Neutral Citation No: [2010] IEHC 25

THE HIGH COURT

2008 1296 P

BETWEEN

SOPHIE WARNOCK

PLAINTIFF

AND

NATIONAL MATERNITY HOSPITAL

DEFENDANT

JUDGMENT of Kearns P. delivered on the 12th day of January, 2010

INTRODUCTION

This is a medical negligence case brought on behalf of the plaintiff against the defendant hospital arising from an injury sustained by the plaintiff during the course of the operative birth of her first child on the 20th of July, 2004.

Following attempted ventouse and a right medial lateral episiotomy, the plaintiff's treating medical specialist, Dr. Sharon Sheehan, achieved delivery of a healthy baby by means of Neville Barnes forceps.

In the course of those procedures, however, the plaintiff sustained a significant 3rd degree tear of both her internal and external anal sphincter. That the injury was caused during the course of the delivery is not in dispute between the parties, nor was it seriously disputed during the trial that the tear occurred as a consequence of the forceps delivery. The plaintiff now has significant ongoing problems of faecal incontinence attributable to the injury sustained whilst in Holles Street.

Had the plaintiff's injury been detected at the time of childbirth in July, 2004 rather than when it was ultimately discovered in February, 2006, the probability is that the injury would have been amenable to effective repair and treatment. As events transpired, the plaintiff's initially mild problems of incontinence increased markedly during the course of her second pregnancy which began in September, 2005 and it was necessary to effect delivery of her second child by caesarean section. At the outset of the hearing, which lasted some 10 days, both sides agreed that the liability issue should be determined first and that any question of damages and the assessment thereof should await the court's decision on the issue of liability.

The plaintiff's case on liability is made on multiple grounds which may be summarised as follows:-

> *(a) That the practices and philosophy of the defendant hospital were at the relevant time not in conformity with good obstetric practice and exposed the plaintiff unnecessarily to the risk of an injury such as that which she sustained.*
>
> *(b) A double instrumental operational delivery should not have been attempted in the instant case*
>
> *(c) There should have been a trial instrumental delivery in the operating theatre.*
>
> *(d) The baby should have been delivered by caesarean section either before or following the failed ventouse application.*
>
> *(e) Alternatively, if a forceps delivery was to be attempted following a failed ventouse procedure, it should only have been carried out by a consultant or under the supervision of a consultant. Dr. Sheehan was not a consultant.*
>
> *(f) Excessive traction was applied during the course of the forceps delivery and such excessive force caused the plaintiff's injury.*
>
> *(g) The plaintiff's injury was detectable and capable of prompt repair by the exercise of reasonable care as defined in Dunne v National Maternity Hospital [1989] I.R. 91 but Dr. Sheehan failed to exercise such reasonable care.*

The defendant vehemently resists and challenges the multiple attacks made on the National Maternity Hospital's practices and philosophy. On the specific issues as to the causation of the plaintiff's tear, Dr. Sheehan, who at the time was a specialist registrar in obstetrics in her third year, gave evidence that she used no excessive force or traction when applying the forceps in this case. She further gave evidence that, following the child's birth, she examined the plaintiff's anal sphincter on two occasions by means of a bidigital examination and did so using all due care and diligence. She found no defect upon such examination. It was contended on Dr Sheehan's behalf that, notwithstanding careful examination following childbirth, a significant number of anal sphincter injuries pass undetected and are occult in nature. In those particular circumstances, it was contended that the injury in question was not one which was reasonably discoverable and negligence was denied.

The plaintiff's baby, Isobel, born on the 20th of July, 2004, is a healthy and normal child, as indeed is her second

child, Elliot, born in 2006.

FACTUAL BACKGROUND

The plaintiff is a nurse who lives in Rathfarnham and who was born on the 22nd of February, 1975. She married Jeremy Warnock, her husband, in 2001.

The plaintiff attended the ante-natal clinic at the defendant hospital for the first time on the 9th of December, 2003, where she requested a 'Domino delivery' (short hospital stay under the care of community midwives to whose care she would be discharged after a few hours). She had a number of follow up visits, either to the hospital or her general practitioner, between January and July and no abnormalities were noted.

On the 19th of July, 2004, the plaintiff was admitted to the defendant hospital under the care of Dr. Mary Wingfield. The pregnancy had reached 42 weeks and 1 day. She was there seen and assessed by Dr Keane. For the purpose of inducing labour, her membranes were ruptured and the liquor was noted to be clear. From 6 pm onwards on the 19th July she was having pain but no contractions. She had a CTG trace applied.

On the following day the plaintiff was moved to the labour ward where the plan was to infuse her with oxytocin to augment her labour and administer an epidural. Another CTG trace was applied. The oxytocin was commenced around 2.20 pm followed almost at once by the first block of epidural. At 5.20 pm she was 3 cm dilated and at 6.30 pm had a foetal scalp electrode applied. By 8.00pm the first stage of labour had ended.

At this time a vaginal examination indicated that the cervix was fully dilated at 10cms with the vertex of the baby's head at the level of the ischial spines. Oxytocin was continued for a short time thereafter while active pushing commenced. Oxytocin was, however, discontinued when late decelerations were noted on the CTG.

At 8.30pm, having reviewed the CTG and having seen on it decelerations which she decided were not reassuring, Dr. Sheehan elected for an instrumental delivery. She suspected foetal distress. She recorded that the vertex of the baby's head was at station 0/+1 (that is to say, at the level of the ischial spines or 1 cm below), and was in the occipito posterior position, that is to say, face up. This form of presentation effectively widens the diameter of the infant's head when passing through the cervix and is a not unusual complication, particularly when the child is a first born.

Having elected to proceed by way of instrumental delivery, Dr. Sheehan first applied a size 5 Ventouse metal cup. However, as she records in her notes, there was but "minimal" descent in three contractions. At this point, as not uncommonly occurs, the cup slipped off.

