appropriate sum to compensate the plaintiff for all of this is the sum of €225,000.

136. Accordingly, therefore, there will be judgment for the plaintiff for the sum of €425,000 plus any agreed special damages.