Neutral Citation Number: [2010] IEHC 211

THE HIGH COURT

2008 3328 P

BETWEEN

DENIS O'LEARY

PLAINTIFF

AND

THE HEALTH SERVICE EXECUTIVE

AND

KHALID M. ALI CHIAD AL-SAFI

DEFENDANTS

JUDGMENT of Mr. Justice John Quirke delivered on the 20th day of May, 2010

The plaintiff is a forty-five year old single man who lives in Knocknaheeney, in County Cork.

In these proceedings he claims damages from the defendants to compensate him for personal injuries suffered as a result of alleged negligence and breach of duty by the defendants.

The first named defendant is the Health Service Executive which is the corporate body established by law with responsibility for the provision of health services within the State. Its responsibilities include the management, control and administration of the Mercy University Hospital in Cork (hereafter "the hospital"), and the provision of urological and related treatment, care and services to patients, (including the plaintiff), who attend the hospital.

The second named defendant, Mr. Al-Safi, is a consultant urological surgeon who, at all times material to these proceedings, was employed by the first defendant as a locum consultant urological surgeon.

The plaintiff's claim is threefold. He claims (1) that as a result of the defendants' negligence his left kidney deteriorated and became non-functioning between 22nd January, 2002, and 8th August, 2002, whilst he was undergoing anti-tuberculosis therapy, (2) that an augmentation cystoplasty was performed upon him unlawfully and without his informed consent because Mr. Al-Safi failed to disclose to him all of the known facts, risks and alternatives associated with that surgery and (3) that, because he was insufficiently qualified and insufficiently experienced to adequately manage and medically treat his symptoms and condition, Mr. Al-Safi negligently subjected him an inappropriate and unnecessary augmentation cystoplasty on the 16th of May 2006.

He claims that, in consequence, he has suffered significant and unnecessary pain, suffering, distress loss and damage.

(1) The plaintiff's left kidney.
The plaintiff presented to the hospital on the 2nd of January 2002 complaining of painless haematuria and other symptoms.

Although a CT scan, undertaken on 31st January, 2002 and intra-venous pyelograms, (IVPs), carried out in the hospital on the 3rd of January 2002 and the 8th of May 2002 had shown little, (if any), appreciable function within the plaintiff's left kidney, a DMSA isotope renogram, undertaken on the 22nd of February 2002, demonstrated significant function (approximately 31%) within that kidney.

The plaintiff was correctly diagnosed with genitourinary tuberculosis and was, quite properly, referred to a consultant physician in infectious diseases (Dr Horgan) in April 2002. Dr Horgan treated him successfully over a nine month period.

Mr. C.M. Bishop, who is a consultant in urological surgery, and who testified in support of the plaintiff, was of the opinion, (in June 2008), that, before referring him to Dr Horgan, the hospital's consultant urologist, Mr. Eamon Rogers should have inserted a stent between the plaintiff's kidney and his bladder, temporarily whilst he was undergoing his anti-tuberculosis treatment.

He took the view that, in the light of the DMSA result, it might have been possible to preserve significant function within the plaintiff's left kidney during and after his anti-tuberculosis therapy by appropriate stenting at the relevant location.

He concluded that the plaintiff had received sub-standard treatment at the Mercy Hospital because that course of action was not followed by Mr. Rogers.

Mr. K.K Sethia,Mr. H.B.Y Gana and Ms Helen Parkhouse, all of whom are consultants in urological surgery who testified in support of the plaintiff's claim, agreed with Mr. Bishop on this issue in reports written between July 2009 and November 2009. All relied upon the DMSA result of 22nd February 2002 (indicating 31% function in the plaintiff's left kidney) in support of their conclusions.

In fact, it has now been agreed by all of the expert witnesses who testified in this case, (including Messrs Bishop, Sethia and Gana and Ms Parkhouse), that the DMSA isotope study undertaken on 22nd February 2002 was, in the words of one witness, "largely useless" because incorrect software was applied to the study and, consequently, its findings were entirely erroneous.

On 12th August, 2002, an isotope study known as a DTPA renogram (with Lasix) of the plaintiff's left kidney was undertaken. The result of that scan indicated that there was no useful function present within the plaintiff's left kidney. That result was consistent with the results of the earlier tests including the CT scan undertaken on the 31st January 2002 and the IVPs of the kidney, carried out on the 3rd of January 2002 and the 8th of May 2002.

Mr. D. Lanigan and Mr. J. Drumm, consultants in urological surgery who testified in support of the defendants were firm in their conclusions that there was no recoverable function within the plaintiff's left kidney in February 2002 and thereafter.

They were of the opinion that stenting between the plaintiff's bladder and his left kidney was neither necessary nor desirable for the plaintiff whilst he was undergoing the anti-tuberculosis treatment in 2002 and 2003. Mr. Eamon Rogers and Mr. Al-Safi agreed.

Messrs Bishop, Sethia and Gana and Ms. Parkhouse argued that, Mr. Rogers ought to have inserted a stent or stents between the plaintiff's left kidney and his bladder in case recoverable function was present and because the DMSA of the 3rd February suggested significant function.

However, Messrs Sethia and Gana and Ms. Parkhouse, agreed in retrospect that, whilst it was possible that there might have been some function within the kidney in February 2002, it was unlikely that recoverable function was present at that time.

Mr. Bishop said that, in retrospective, he simply did not know whether or not there was recoverable function within the Plaintiff's left kidney in February 2002.