As will be apparent from the expert evidence later on, Dr. Sheehan had the option, both before and after the ventouse procedure, of sending the plaintiff to the operating theatre for an immediate caesarean section. She could also, according to the plaintiff's experts, have opted to conduct a trial instrumental delivery in an operating theatre. A further option, which she exercised in this case, was to attempt a second instrumental procedure, namely, the application of Neville Barnes forceps.

The experts called on behalf of the plaintiff in this case believed that the first option should have been exercised, whereas those called on behalf of the defendants argued that the course adopted by Dr. Sheehan was appropriate and reasonable in the circumstances. The plaintiff's expert obstetrician, Mr. Roger Clements, while conceding that a second instrumental procedure was not impermissible, contended that a sequential instrumental delivery by forceps was acceptable only when it was carried out either by, or under the supervision of, a fully qualified consultant. He contended that Dr. Sheehan, notwithstanding her considerable experience, had not achieved that status and that, therefore, to proceed as she had done was a breach of her duty of care to the plaintiff. The defendant's experts, including the former Master of the maternity hospital, Dr. Peter Boylan, contended to the contrary, stating that Dr. Sheehan had all the requisite qualifications and experience to make the decision to proceed by forceps delivery.

The blades of the forceps were applied and a right medial lateral episiotomy was performed. An episiotomy may be described as a surgical incision into the perineum and vagina to increase the space available to the descending head of the infant.

It is important to stress that this incision, although it came relatively close to the anal sphincter, did not of itself cause the tear which is the subject matter of the present proceedings. It did, however, have a particular significance in the context of the discoverability of the anal sphincter tear to which I shall later return.

Having applied the blades of the forceps to the infant's head the baby was then delivered in the occipito posterior position in two contractions.

According to the plaintiff, she was pulled with such force in the course of one or other or both these procedures that her buttocks slipped over the end of the bed and she had to be pulled back on each occasion by the midwives. It is part of the plaintiff's case that excessive traction was applied during the course of the sequential procedures and that such excessive force caused or contributed to her injury.

Following the birth of the baby some meconium grade III staining was noted. The time of delivery was 8.53pm, some 53 minutes after full dilatation and some 23 minutes after the initial ventouse.

Dr. Sheehan swabbed the plaintiff's vagina following delivery of the placenta, using and then removing a tampon for that purpose. It was her evidence that, before repairing the episiotomy incision, she carried out a bidigital examination of the plaintiff's anal sphincter using her thumb and index finger for that purpose, inserting one finger into the rectum and the other into the fourchette of the vagina.

She then carried out a repair of the episiotomy in layers with vicryl rapide.

Having completed this procedure, her evidence at trial was that she carried out a subsequent bidigital examination for the same purpose and was satisfied from the two examinations that no damage had been caused to the plaintiff's anal sphincter as a result of the forceps delivery.

In the course of her evidence, the plaintiff said that she herself as a nurse was conscious that an instrumental delivery carried a risk of a third degree tear of the anal sphincter. She had been doing perineum massage, yoga and aqua natal to try and reduce the chance of this happening. She gave evidence that she asked one of the midwives present at the delivery if she had a third degree tear and was reassured that she had not.

Following her discharge from hospital on the 22nd of July, 2004, the plaintiff's perineum remained extremely tender and sore for weeks.

Some days after her discharge from hospital, the plaintiff developed symphysis pubis dysfunction which required her to use crutches for several months, a matter which is unrelated to the particular injury the subject matter of the present claim.

As time went on, the plaintiff noticed that she had incontinence of flatus with occasional faecal staining, which she attributed to the fact that she had a "nervy gut" or to the possibility that she was not carrying out her recommended exercises properly.

In October, 2004 she consulted her general practitioner with complaints of bleeding on intercourse. Her general practitioner referred the plaintiff to the perineal clinic in Holles Street where she first saw Dr. Myra Fitzpatrick on the 27th of October, 2004. She gave evidence that she asked Dr. Fitzpatrick at that time if she had a third degree tear of her anal sphincter. Dr. Fitzpatrick accepts she received such a question and did in fact carry out a manual examination but failed to discover any tear. According to the plaintiff, Dr. Fitzpatrick simply inserted one finger into her rectum for the purpose of this examination.

On a follow up visit to Dr. Fitzpatrick in January, 2005, Dr. Fitzpatrick did not carry out any further digital rectal examination and the plaintiff accepted she was making no complaints at that time to Dr. Fitzpatrick about symptoms of flatus or faecal staining.

The plaintiff was due to return to work in January, 2005 but did not do so. She would have been working in close proximity with people and not being able to get to the toilet quickly was very distressing. She then signed up with a nursing agency and did shift work for that agency in St. Vincent's Hospital and in the Blackrock Clinic. In September, 2005 she obtained a permanent position in Tallaght Hospital where she was employed in a male surgical ward specialising in pancreatic and bowel surgery mainly. She did weekend shifts which she could manage because it was fairly quiet at that time and the toilets were readily accessible at moments of urgency.

She became pregnant at the end of September, 2005 with her second child, Elliot. After a short time, she began to develop diarrhoea which became completely uncontrollable. In February, 2006, she again consulted Dr. Fitzpatrick in the perineal clinic, and while the diarrhoea had stopped at that stage, she had by then very marked symptoms of faecal incontinence.

Dr. Fitzpatrick commissioned an anal ultrasound and the plaintiff was subsequently informed by Dr Fitzpatrick that this ultrasound revealed a two quadrant defect in her anal sphincter. According to the plaintiff she was informed by Dr. Fitzpatrick that she had a "barn door of a tear".

Her injury having thus come to light and been diagnosed, she was advised that she would need a caesarean section for her second childbirth.

Subsequent ultrasound and manometry tests commissioned by Mr. Neary, Consultant Colorectal Surgeon in Tallaght Hospital, confirmed the findings delivered to the plaintiff by Dr. Fitzpatrick in February, 2006. As of date of trial, the plaintiff has significant problems of faecal incontinence and is under severe constraint as to what she can eat and drink and requires to wear a nappy at all times. Having consulted with a large number of medical experts, the plaintiff is now willing to undergo surgery to repair both her internal and external anal sphincter.