On that particular issue the evidence adduced on behalf of the defendants was not inconsistent with the evidence adduced by the four urological surgeons called to testify in support of the plaintiff's claim.

I am satisfied, on the evidence, that as a matter of probability, there was no recoverable function within the plaintiff's left kidney when he attended the Mercy Hospital in Cork on 2nd January, 2002.

Accordingly, whilst the application of incorrect software to the DMSA isotope renogram comprised negligence by the Hospital, the plaintiff has not established on the evidence and on the balance of probabilities, that he has suffered any consequent injury loss or damage.

There has been conflicting expert evidence adduced on behalf of the parties in relation to;

> (a), the nature and level of investigation which was required and undertaken by Mr. Rogers in early 2002, particularly in relation to appropriate urodynamic investigation and a cystoscopy.
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> (b), whether Mr. Rogers, ought to have inserted a stent between the plaintiff's kidney and bladder in February 2002 (and in particular after the DMSA isotope renogram on the 22nd of February 2002) and
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> (c), an alleged absence of a systematic approach in 2002 to the investigation and treatment of the plaintiff's urinary problems, (with particular reference to the recoverable function within his left kidney).

Having regard to the finding which I have now made, I believe that it is unnecessary for me to make any findings on those matters.

(2) Informed consent
It is claimed on behalf of the plaintiff that, before commencing augmentation cystoplasty Mr. Al-Safi had a duty to disclose to the plaintiff of all of the known facts, risks and alternatives which are associated with that particular surgery.

It is contended that Mr. Al-Safi did not disclose to the plaintiff all of the relevant facts, risks and alternatives and that, if he had done so the plaintiff would not have undergone the surgery and would not have suffered the injury alleged.

(i) Evidence on informed consent
Mr. Bishop stated that before performing an augmentation cystoplasty prospective patients should be warned that the surgery can have troublesome side effects which adversely affect quality of life. He said that these complications include recurrent infections, stone formation, mucus production, blood electrolyte abnormalities and bowel dysfunction, (including chronic diarrhoea).

He said that patients should also be warned that there is a significant risk that the surgery may fail to relieve frequency, urgency and pain, and to provide an efficiently emptying urinary reservoir.

He also stated that the plaintiff ought to have been warned before surgery, (a) of the absence of medical consensus on the risk of malignancy after joinder of bowel musosa to the bladder and, (b) of the need for follow up cystoscopies on an annual basis, particularly in respect of patients such as the plaintiff, who had suffered from tubercular cystitis.

Mr. Sethia said that Mr. Safi had an additional duty, (i), to explain to the plaintiff, prior to surgery, that his condition could be treated either by conservative or by surgical means in the first instance; (ii), that additional risks included incontinence and metabolic disturbances, and. (iii), that the surgery was likely to require him to perform self-catheterisation for life.

Mr. Gana repeated the views expressed by Mr. Bishop and Mr. Sethia as to the nature and extent of warning which should have been given to the plaintiff prior to surgery.

Ms. Parkhouse was in broad agreement with the views expressed by Mr. Bishop on this matter and she said that, based upon her examination of the notes and records with which she had been provided, she had formed the opinion that the plaintiff had not been adequately warned

The plaintiff said that after the completion of his anti-tuberculosis therapy, he had felt very well for between twelve and eighteen months, but then suffered from urinary frequency and pain and had sought an appointment with Mr. Rogers in the Mercy Hospital.

He stated that after Mr. Rogers, having carried out a series of tests, told him that his bladder had been "shrinking" and that he needed surgery. He said Mr. Rogers also told him that he had "a bad kidney" which was affecting his good kidney, and that the recommended surgery was required in order to address and reduce the risk of kidney failure and the requirement for dialysis at a later stage.

He said that Mr. Rogers had told him that he would need to self-catheterise for a short time after surgery, but that the surgery was "a routine operation" which he, (Mr. Rogers), had performed many times.

He said that he asked Mr. Rogers "is there any other way?" and that Mr. Rogers replied "no, we need to work fast on this".

He said that when he attended the hospital for the surgery, he was surprised when he was introduced to Mr. Al-Safi. He was told that Mr. Rogers had moved to another hospital a short time prior to his attendance.

He said that he was unwilling to proceed with the surgery because he did not know Mr. Al-Safi "as a doctor".

He said that Mr. Al-Safi "more or less pressurised me to get the operation", stating that the surgery would be of benefit to him and would avoid or reduce the risk of kidney failure with the consequent requirement for dialysis or a possible kidney transplant.

He said Mr. Al-Safi told him that the operation was a routine operation which would be "100% successful" and that after the surgery he would be able to lead a normal life.

He said that when he first met Mr. Al-Safi, he was told by Mr. Al-Safi that Mr. Rogers would be performing the surgery upon him, that he would benefit from the surgery, which was an easy procedure, and that after the surgery he would lead a normal life, would return to urination every five or six hours and would be able to sleep peacefully and normally.

He said that the first time he discovered that Mr. Al-Safi was performing the surgery was the night before it was scheduled, when Mr. Al-Safi came to speak to him in hospital.

He said that he told Mr. Al-Safi that he did not want to have the surgery, but Mr. Al-Safi pressurised him and asked him to think about it overnight. He said he was given "twelve hours to think about it".

In cross-examination he said that on the morning of the surgery, he again told Mr. Al-Safi that he did not want him to perform the surgery but Mr. Al-Safi pressurised him and frightened him into agreeing to undergo the surgery.

He said that Mr. Al-Safi again told him that if he did not undergo the surgery he would require dialysis and possibly a kidney transplant, that his chances of successful surgery were 100% and that, after the surgery, he would be "perfect".

He said that his sister was present with him when he made his decision and that he discussed the matter with her and decided to agree to the surgery because Mr. Al-Safi had "guaranteed me that it would be 100%".

He said that four days after the operation, Mr. Al-Safi came to him and told him that he would have to return to the hospital every twelve months for a bowel biopsy because he would be prone to cancer within ten years of the surgery.

He said that this was the first time that he had learnt of any risk of cancer and that he had been told that he was at any risk in respect of cancer, he would not have agreed to the surgery because his mother had died young from cancer.

Although the plaintiff's sister was in court and in contact with the plaintiff during his testimony she did not testify in these proceedings.

Mr. Al-Safi stated that he first met the plaintiff on the 12th of April 2006 in the Mercy Hospital.

He had noted the plaintiff's presence on the waiting list and had called him into the hospital to discuss his symptoms and treatment.

He said that the plaintiff told him that he had been expecting to be provided with a date for the augmentation surgery which Mr. Rogers had discussed with him.

Mr. Al-Safi said that he explained the nature and extent of the surgery to the plaintiff in detail, and that the plaintiff told him that he was looking forward to the surgery because he believed it would relieve his symptoms.

Mr. Al-Safi said that he explained to him the significance of his small bladder and non-functioning left kidney with the consequent risk for his right kidney.

He said he discussed the need for a cystoscopy and a biopsy in order to out rule any possible cancerous condition.

He said that he explained the need for an increase in the capacity of the plaintiff's bladder and that after the surgery he would need to self-catheterise on a number of occasions every day.

He said that he had warned the plaintiff that this self-catheterisation might be permanent and lifelong.

He also said that explained to the plaintiff that he might need re-exploration surgery if there was a bowel obstruction or complications resulting from the surgery because it involved transplanting sections of his bowel.

He also said that he explained to the plaintiff that he would have to drink significant quantities of water after surgery regularly because of the likely presence of mucus within his bladder. He said that he also warned of the risk of nocturnal wetness and of the risk of infection and stones.

He said that he had warned the plaintiff of the risk of cancer, telling him that the risk was very small, but nonetheless, was real, and would probably need to be investigated between ten and fifteen years after the surgery.

He said he told the plaintiff that the principal objective was to augment his bladder and reduce the symptoms whilst protecting his right kidney which was under threat.

He said that he told the plaintiff that he could not guarantee the success of the treatment and that it would be necessary to keep him on medication post-operatively because of the likelihood of residual symptoms.

He said he believed that the plaintiff understood what he was telling him, indicating that this discussion with the plaintiff took place on the night before surgery whilst the plaintiff was watching films on television.

He said he told the plaintiff that the biopsy results were fine and had shown nothing sinister.

He said that he had made no attempt to persuade the plaintiff to undergo the surgery and that the plaintiff was anxious to proceed,

believing that the surgery would help to relieve his symptoms.

Messrs Lanigan and Drumm were in broad agreement with the plaintiff's expert witnesses in relation to the nature and level of disclosure and the warnings required before the performance of an augmentation cystoplasty.

They were both of the opinion that the note made by Mr. Al-Safi on the 12th April, 2002, was consistent with his evidential account of the disclosure and warning which he gave to the plaintiff.

Both said that it was not feasible or customary for urological surgeons to record in detail every aspect of the warnings and advice given to patients for whom surgery was being recommended. They said that notes such as that made by Mr. Al-Safi on the 12th April 2002 were normal in such circumstances.

Mr. Drumm said that if complex detailed records of warnings given by all surgeons on all relevant occasions are to be required then the number of patients who can be accommodated in clinics will be greatly reduced.

Decision
Mr. Al-Safi made the following entry in the note recording his interview with the plaintiff on 12th April, 2006: "Aug cyst explained fully to him: need for I.S.C.; noct wetness; bowel obst and re-exploration; need for post-op medications to control symptoms."

It has been suggested by Mr. White, on behalf of the plaintiff that Mr. Al-Safi could not have made adequate disclosure of the relevant risks to and options for the plaintiff within the 20 minute period of his interview with him. I do not understand why he would not have been able to do so within that time.

Additionally, Mr. Al-Safi said in evidence that the two men discussed some of the relevant matters on the evening before surgery.

The plaintiff, in his evidence, confirmed that some of those matters were indeed discussed between them on that evening but he gave a different account of what was said. He said that his discussion with Mr. Al-Safi on the evening before the surgery had been witnessed and fully overheard by his sister.

During his evidence he pointed to his sister who was present in court throughout his testimony and stated that she would corroborate his account of his conversation with Mr. Al-Safi.

No corroborative evidence was adduced by the plaintiff's sister in support of the plaintiff's account of what was said.

I did not find the plaintiff to be a reliable or credible witness. I am not satisfied that he has established, on the evidence and on the balance of probabilities, that Mr. Al-Safi failed to advise him of all the known facts and risks associated with augmentation ileocystoplasty.

I found Mr. Al-Safi to be a conscientious witness and I believe that his account of the warnings which he gave to the plaintiff in respect of the risks associated with augmentation cystoplasty is probably an accurate and correct account.