STRUCTURE OF JUDGMENT

Because I propose to write this judgment from the starting position of the actual injury and its discoverability, I will deal first with the evidence in relation to the causation and discoverability of that injury and set out my conclusions as to liability on issues (f) and (g) as set out above. I will thereafter deal with the issues at (a) – (e). A great deal of the evidence is, of course, common to both sets of issues but there was evidence of importance given at trial in relation to the option in this case of providing a caesarian section to the plaintiff and some additional matters pertaining to that issue, along with the other issues at (a) – (e), are dealt with in the latter part of the judgment.

SUMMARY OF EVIDENCE

The plaintiff's evidence in relation to the force applied during the instrumental delivery was to the effect that she was lying on her back with her feet against the midwives hips while Dr. Sheehan first applied the ventouse and then the forceps. She recalled being pulled at some point in the process in such a way that she came off the end of the bed on three occasions and had to be helped back up. She said that Dr. Sheehan had one foot on the end of the bed while she was pulling. When the baby was born the plaintiff noted she had some bruising and a cut to her face from the forceps. She recalled asking one of the midwives if she had sustained any anal tear and was told she had not.

Professor Michael Keighley is a Gastrointestinal Surgeon, whose clinical practice was almost exclusively devoted to colorectal disease. His is Emeritus Professor of Surgery having been Barling Professor and head of the University

Department of Surgery, University of Birmingham, Queen Elizabeth Hospital, Birmingham, and is the author of over 500 publications. He explained the different functions of the internal and external anal sphincters. The internal sphincter is the muscle that keeps the anus closed at rest and operates involuntarily. Squeeze pressure is exerted by the external sphincter and it is more like an elastic band under tension. His evidence was that instrumental delivery creates a particular risk of sphincter injury. It was his view that it was absolutely essential in a high risk patient, such as the plaintiff, that a very careful inspection be made to ensure that no sphincter injury had actually occurred. Because an episiotomy had been performed in this case, it provided an enhanced opportunity to carry out such a check. The doctor could part the edges of the episiotomy incision and visually inspect the sphincter muscle. A bidigital rectal and vaginal examination would then be performed before any suturing of the episiotomy occurred, which provided a further checking opportunity also enhanced by the existence of the episiotomy.

He examined the plaintiff on the 25th of June, 2008. It was immediately apparent to him that the plaintiff had a defect in the front of the sphincter. He conducted a digital rectal examination from it was quite evident there was no support tissue on two sides and it was also evident that there was a large rectocele above and a deficient perineal body.

He believed that a careful examination at the time of birth would have demonstrated a deficient anterior sphincter, a deficiency in the perineal body which extended up into the rectovaginal septum. The existence of the open episiotomy should have revealed the external anal sphincter itself and the damage to it. He did not believe that a second bidigital examination following closure of the episiotomy would have been as reliable. An immediate diagnosis of the defect would have provided a 75% - 80% chance of successful repair. Professor Keighley confirmed that the internal anal sphincter and the external anal sphincter had been damaged.

In cross -examination it was put to Professor Keighley that there was a high incidence of failure to detect anal sphincter injury. Professor Keighley agreed but said the defect in the instant case should have been clearly detectable because the injury was extensive and involved half of the circumference of the sphincter. He accepted that there were occult injuries which could pass undetected or which only became apparent on anal ultrasound, but in his view these occult lesions were frequently well away from the midline anteriorally, so they were lesions that would not be seen through an episiotomy. Professor Keighley did not believe that it was appropriate to use the term "occult" to describe the large sphincter injury in this case when it was clinically evident to all of the colorectal surgeons who later saw the plaintiff and which was clearly identified as a major injury on anal ultrasonography. Further, the injury was to the front of the anus at a site where it could more easily be detected. Professor Keighley further stated that in his opinion a digital rectal examination was a more reliable means of diagnosing the presence of anal sphincter injury than an anal ultrasound picture. In his opinion ultrasound grossly over - diagnosed defects in the sphincter that were not of clinical relevance. In his view, in the case of large defects, digital rectal examination detects them all.

Mr. Roger Clements is a Consultant Obstetrician and Gynaecologist now retired from clinical practice.

In his opinion, the procedure adopted by Dr. Sheehan provided a high risk of causing an anal tear. This arose from a combination of factors, including the fact that this was a first born child, the head was in the occipito posterior position and it was an instrumental delivery.

He believed that for those reasons there should have been a caesarean section from the outset. Alternatively, an attempted instrumental delivery should have been by means of trial in an operating theatre with every preparedness for intervention by way of caesarean section.

He did not believe Dr. Sheehan was sufficiently qualified or experienced to deploy a second instrument, in this case the forceps. In his view the only circumstance in which a second instrumental attempt was a proper and appropriate procedure was where a consultant was supervising a junior doctor.

In his view, the injury was caused when the baby's head was being pulled through with the forceps. He believed the degree of traction applied during the course of the forceps delivery was unacceptable and referenced that view to the evidence offered by the plaintiff. He also stated it was unusual that the forceps would actually break the skin on the baby's face. All of this had happened because this was a well grown baby in the occipito posterior position who as a result required a great deal more force and a great deal more room to deliver than would be the case for a well flexed occiput anterior position. It increased the risk of injury to both mother and baby, resulting in a muscle tear which went into the anus.

In his opinion a competent experienced doctor would have found the anal tear injury. Uniquely, there were two opportunities to detect the tear. First, the doctor could have separated the edges of the episiotomy wound to make a visual inspection of the sphincter. There was no soft tissue intervening and, given that the anal sphincter is about as thick as an adult index finger, a big tear in both the internal and external sphincter should have been noticed in the course of such an examination. The doctor also had a bidigital examination opportunity which was facilitated by the episiotomy incision. He described how the external anus sphincter was like an elastic band which, if cut, retracts so that when a finger and thumb test is carried out there would have been no resistance. If one were to superimpose a clock face on the anus, the tear to the external sphincter in this case was noted clinically to be between 10.00 o'clock and 2.00 o'clock, ie., 120 degrees. Ultrasonically, the internal sphincter injury was actually larger, between 9.00 o'clock and 3.00 o'clock. Mr. Clements described it as "massive" – a big tear right at the front.