It follows that I am satisfied on the evidence and on the balance of probabilities;

> (a), that he explained to the plaintiff in full the nature and extent of the surgery which he was recommending and the need for a cystoscopy and biopsy in order to rule out any possible cancerous condition,
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> (b), that he warned the plaintiff that self-catheterisation might be a consequence of the surgery and might be permanent and lifelong,
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> (c), that he explained to the plaintiff that he might need re-exploration if there were bowel obstructions or complications resulting from the surgery, and
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> (d), that he also warned the plaintiff of the risk of nocturnal wetness, infection, stones and the presence of mucus within his bladder.

It is also probable that Mr. Al-Safi warned the plaintiff of the risk of cancer resulting from the surgery, but told him that it was a very small risk and might need to be investigated between ten and fifteen years after the surgery and that he could not guarantee the success of the treatment, but was hopeful that it would relieve the plaintiff's symptoms and protect his left kidney.

In particular I do not believe that it is likely or probable that Mr. Al-Safi told the plaintiff that his chances of successful surgery were 100%.

It was suggested during the course of the proceedings that there was an obligation upon Mr. Al-Safi, (having first explained the known facts and risks associated with each procedure), to give the plaintiff the option of choosing between three surgical procedures, (augmentation cystoplasty, substitution cystoplasty and diversion by ilial conduit), which are sometimes used for the treatment of his urological symptoms and condition.. I do not accept that there was such an obligation upon Mr. Al-Safi.

Both Mr. Rogers and Mr. Al-Safi stated in evidence that, exercising their clinical judgment, they each believed that the successful treatment of the plaintiff's symptoms and condition could be best achieved by augmentation cystoplasty. Mr. Lanigan and Mr. Drumm were of the same opinion.

Mr. Al-Safi explained that, in his opinion, there were significant risks to the plaintiff's health and wellbeing associated with both substitution cystoplasy and diversion by ileal conduit and he did not believe that it was in the plaintiff's best interests for him to be submitted to either procedure.

Why then should Mr. Al-Safi be expected to offer to perform such surgery for the plaintiff?

Mr. Al-Safi was under a duty to explain to the plaintiff the nature and extent of the augmentation cystoplasty which he was recommending and to further explain to him that the decision as to whether or not this surgery should be undertaken was for the plaintiff to make and not for Mr. Al-Safi. I am satisfied the he did so.

The plaintiff was quite entitled to choose not to undergo the surgery and, indeed, was entitled to choose not to accept any treatment.

I do not, however, accept that Mr. Al-Safi was under a duty to offer the plaintiff any surgical procedure which he was not recommending and which he did not consider was an appropriate treatment for the plaintiff's symptoms and medical condition.

I accept the evidence of Mr. Lanigan and of Mr. Drumm that the warnings given by Mr. Al-Safi to the plaintiff in respect of the augmentation cystoplasty were the appropriate warnings which should be given to patients in respect of the relevant urological surgery in 2006.

It follows from what I have just found, that the plaintiff has not established, on the evidence and on the balance of probabilities that Mr. Al-Safi failed to disclose to him all of the known facts and risks associated with the augmentation iliocystoplasty which was performed by him upon the plaintiff on 16th May, 2006.

(3) Qualification, management and treatment

(i) Evidence of qualification
Mr. Bishop stated that Mr. Al-Safi was neither sufficiently qualified nor experienced to adequately manage and medically treat the plaintiff's condition in April and May 2006. He said that the plaintiff should have been referred to and treated by a urological surgeon with a special interest and expertise in reconstructive surgery of the type which was in contemplation and;

> (a), that the surgery should not have been undertaken by a urological surgeon with occasional experience in this type of surgery, and should never have been undertaken by a locum surgeon because of the likelihood that such a surgeon would be unavailable to continue treatment after surgery
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> (b), that in 2006, a patient suffering from the plaintiff's symptoms was entitled to expect management and treatment from a unit comprising medical, nursing and administrative staff who should be familiar with the problems which the plaintiff was experiencing and
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> (c), that if such a unit was not available within the Mercy Hospital when the plaintiff attended with his complaints, then the plaintiff should have been referred to a hospital where such a unit was available, or alternatively to a hospital where a consultant urological surgeon with sufficient specialist qualification and experience would have been available to properly manage and treat the plaintiff.

He was critical of the fact that in May 2006, the audited account of the surgery undertaken by Mr. Al-Safi disclosed that he had performed no more than five augmentation cytoplasties prior to the surgery undertaken upon the plaintiff, and that some of those surgical procedures were performed under supervision.

Mr. Sethia and Dr. Parkhouse were also critical of Mr. Al-Safi's qualifications and experience and Mr. Gana, additionally, took the view that the appropriate level of qualification included entry upon a specialist register which he said was applicable to this jurisdiction and the United Kingdom.

In summary, the expert medical witnesses who testified in support of the plaintiff's claim took the view that the management of the plaintiff's medical condition in April and May 2006, was inappropriate and was below the requisite level required for the appropriate management and treatment of the plaintiff's condition and that this deficit was caused or influenced by Mr. Al-Safi's inadequate qualification and experience.

However, all of the expert witnesses who testified in support of the plaintiff's claim acknowledged that the augmentation cystopasty performed by Mr. Al-Safi upon the plaintiff in May 2006, was performed competently, efficiently and carefully and that the technique and skill level demonstrated by Mr. Al-Sasi in the performance of that surgery was fully in accordance with general and approved medical practice applicable in this jurisdiction in 2006.

Mr. Al-Safi stated that he had considerable experience of reconstructive urological surgery throughout his career. He outlined his experience of reconstructive surgery during Iraq's war with Iran during the 1980s, and later in Jordan and in Sudan. Recording surgical procedures in a logbook was not a requirement in any of the jurisdictions where he worked other than Ireland and the United Kingdom.

He confirmed that he possessed all of the qualifications required for the management of the plaintiff's symptoms and for the position which he occupied as a locum consultant urological surgeon in the Mercy Hospital in 2006.

Mr. Lanigan, said that Mr. Al-Safi was perfectly well trained and possessed all of the requisite qualifications for the post which he occupied in the Mercy Hospital.

He said that he could understand how an English or British urologist might take the view that the plaintiff should have been referred to an urologist with constant experience of augmentation and who performed little other surgery in practice.

However, that was not and is not an option in Cork, which is a relatively small city in which there are still only five urologists in practice working on a rota system. All five urologists still cover all of the hospitals within Cork city at weekends.

He said that augmentation cystoplasty is at the lower end of complexity for reconstruction within this jurisdiction where most urologists, placed in the plaintiff's situation, would "have just got on with it".

He said that he had spent two years in Cork and had attended education meetings and training sessions with Mr. Al-Safi. He found Mr. Al-Safi to be an impressive and well-trained individual with an unusual sub-speciality of laparoscopic urology and perfectly adequate experience.

He said, presently, in the Mercy Hospital, another consultant occupies the post formerly occupied by Mr. Rogers and the post formerly occupied by the other consultant is now occupied by a locum consultant who has spent four years in that post.

He said that in the NHS in England, there are sufficient numbers of urologists for the provision of genuine sub-specialities such as reconstructive urology, but that is not the case in Ireland. There are only three urologists in this jurisdiction with a specialist interest in reconstructive urological surgery. Those three only take referrals in particularly difficult or unusual cases. He said augmentation

cystoplasty is undertaken routinely by urological surgeons in Ireland and is not regarded as a difficult or unusual procedure.

He said that the number of urologists in Ireland is inadequate. Almost all deal with general urology. There is no specialised unit for reconstructive urology, although there is a transplantation unit in Beaumont Hospital where renal transplantation and general urological surgery is performed. Mr. David Hickey is the Director of that unit.

Mr. Drumm said that Mr. Al-Safi was an extremely well-trained urologist who was fully qualified to act as a temporary locum consultant in the Mercy Hospital in 2006.

He had all the qualifications required by the contract for the post which he occupied in the Mercy Hospital and he would have been entitled to apply for the permanent post formerly occupied by Mr. Rogers if that post had become available.

In 2006, a specialist register was established by the Irish Medical Council which entitled specialist surgeons to apply for registration on an optional basis. Mr. Al-Safi would not have been eligible for registration in 2006.

On 16th March, 2009, the Medical Practitioners Act 2007 (Commencement Order 2009) (S.I. No. 40 of 2009) came into effect, requiring surgeons who wished to engage in sub-specialities to apply for registration as a specialist upon the register.

Mr. Drumm explained that there are now three registers maintained by the Medical Council; a general register, a specialist register and a training register. Mr. Al-Safi is now entitled to seek registration on the specialist register within this jurisdiction because he has all the appropriate qualifications for registration within the Irish system.

Registration on the specialist register is not compulsory in the private sector but is compulsory in the public sector.

Mr. Rogers, in evidence, stated that most urologists, such as he who had completed a period of general surgery in their training, were comfortable performing augmentation cystoplasty surgery.

He said that for a general surgeon, it was not a difficult procedure, and he had never encountered a surgeon who had felt it necessary to refer an augmentation cystoplasty to a specialist surgeon.

He said there is no specialist unit for specialist urological surgery in Ireland.

Mr. David Hickey, who is the director of transplantations, urology and nephrology at Beaumont Hospital in Dublin, and the director of the National Kidney Transplant Unit, stated, in evidence, that Mr. Al-Safi came to work in his unit in Beaumont Hospital in 2001, and spent three years in the Urology and Transplantation Department.

He said that Sudan University was a highly respected centre with huge volumes of work and Mr. Al-Safi had substantial experience in reconstructive urological surgery arising out of his work in Sudan and in Iraq and in Jordan. He had no doubt whatever as to his capacity to deal with the plaintiff's symptoms in a competent and appropriate manner.

He said that augmentation was not a technical challenge for someone of Mr. Al-Safi's ability and experience and he would be happy to refer patients to Mr. Al-Safi for such surgery then and now.

He said that the plaintiff was already a very talented and well-trained urologist when he arrived in Beaumont Hospital. On the basis of his performance there, and with the hope of recruiting him to work in Beaumont Hospital, a €20,000 grant was procured for him to go to Heilbronn in Heidelberg in Germany. He said this was a mark of the hospital's interest in investing in Mr. Al-Safi's future within Beaumont Hospital.

He said that, regrettably, it is not possible for Mr. Al-Safi to return to Beaumont Hospital, but he was aware of his professional education as an urologist in Iraq and, later, that he had acquired an international reputation.

(ii) Evidence on management and treatment

Mr. Bishop agreed that when the plaintiff returned to the Mercy Hospital in September 2005, his initial management and treatment by Mr. Rogers was appropriate and efficient.

He also agreed that Mr. Rogers was correct to make a provisional recommendation for surgery.

He said that urodynamic and cystoscopic assessments were necessary before proceeding to surgery and that the surgery should be directed towards lowering pressure within the bladder in order to protect existing renal function and to improve the plaintiff's symptoms.