In cross- examination it was put to Mr. Clements that the fact the plaintiff was pulled down the bed was not necessarily indicative of excessive traction, particularly having regard to the fact that the buttocks are positioned at the very edge of the bed and that the under-sheet may be rendered slippy by liquor. Mr. Clements agreed and further agreed it was not unusual for forceps to leave marks on a baby's face.

As to the use of the forceps, he adhered to his position that the sequential use of instrumentation should only be undertaken by or under the supervision of an experienced senior consultant.

It was put to Mr. Clements that Dr. Sheehan performed a bidigital examination both before and after she repaired the episiotomy and that her failure to detect any anal defect could mean only that the injury was occult in nature.

Mr. Clements did not accept that the injury was not readily detectable. He stated he could not understand how Dr. Sheehan could possibly have missed a defect involving two quadrants of the sphincter. He believed it was simply not credible. It was beyond his understanding how she could have missed it. While certain anal sphincter injuries were not detected, they were occult injuries in the sense they were asymptomatic and probably not in the part of the sphincter that comes into the view and the ability to feel of the person doing an episiotomy repair. This could occur where the injuries are on the other side of the anal canal and not between 10.00 o'clock and 2.00 o'clock as was the case here, a position which placed the sphincter in the view of the person doing the episiotomy. Asked if he could explain why Dr. Myra Fitzpatrick also missed the anal tear, Mr. Clements stated there was no comparison whatsoever between Dr. Sheehan's opportunity and Dr. Fitzpatrick's opportunity. Dr. Sheehan's opportunity was both visual and tactile. Dr. Fitzpatrick, on the other hand, had no chance of seeing the injury because the episiotomy repair had long since taken place. Secondly, the plaintiff was not at that time complaining of a history of incontinence which would trigger a bidigital examination. It was his belief that Dr. Fitzpatrick did a digital rectal examination only. Further, as the plaintiff was complaining of pain on intercourse and had some granulation tissue which was exquisitely tender in her vagina, a bidigital examination would have been extremely painful.

In further cross examination, Mr. Clements accepted that the manner in which the forceps delivery was performed was not incompetent in any way. The real issue was whether it should have been performed at all. In his view, it should not have been. In his view, given that the plaintiff was a primagravida, it was more likely in her case that she would encounter the particular problems which arose in this case of the head arresting in the mid pelvis and malrotating. However, there was nothing wrong with the way in which the actual delivery was performed.

A further consultant obstetrician and gynaecologist, Dr. Gareth Thomas, also gave evidence on behalf of the plaintiff. In his view, an error was made by Dr. Sheehan when she determined upon vaginal examination at full dilatation that the position of the baby's head was occipito posterior. She suspected foetal distress. In those circumstances he felt that Dr. Sheehan could not be confident of achieving an operative vaginal delivery safely. In his view she should have opted, at least, for a trial of operative vaginal delivery. If she felt the CTG was pathological, she should have opted for immediate caesarean section.

A trial of operative vaginal delivery is an attempted operative vaginal delivery where the obstetrician expects to succeed but also knows there is small chance that delivery will not succeed vaginally or, could be complicated by worsening foetal conditions. A trial carried out in an operating theatre with facilities to convert within minutes to caesarean section should the need arise is, therefore, a safer and preferable option. In his view the CTG scan did not indicate any grave emergency and he felt there was still some thirty minutes from the end of the CTG trace to effect delivery, plenty of time in which to carry out a caesarean section.

Following the failure of the ventouse procedure to either rotate or descend the baby's head, he did not believe a second form of instrumental delivery was appropriate. The Neville Barnes forceps do not rotate the head. The position of the baby's head represented a 2cm addition to the diameter of the skull as it passed through, to which some further small addition had to be made for the blades of the forceps. In his view, an excessive amount of traction was applied to effect the delivery by forceps. He did not believe Dr Sheehan had sufficient experience to adopt or implement the procedures undertaken in this case, it required either a consultant or fifth year senior registrar. There was a high risk of a third or fourth degree perineal tear in this case. Dr. Thomas referred to guidelines published by the Royal College of Obstetricians and Gynaecologists in July, 2001 which listed eight risk factors for such an injury. Six of those factors were present in the instant case, including persistent OP position, nulliparity, induction of labour, epidural analgesia, episiotomy and forceps delivery. That being so, extra special care was required to ensure that no third degree tear of the anal sphincter would occur. While there was no guarantee that a third degree tear involving only the internal sphincter would have been discovered, a tear of both sphincters would, in his view, be unlikely to be missed following careful examination. In his opinion, a fingertip test of the external anal sphincter would demonstrate if it was intact. He did not agree with suggestions that most tears are missed, particularly in circumstances where the external sphincter injury was, as in this case, there to be seen.

Dr. Sheehan gave evidence that she had no specific recollection of her dealings with the plaintiff and was relying on both her notes and usual practice when giving her evidence. She met the plaintiff for the first time at 4.00pm on the 20th of July, 2004. She had occasion to meet and talk with her on three further occasions during the course of her labour.

She explained how at 8.30pm the CTG showed evidence of late decelerations indicative of possible foetal distress. There was also meconium grade II staining. In being aware that the baby's head was in the OP position, she was nonetheless satisfied that this fact *per se* was not necessarily a marker indicating an immediate requirement for caesarean section.

Her preferred option was to proceed initially by ventouse, given that the application of the ventouse cup can effect rotation of the baby's head into the anterior (face down) position. She explained that rotational forceps are not used any longer in Holles Street or generally. She believed she achieved some slight descent from the application of the ventouse. She was firmly of the view that a trial of ventouse in theatre would have yielded no different result in this case.

The ventouse having failed, she opted for a forceps delivery rather than a caesarean, principally because she felt there was some descent evident. The baby's head was at a level which permitted application of the forceps. While one would not set out to deploy sequential use of instruments, it is nonetheless an option and a decision which she felt, having regard to her experience and expertise, she was entitled to make. She pointed out that a caesarean section is not a risk free option. It is a procedure which carries a significant risk of haemorrhage, particularly when the baby's head is well descended towards the pelvic floor.

She said she knew there was an increased risk of anal sphincter damage because of the combination of a number of factors in this case. However, there was no rule against using forceps for delivery of a baby whose head was in the OP position. Even had she been in the operating theatre in trial conditions, she would still have availed of forceps to try and deliver this baby.

She did not accept that any excessive force had been applied during the forceps procedure. A mother could slip down the bed on the plastic drapes for any reason, including some movement on the part of one or other midwife. It

was not a normal bed, but rather in the nature of a half bed where the mother's buttocks rested on the edge of the bed.

She explained how following delivery she swabbed out using a tampon and swabs and then did a bidigital examination of the plaintiff's anal sphincter. She described the fingertip test as a "pill rolling" action, whereby she rolled the sphincter from side to side between her fingertips and up and down. She stated that she felt an intact sphincter. She also stated that she would have recognised a third degree tear and could not explain how in this case she did not find it. She was part of a medical group which had pioneered the work of seeking to detect anal sphincter tears.

Following closure of the episiotomy, she had carried out a further bidigital examination which had again failed to reveal any defect in the anal sphincter.

In cross examination she vehemently contested any suggestion that she was not sufficiently experienced. She explained that she was in her seventh year following graduation and was in her third year of working unsupervised. She was in the second year of her specialist registrar course and had done in excess of 160 instrumental deliveries, representing a combination of supervised and unsupervised deliveries. She had performed 45 deliveries during her first year SPR, some 40 deliveries in the Rotunda and approximately 90 deliveries in the National Maternity Hospital. As of the July, 2004, she estimated she had carried out in excess of 15 forceps deliveries unsupervised. She had done maybe above 12 ventouse and forceps deliveries and had carried out 15 repairs of third degree anal tears.

Dr. Sheehan accepted that the delivery in this case did pose a significant risk of trauma to the mother. She accepted that the risk of an anal sphincter tear was of the order of 7% - 10% when the various risk factors in this case were added together. However, she reiterated that there were also significant risks attaching to the alternative option of a caesarean section.

She agreed, however, that the particular circumstances of this case did impose a special responsibility on her to check for an anal sphincter tear. She did this – twice. She also gave the plaintiff a rectal suppository of difene having conducted two bidigital examinations. She found nothing amiss then either.

She did not agree that laying open the episiotomy incision afforded a good view of the anal sphincter. This was because of swelling and bruising and other intervening tissues. While sometimes one might see the anal sphincter, usually one could not.

Dr. Myra Fitzpatrick is an obstetrician and gynaecologist who works as an associate specialist in the National Maternity Hospital specialising in perineal medicine. There is a perineal clinic attached to the National Maternity Hospital and in that clinic she sees a variety of patients with a variety of injuries and problems. Its essential focus is to deal with perineal injuries sustained during childbirth.

She saw the plaintiff at fourteen weeks post natally and found some granulation tissue along the episiotomy wound which was accounting for her pain and bleeding during intercourse. She also found a small, raw surface on the vagina. Her notes did not indicate that the plaintiff made any complaints of faecal incontinence. She would not contradict any assertion by the plaintiff who had said in evidence that she inquired of Dr. Fitzpatrick if she had a third degree tear. She would, however, have told the plaintiff that she did not have an anal sphincter tear. This opinion was based on both a visual examination and a vaginal examination. She did observe a thin perineal body. She also carried out a digital rectal examination. This involved inserting an index finger into the anal canal and asking the patient to squeeze so as to get an idea of the tone of the muscle. In addition, one puts one's thumb into the posterior foruchette of the vagina, and, using a pill – rolling action, one can feel the muscle between the fingertips. She concluded there was no defect and so advised the plaintiff's general practitioner. She now accepted there was a defect but that she "missed it". As to why she missed it, she could only say "these things can happen and do happen". However, where women are referred specifically with a problem of fecal incontinence, the clinic follows up with an ultrasound scan. The ultrasound scan will pick up any problem. However, at this stage there was no indication for an ultrasound scan because she had no symptoms and made no complaints of faecal incontinence at that time.

As regards the plaintiff's injury, she stated that the anal sphincter was only 1cm thick. It was a small organ and subtle changes could occur in it so that a defect even of this size could be missed.

Under cross -examination Dr. Fitzpatrick maintained it was extremely difficult to pick up such an injury by means of visual examination at time of birth having regard to the disruption of fibres and muscles in the vaginal area.

Dr. Fitzpatrick conducted a further examination of the plaintiff in January, 2005 at which point she had no complaint of faecal incontinence of any kind. The plaintiff's third visit occurred on the 22nd of February, 2006, when she was complaining of marked symptoms of faecal incontinence. The anal ultrasound revealed a two quadrant internal and external anal sphincter defect. The results of testing disclosed a significant reduction of squeeze pressure of the anal sphincter and it was felt that an anal sphincter repair would be required. Dr. Fitzpatrick confirmed that the tenderness in the plaintiff's vagina at the time of her bidigital examination would not have impeded her examination in any way. Dr. Fitzpatrick stated that she had never used the expression "barn door tear" to the plaintiff, that it was an expression which would not be in her vocabulary.

Professor John Morrison is Consultant Obstetrician and Head of Obstetrics at Galway University Hospital.