He said that Mr. Rogers should have modified his decision to recommend the plaintiff for augmentation cystoplasty when he received the results of the cystoscopy which was performed on 8th February, 2006, because this disclosed bleeding after distension with bladder capacity reduced to 200ml.

He approved of Mr. Al-Safi's decision to arrange for a second cystoscopy on 27th April, 2006, to obtain biopsies, but criticised Mr. Al-Safi's decision to proceed with surgery after the second cystoscopy demonstrated chronic inflammatory infiltrate and a "golf hole" appearance in the right ureteric orifice.

He stated that since the plaintiff was now complaining of bladder pain, in addition to his other symptoms, Mr. Al-Safi should have postponed the reconstructive surgery for a period and attempted conservative methods including medication, hydro-distension of the bladder under anaesthetic, and other therapies.

He agreed that if these methods were unsuccessful, surgery might have been required, but he believed that substitution cystoplasty or ileal conduit surgery would have been preferable to augmentation cystoplasty.

Mr. Sethia agreed with Mr. Bishop. He said that although conservative treatment might have ultimately failed, it would have delayed the need for surgery for some time.

He said that, if surgery became necessary, a substitution rather than an augmentation cystoplasty would have been his preferred option.

Mr. Gana was in agreement with Mr. Bishop in relation to the management of the plaintiff's symptoms by conservative measures in the first instance.

He said that he considered the decision by Mr. Al-Safi to perform an augmentation cystoplasty was inappropriate because it maintained the diseased bladder and would not have reduced or eliminated the plaintiff's plain.

Ms. Parkhouse stated, in evidence, that reconstructive surgery of the kind contemplated should never be undertaken without prior urodynamic investigation. She said that this applied to all of the pre-surgical options under consideration.

She said if the plaintiff was to undergo any surgery then it ought to have been a cystecomy which would have required removal of the bladder and its replacement with a new bladder made from bowel, or alternatively, a diversion into an ileal-conduit.

It was acknowledged by all of the expert witnesses who testified in support of the plaintiff's claim that because he has a small contracted and diseased bladder, with "golf hole" configuration at the ureteric orifice, his remaining functioning kidney (the right kidney) was under threat in 2005, when the plaintiff was first seen by Mr. Rogers.

It was not conceded by those witnesses that the creatinine measurements which were recorded between November 2005 and May 2006, necessarily demonstrated any evidence of deterioration of renal function in that kidney.

Mr. Eamon Rogers said that during 2003, he had made several attempts to persuade the plaintiff to attend for a cystoscopy without success. The plaintiff had failed to attend in August and September 2003 and had a history of not wanting certain examinations. He was satisfied that the plaintiff could not tolerate urodynamic tests or scrotal examination at that time.

He disagreed with the view of Ms. Parkhouse that an augmentation cystoplasty should never be performed without prior urodynamic testing. He said that the principal consideration during contemplation of an augmentation cystoplasty, is the capacity of the bladder which can be established by performing a cystoscopy.

Whilst urodynamic investigation was desirable, he had expressly recorded that the plaintiff "will not tolerate urodynamics under any circumstances", which was a very unusual comment for him to make and indicated that the plaintiff was adamant that he would not undergo such tests.

He said that urodynamic investigation is required for the purpose of measuring bladder pressure. Whilst that would have also been of some assistance in the plaintiff's case, a cystocopy was the required and appropriate investigative test prior to the performance of an augmentation cystoplasty.

He was quite satisfied that proper practice required him to exercise his clinical judgment as to whether or not surgery was the appropriate treatment for the plaintiff and he did so based upon the plaintiff's poor bladder capacity and the threat to his functioning right kidney.

He had treated the plaintiff in the first instance by conservative measures including medication, but when he examined the plaintiff on 22nd February, 2006, he discovered that the plaintiff was then voiding every thirty minutes, as distinct from every sixty minutes in November 2005.

He concluded that his conservative measures were not working and he inferred from his clinical observations that the plaintiff now had reduced bladder capacity which was a pro-mobid factor which would contribute to renal deterioration.

He believed that an augmentation cystoplasty was the appropriate surgery required in order to reduce or eliminate the plaintiff's pain, frequency and urgency, to improve his quality of life and to reduce the risk to his right functioning kidney.

Based upon his observations, he discussed surgery and, in particular, augmentation cystoplasty with the plaintiff and told him that there was a threat to his right kidney and that if he did not have surgery, it was his opinion that his right kidney could fail and that he might need dialysis or a kidney transplant.

He said that he told the plaintiff that he should not embark on surgery until he had first learnt self-intermittent catheterisation which is a method of emptying the bladder. That method is difficult and requires training.

He was doubtful that the plaintiff would be able to master self- catheterisation, notwithstanding the fact that there was an excellent training unit for this procedure within the Mercy Hospital.

He said that he did not tell the plaintiff that he would be required to self- catheterise for approximately four weeks before his bladder function would then return to normal urination.

He said that he did not ever tell the plaintiff that augmentation cystoplasty or any other type of surgery would have a 100% chance of success.

Mr. Rogers left the Mercy Hospital on 15th March, 2006, before the plaintiff had completed training in self-catheterisation.

Mr. Al-Safi, in evidence, stated that he was appointed as a locum consultant urologist in the Mercy Hospital in Cork, commencing on 20th March, 2006.

He said that he immediately examined the waiting list at the hospital, and noted that the plaintiff was awaiting an augmentation cystoplasty and had been referred for training in intermittent catheterisation which was the fundamental step towards embarking upon augmentation cystoplasty.