He told the court that in his opinion the CTG decelerations in this case were "ominous" at 8.20pm and required action to achieve delivery of the plaintiff's baby without delay. He stated that in Galway, operative vaginal delivery is permissible at station 0/+1, that is to say once the baby's head has descended to the level of the ischial spines. In his view, the level of descent achieved by the baby's head in this case was adequate, even allowing for the fact that the baby's head was in the OP position.

He also stressed that the sequential use of instruments in an operative delivery always involved using the ventouse first, then the forceps. While a caesarean section was an alternative, there were equivalent or possibly higher risks attaching to a caesarean, particularly one carried out late in labour. This was not simply because the head is well

impacted in the pelvis but also because the uterine lower segment is stretched and there is thus a lot of oedema of the tissues. Lacerations and tears in the lower uterus can easily occur extending into the uterine vessels. He had seen instances where hysterectomy occurred in such circumstances.

On the issue of trial delivery, he did not feel that operative deliveries by means of trial in theatre were well evaluated. It happened in a small number of cases only.

He was also satisfied that Dr. Sheehan had the requisite experience to proceed as she had done and would not criticise her experience. He noted that she had done 160 instrumental deliveries by the time of this delivery in July, 2004.

During the course of a forceps delivery, a tear can occur without negligence. He believed it was reasonable and within the limits of normal practice to attempt an assisted delivery by means of the forceps in this case. He believed that because Dr. Sheehan failed to detect the third degree tear that "it must therefore be the case that the anal sphincter damage was not readily apparent, or was occult".

He also gave evidence, as per his report, that endoanal ultrasound will reveal sphincter tears in varying proportion (7 – 30%) of primiparous women who have delivered vaginally who had no anal sphincter tears diagnosed clinically in circumstances similar to those which pertained to the plaintiff after her first delivery. While the plaintiff undoubtedly had sphincter damage at her first delivery, it presented only in an unusual way sixteen months later.

Dr. Peter Boylan is a Consultant Obstetrician and former Master of the National Maternity. He gave evidence in relation to the practices and philosophy of Holles Street, stating in particular that it was appropriate to effect an operative vaginal delivery when the vertex of an infant's skull is at station 0/+1. This was consistent with the policy adopted in other Irish maternity hospitals. Holles Street did not differentiate between high cavity/mid cavity and low cavity in this regard, but rather availed only of high/low categorisation. As far as he was concerned at station 0/+1 the head of the infant is on the pelvic floor.

It was not the practice in Holles Street to carry out trials of operative deliveries on a regular basis.

In his opinion, Dr. Sheehan was more than qualified to deploy a sequential use of instruments for operative vaginal delivery. Holles Street was the largest maternity hospital in Europe and, in his opinion, Dr. Sheehan had acquired proportionately a great deal more experience than would some other practitioner with the same number of years working in other maternity hospitals.

The final witness called on behalf of the defence, Dr. Bryony Strachan, Consultant Obstetrician, also gave evidence to the effect that Dr. Sheehan was sufficiently experienced for the procedures which she carried out. In her view, she may have had more experience than a final year trainee.

Asked to comment on the views of the plaintiff's experts as to the discoverability of the anal sphincter tear, Dr. Strachan agreed that two examinations at the time of the child's birth would provide the best chance of finding the tear. In her opinion, a visual inspection through an episiotomy incision was not usually effective. She also stated that palpation was not 100% reliable. In her opinion, the marks on the baby's face in this case were not excessive. In so far as trial of instrumental delivery in theatre was concerned, while such a provision was contained in the RCOG Guidelines issued in 2005, this was reflective of practice developing over previous years and was largely informed by defensive practices developing in the U.S.. She did not feel Dr. Sheehan did anything wrong in not availing of this particular option. Nor did she fault Dr. Sheehan for electing to perform an operative delivery when the infant's head was at station 0/+1, rather than performing such a procedure only when the baby's head had descended 2cm or more below the level of the ischial spines. The sequential use of instruments was, in her opinion, a judgment call for the clinician. She stressed that there were significant risks attached with caesarean section once full dilatation had been arrived at. She agreed that the forceps had probably caused the damage to the plaintiff's anal sphincter in this case.

In cross examination she agreed it was a large tear and further agreed that if one found a tear of the external anal sphincter, one would, or should, realise that there might well also be a tear of the internal anal sphincter.

She also agreed that the episiotomy made it easier to detect and palpate the external anal sphincter. Equally, it followed that the closer the episiotomy incision went to the anal sphincter, the easier it became to palpate the anal sphincter muscle.

RELEVANT MEDICAL LITERATURE

Extensive recourse was made by both sides to a wide range of medical literature. However, for present purposes I propose only to refer to those publications which have a particular relevance to the incidence of anal sphincter tears during childbirth and the degree to which they are discoverable.

Sultan's "*Anal Sphincter Disruption during Vaginal Delivery*" (1993 New England Journal of Medicine) concluded that external sphincter defects were associated with augmentation of labour, epidural analgesia, posterolateral episiotomy and forceps delivery. The paper states:-

> *"On step wise logistic – regression analysis, the single independent factor associated with the development of an external sphincter defect was forceps delivery."*

3% of the primiparas studied sustained an injury to the anal sphincters during delivery that was apparent on clinical examination – i.e., a third degree or fourth degree tear. Endosonography, however, revealed sphincter damage in 35% of such patients. The paper also notes that the risk of sphincter damage is greatest during the first vaginal delivery.

Cook and Mortensen concluded in "*Management of Faecal Incontinence following Obstetric Injury*" (British Journal of Surgery 1998) that anal sphincter damage following vaginal delivery is common. If instrument assisted delivery is needed, vacuum extraction appears to be associated with reduced incidence of sphincter injury than forceps delivery.

In a paper published by Ezenagu, Kakaria and Bofill: "*Sequential Use of Instruments at Operative Vaginal Delivery*" (Am J Obstet Gynacol, June 1999) the authors concluded that the prudent use of sequential instruments at operative vaginal delivery did not engender higher rates of maternal morbidity.

On the issue of the discoverability of anal sphincter tears by means of bidigital examination, the most important publication is one published in 2007 by Dobben et al. It concluded that anal inspection and digital rectal examination can give accurate information about internal and external anal sphincter function, but are inaccurate for determining external anal sphincter defects of less than 90 degrees. An important diagram appears at p. 787 of this study to demonstrate that external anal sphincter defects of the dimensions arising in the instant case were discovered in over 60% of cases by means of digital rectal examination and in all cases where larger defects had occurred. However, the paper also notes that endoanal ultrasonography picks up far more defects, including minor defects, which are often not palpable on bidigital examination.

It is perhaps important to note at this juncture that both sides accepted that anal endosonography immediately after vaginal delivery is not a practical proposition, both because obstetricians are not necessarily trained in the technique and the examination itself might be more difficult to interpret due to fresh perineal tears and edema following delivery (as per paper published by Faltin et al, 2003).

Finally, and while I readily accept this is by no means a full review of the medical literature, a paper prepared from within the Department of Obstetrics in UCD and the National Maternity Hospital in 2001 ("*Influence of Persistent Occiput Posterior Position on Delivery Outcome*" by Fitzpatrick, McQuillan & O'Herlihy) noted that the incidence of persistent occiput posterior position was significantly greater among primiparas and that the particular head position was also associated with a seven fold higher incidence of anal sphincter disruption. The authors concluded:-

> *"Our results have clearly shown that persistent occiput posterior position poses a significant risk factor for anal sphincter injury, presumably because of the greater cephalic diameter presenting to the perenium and its altered angle of incidence. Recognition of this greater susceptibility to serious perineal injury at occiput posterior delivery should help to reduce its occurrence. Although both third degree tears and instrumental deliveries are generally more common among primiparas than multiparas, we found no significant differences in either rate with parity, in association with persistent occiput posterior position, thus emphasising that this malposition also carries significant perineal risks for paras women in whom anal sphincter injury is generally much less frequent."*

CONCLUSIONS ON ISSUES (f) – (g)

I should perhaps at the outset emphasise how impressed I was by the evidence of both the plaintiff and Dr. Sheehan in this case. The trial has undoubtedly been a most traumatic experience for both women and I commend both for the great sense of responsibility, fairness and even-handedness which they demonstrated in their respective accounts of events in this case.

Notwithstanding the account furnished by the plaintiff as to the levels of traction and force that were applied during the forceps delivery in this case, I am satisfied from Dr. Sheehan's evidence and the evidence of the other specialists called on behalf of the defendant that excessive traction was not applied during the forceps delivery, and that delivery was quite rapidly achieved after two contractions. The records do not indicate that any difficulty was experienced during the forceps procedure. I think one must expect a certain level of subjectivity in the account furnished by the plaintiff as regards what occurred at this particular stage, notably in circumstances where it was her first childbirth. Indeed, Mrs. Warnock seemed somewhat unsure and uncertain in her evidence as to whether she slipped off the bed during the course of the ventouse or the forceps procedure. The report of Dr Gareth Thomas, for example, records that the plaintiff "recalls being pulled down the bed with each pull of the ventouse". Whichever may have occurred, I am satisfied that the design of the bed, covering sheet and/or presence of liquor, or indeed casual movement by one of the midwives, could have accounted for the movement of the plaintiff's buttocks over the edge of the bed, and I am further satisfied that excessive importance should not be attached to the fact that some such movements may have taken place.

By the same token, it is not uncommon for forceps to leave marks on a baby's face and while there was in addition in this case a scratch on the baby's face, I do not regard this as establishing, on the balance of probabilities, that excessive force was applied during the forceps procedure.

For the sake of completeness, I should confirm that I find as a fact that the tear to the plaintiff's internal and external anal sphincter was nonetheless caused during the course of the forceps delivery. That said, I should also note, however, that even spontaneous vaginal deliveries can result in perineal tears as the literature demonstrates.

Dr. Clements himself, apart from his view, referenced as it was to the plaintiff's evidence, that excessive traction had been applied, did not otherwise fault the technical competence of Dr. Sheehan in the execution of the forceps procedure or the manner in which it was carried out.

On the issue of the discoverability of the sphincter tear, however, I prefer and accept the evidence which was led on behalf of the plaintiff.

While Dr. Sheehan frankly conceded in evidence that she had no precise recollection of this patient's case, she did give a detailed description of what she normally does by way of checking for anal sphincter injury, and in this regard readily accepted that she had a special duty to take care having regard to the high incidence of anal sphincter injury following instrumental delivery using forceps.

Professor Keighley, whose evidence was not contradicted by any colo-rectal expert called on behalf of the defendant, gave evidence of the dimensions of the defect in this case. More importantly, he gave evidence as to

the position of the injury towards the front of the anus, a circumstance which, in his view, rendered the injury more readily detectable. Professor Keighley believed that two opportunities were provided to carry out an effective examination in this case, the first being a visual examination, achieved by parting the episotomy margins to inspect the anal sphincter, and the second consisting of a bidigital examination of rectum and vagina.

Having regard to the evidence adduced on behalf of the defendant, notably from Dr. Fitzpatrick and Dr. Strachan, I am not satisfied on the balance of probabilities that a visual inspection would necessarily have revealed the nature of the damage in this case. I say this because the evidence of those witnesses, and indeed of Dr. Sheehan, was to the effect that bruising and disruption to the vagina may render it difficult to carry out an effective visual examination in any particular case and none of the experts, other than Dr Sheehan, can really say what was visible or not visible at the critical moment on 20th July, 2004.

However, as Professor Keighley pointed out, the episiotomy has a crucial significance in another way. It provided a major diagnostic opportunity when it came to the bidigital examination. It meant that Dr. Sheehan could insert her thumb without the hindrance of any major intervening tissue to a position in which she could most effectively palpate the external anal sphincter using the tips of both thumb and index finger. I accept entirely Professor Keighley's evidence on this aspect of the case, including his evidence that Dr. Sheehan had a far greater opportunity at this point in time of detecting the anal tear than had Dr. Fitzpatrick some fourteen weeks later when the episiotomy had been closed and the wound largely healed.