He said that he was advised that the training had been successful and, based on his experience in Iraq and in Jordan with patients suffering from tubercular cystitis he believed that a biopsy of the plaintiff's bladder was necessary before embarking upon the recommended surgery.

He said he asked the plaintiff to attend the Outpatients Department and took a full history of his medical symptoms and condition from him. He noted that the plaintiff was enthusiastic about the proposed surgery and was concerned that the biopsies and cystoscopy might cause a delay.

He said that the results of the cystoscopy indicated that the left ureter was fibrosed and obliterated, with the right ureter widely open, giving a "golf hole" appearance.

He said that he had no doubt that this cystocopy disclosed an "end stage" bladder secondary to chronic tuberculosis, and he was quite convinced that the correct decision was to proceed with augmentation cystoplasty.

He said that suprapubic pain relating to the filling of the bladder is a very common indicator that surgery should be performed, because a small bladder cannot hold much water.

He said that a small, contracted bladder, such as the plaintiff's, was likely to cause him pain because of its reduced capacity, and this was an indication for surgery by way of augmentation cystoplasty to increase the capacity of the bladder and reduce pressure.

Additionally, and importantly he believed that the augmentation cystoplasty would have an effect of significantly reducing the very real threat to the plaintiff's right kidney so he was satisfied that it was the appropriate treatment for the plaintiff's condition. It was upon that basis that he decided to proceed with the surgery. He retains the view that this was the correct course, in the circumstances.

Mr. Lanigan said that when the plaintiff presented to Mr. Rogers in November 2005, capacity tests were necessary and were undertaken. He said that the decision by Mr. Al-Safi to undertake a cystoscopy was correct and appropriate in the circumstances, and he explained why.

He said that whilst urodynamics might have been helpful, they were not necessary in the circumstances because they are not regarded as physiological tests and can have poor predictive value in relation to the success of surgery.

An urodynamic test is helpful in relation to bladder pressure but the relevant factor for the plaintiff was his bladder capacity. A cystoscopy was the appropriate test for that purpose.

He disagreed fundamentally with the view of Ms. Parkhouse that urodynamics, prior to augmentation cystoplasty, is mandatory. He said that a urodynamic test would not have changed the course or the decision making process for the plaintiff. Augmentation cystoplasty was the correct procedure in the circumstances. The process of investigation undertaken by Mr. Rogers was normal and appropriate, as was Mr. Rogers' recorded decision "needs augmentation cystoplasty".

He was of the opinion that Mr. Rogers was correct to require that the plaintiff should be trained in self-catheterisation, and he noted that Mr. Rogers was doubtful of the plaintiff's capacity to learn that technique.

He was of the opinion that conservative treatment of the kind recommended by Mr. Bishop and Mr. Sethia and Mr. Gana might well have been appropriate if the plaintiff was suffering from interstitial cystitis, but the plaintiff had a contracted bladder with scarred tissue and was significantly symptomatic with daytime frequency and night time voiding discomfort caused by tubercular cystitis. .

He rejected any contention that the plaintiff had dual pathology in his bladder.

He said that pain is noted in medical literature as a common and typical feature of tubercular cystitis. Pain is cited as one of the reasons why augmentation cystoplasty should be undertaken in extracts from the 6th and 9th Editions of Campbell and Walsh "*Urology*" which is a leading textbook on that topic.

Mr. Drumm was quite satisfied that the plaintiff was suffering from tubercular cystitis when he presented in February 2006, and thereafter stating that, ". . . you have to convince yourself that he had interstitial cystitis if you are going to justify considering other procedures and there was no question of that here."

He dismissed the suggestion of dual pathology within the plaintiff's bladder, stating that since 1950, there has never been a recorded case of tubercular cystitis and interstitial cystitis in the same patient. The plaintiff had end-stage tubercular cystitis and augmentation cystoplasty was required as a first procedure

He said that suprapubic pain was not a contraindication to the surgery because the plaintiff was a man with a small fibrosed bladder with a urinary capacity of less than 200cc's (whilst asleep). This would have given rise to discomfort and suprapubic pain. He relied also upon published medical literature in support of his contention and, in particular, the 6th and 9th Editions of Campbell and Walsh's '*Urology*'.

Both Mr. Lanigan and Mr. Drumm disagreed with the view of Mr. Bishop that the U.S medical understanding of "augmentation cystoplasty" as described in Campbell and Walsh is different from the understanding of that term within this jurisdiction.

Both Mr. Lanigan and Mr. Drumm ruled out substitution cystoplasty and ileal conduit surgery as options when the plaintiff attended the hospital in 2006.

Mr. Al-Safi stated that he had also considered and ruled out substitution cystoplasty and ileal conduit surgery at that time as inappropriate in the circumstances.

Mr. Lanigan and Mr. Drumm disagreed fundamentally with the suggestion that the plaintiff should have been treated conservatively when he presented in February 2006. Both said that he had already received conservative treatment by way of medication and bladder distension, without success and were insistent that, accordingly, the appropriate treatment was now surgery.

Both surgeons were firmly of the opinion that Mr. Al-Safi had managed and treated the plaintiff's symptoms and condition in a competent, efficient and appropriate manner and in a manner consistent with the general and approved medical standards which were applicable within this jurisdiction in May 2006.

Decision

Mr. Al-Safi's skill as a urological surgeon, capable of performing augmentation cystoplasty expertly and successfully, is not in question in these proceedings.

However his qualifications and experience as a urological surgeon capable of managing the plaintiff's symptoms and medical condition in April 2002 have been challenged and called into question by the expert witnesses called on behalf of the plaintiff.

I do not believe that it is necessary for me to deal in any great detail with this allegation.

I am satisfied, on the evidence, that Mr. Al-Safi had all of the qualifications which were required for the management and treatment of the plaintiff's condition at the time when he did so.

It is not the function of this court to assess or review the level of qualification required for particular professional medical appointments made by Hospital or other medical authorities have been adequate or appropriate. Such matters are within the jurisdiction of the relevant State and professional authorities.

The courts may intervene upon evidence of illegality or misconduct but, *prima facie*, the qualifications required by relevant State and statutory authorities for medical posts such as that occupied by Mr. Al-Safi are presumed to be adequate and appropriate until the contrary has been established. The onus of proof, which rests upon the plaintiff in this case has not been discharged by him.

Having regard to the very substantial amount of reconstructive and other urological surgery which he had performed earlier in Iraq and in Jordan, and having regard also to his further training and experience within this jurisdiction I am satisfied that he was sufficiently experienced to manage and treat the plaintiff adequately.

Mr. Al-Safi's decision to recommend that the plaintiff should undergo an augmentation cystoplasty has been severely criticised as inappropriate in the circumstances.

Implicitly, Mr. Eamonn Rogers, whose qualifications as a consultant urological surgeon have not been called in to question by the plaintiff's expert witnesses, can also be deemed to be criticised because in February 2006 he recommended to the plaintiff that he should undergo an augmentation cystoplasty for his symptoms. He prescribed training in self- cathetherisation for the plaintiff in order to accommodate that surgery.

There has been a conflict between the expert evidence adduced on behalf of the plaintiff in these proceedings, and the expert evidence adduced on behalf of the defendants. It is not the function of the court in proceeding such as these, to review conflicting professional expert evidence and to come down on one side or the other.

It has been repeatedly explained by the courts that where there is genuine conflicting expert medical opinion upon the appropriate medical management or treatment of a patient, a medical practitioner cannot be deemed negligent simply because the management or treatment which he or she has chosen or prescribed or undertaken does not achieve its desired objective or is otherwise unsuccessful.

The fact that medical treatment is unsuccessful is not evidence that the treatment was negligently prescribed or performed. Indeed, on the evidence, there are two genuinely held expert professional medical views as to whether or not the surgery performed upon the plaintiff can be deemed to have been unsuccessful.

There certainly have been two genuinely held expert professional views expressed in this case as to the appropriate management of this plaintiff's medical condition when he attended the Mercy Hospital in November 2005 and thereafter in 2006.

Mr. Rogers and Mr. Al-Safi retain the expert medical opinion that the appropriate management of the plaintiff's condition in 2006 was to offer him augmentation cystoplasty surgery. Mr. Lanigan and Mr. Drumm, in unequivocal expert medical evidence, have supported that medical opinion.

Mr. Bishop, Mr. Sethia, Mr. Gana and Ms. Parkhouse in equally unequivocal expert evidence have expressed a contrary medical opinion.

This Court is not competent to determine which expert medical opinion is the correct one, or, indeed, if either medical opinion can, in fact, be deemed to be precisely correct. On the expert evidence the issue remains in dispute. This Court cannot and should not impose its own views in such circumstances.

The question for this Court to determine is whether, in the circumstances, Mr. Al-Safi acted reasonably.

The principles identified by the Supreme Court in *Dunne v. National Maternity Hospital* [1989] I.R. 91, have a clear applicability to the facts of this case. Of particular relevance is the following extract from the judgment of Finlay C.J. (at p 109);

> *"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 for a person of his qualification . . .*
>
> *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 it 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 the careful conduct of a medical practitioner of like specialisation and skill to that professed by the defendant……..*
>
> *'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."*

The management of the plaintiff by Mr. Al-Safi was consistent with that which had been separately adopted by Mr. Rogers a few months earlier. It was management and treatment which, on the evidence, Mr. Lanigan and Mr. Drumm believed to have been appropriate in the circumstances.

Mr. Rogers, Mr. Lanigan and Mr. Drumm are reputable consultant surgeons who have relevant specialist qualifications and who practice urological surgery successfully within this jurisdiction.

All three have stated, in evidence, that, had they occupied Mr. Al-Safi's position in 2006, they would have followed the course which he took and managed the plaintiff's condition in the manner in which he (Mr. Al-Safi) managed it.

It is true that the expert witnesses who testified in support of the plaintiff's claim disagreed, in evidence, with Mr. Al-Safi's recommendation and the course which he followed. They stated, in evidence, that, faced with the same decision, they would have recommended alternative management, including initial conservative measures followed, possibly by alternative forms of surgery if that proved unsuccessful.

The cumulative evidence adduced on behalf of the parties on this issue falls far short of evidence from which this court could possibly find or infer that Mr. Al-Safi at any point deviated from proper medical practice or followed a course 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".*

It also falls far short of evidence from which the court could find, on infer, that Mr. Al-Safi failed to act reasonably in the circumstances, or failed to follow general and approved medical practice in respect of the management and treatment of the plaintiff's condition.

Accordingly, the plaintiff has not established, on the evidence, that Mr. Al-Safi was in any way negligent in his management of the plaintiff's condition, in recommending augmentation cystoplasty to the plaintiff or in the performance of that surgery for the plaintiff or on any other respect.

It follows that the plaintiff's claim fails and must be dismissed.