While I have no doubt that Dr. Sheehan is a medical practitioner of the highest competence, she is, like virtually every medical practitioner confronted with later court proceedings, handicapped by the fact that she has no precise recall of this particular case and must perforce rely on her customary practice and notes.

She described that her usual practice, which she would have followed on this occasion, was one whereby she conducted a "pill-rolling" exercise, rolling the external sphincter between her fingertips, not just to left and right, but up and down also. She did not say that carrying out such a test posed any particular difficulty for her or that she had had unsatisfactory results in using this method to check for significant tears. On the contrary, she felt able to tell the Court that, as per her notes, she must have found the external anal sphincter to be intact. The notes in this regard record only that she ticked a box on a pro forma sheet. She did this once only and provided no further note to say she had conducted a second check. I would observe only in this regard that it would have been a simple matter to tick the box twice or to insert a "x2" note beside the box on the sheet to denote that two such examinations had in fact taken place.

Having regard to the evidence given by Professor Keighley, and to some extent by Mr. Clements also, as to the behaviour of the sphincter following a tear of this magnitude, I am driven to conclude that Dr. Sheehan did not, in fact, conduct such a test in the instant case, or, if she did, it was not carried out as it ought to have been. The fact that Dr. Sheehan following closure of the episiotomy carried out a further bidigital examination (although as I have noted this is not anywhere recorded), drives me also to the same conclusion, namely, that Dr. Sheehan did not conduct such a check or did not do so on this occasion in her usual thorough manner.

I find as a fact that this was not an "occult" injury. It is a false logic to argue that, because Dr. Sheehan did not find the tear that it must therefore follow that it was occult in the sense of being undiscoverable. This was not an injury at the posterior side of the anal canal, but rather in a frontal position where, as was stated without contradiction by Professor Keighley, it was more readily discoverable.

Ultimately, Dr. Sheehan herself was unable to explain why she had missed this significant tear. I again repeat that this was not a minor defect which could easily pass undetected even on careful bi-digital examination. This injury did not fall into the basket of injuries which are picked up only anal endosonography but not on bidigital examination. I am satisfied, as a matter of probability in this case, that a careful bidigital examination of the plaintiff's external sphincter injury would or should have revealed the third degree tear in this case.

If follows in consequence, as was conceded by Dr. Strachan, that the discovery of the damage to the external sphincter would have flagged the existence of the internal sphincter damage also. I, therefore, conclude that the failure to diagnose and promptly treat both injuries sustained by the plaintiff arose from a breach of the duty of care owed by the defendant to the plaintiff.

OTHER ISSUES IN THE CASE

I appreciate that the findings I have made do not entitle the plaintiff to additional compensation for the causation of the anal sphincter tear unless I hold in favour of the plaintiff on one or more of the grounds (a) – (e). I propose to deal with those grounds together because they are, in my view, all interlinked to a greater or lesser degree.

Commencing in reverse order, I am satisfied that Dr. Sheehan was and is a medical practitioner of the highest competence and that she had the requisite experience to decide upon and adopt the procedures which she deployed on the occasion of this childbirth. Ezenagu states in his paper that:-

> *"The decision to use a second instrument or to proceed to caesarean delivery should be individualised and naturally depend on the training and experience of the attending physician…these sequential operative vaginal deliveries are not for the neophyte. We do consider that our data (as well as those of others does) argue persuasively that the sequential use of instruments at operative vaginal delivery, in trained hands, is a viable alternative to caesarean delivery in certain circumstances."*

I prefer the evidence of Dr. Boylan and Dr. Strachan, and indeed that of Dr. Sheehan herself, to that offered by Dr Clements with regard to the suitability and adequacy of Dr. Sheehan's experience. She was working as a highly experienced member of a team in the biggest maternity hospital in Europe. Dr. Boylan gave evidence that she would accordingly have acquired proportionately a great deal more experience than another senior registrar with the same number of years in practice elsewhere. She had over 160 operative deliveries to her credit in July, 2004 and had

dealt with various forms of complications, including anal sphincter tears, on a significant number of occasions. She most definitely was not a neophyte. I find as a fact that she was sufficiently experienced and sufficiently qualified to decide upon and conduct a sequential instrumental delivery in this case.

The essential questions to which the various issues of (a) – (e) boil down to is whether Dr. Sheehan should have elected for for a trial delivery in the operating theatre and/or a caesarean section once she noted that this primipara was presenting with an infant's head in the occipito posterior position.

I prefer the evidence of the defendant's experts to the effect that trial instrumental delivery in an operating theatre is not particularly well evaluated and is not common practice in Holles Street or in other Irish maternity hospitals. I also take into account Dr Sheehan's evidence that she would not have done anything differently in this case had she adopted such a course. In a perfect world, such an approach might represent the optimum form of treatment, but one must in a practical sense bear in mind that operating theatres, of which they are apparently two in Holles Street, may at any time be required for a major emergency, particularly in a busy maternity hospital. I do not believe the plaintiff has established a breach of duty of care on this ground.

A great deal of time was taken up at the hearing in what I can only describe as an omnibus attack on the defendant hospital, its practices and philosophy. At various points in the evidence it was suggested that its obstetric practices were no longer in accord with the latest obstetric thinking in the US and in Britain or, more accurately, as delineated in the Royal College of Obstetricians Guidelines which were revised in October, 2005. The Holles Street categorisation of foetal descent by reference to high cavity/low cavity only is at variance with the guidelines in question, which set out a categorisation in three divisions, namely, high/mid and low cavity. In essence the Royal College Guidelines would suggest that instrumental delivery by forceps is contra-indicated unless the infant vertex has achieved 2cm or more descent below the level of the ischial spines – the point where those Guidelines state that the vertex has moved from mid-cavity to low cavity.

As the evidence progressed, it became clear that in Holles Street the use of forceps for low cavity presentations included presentations where the vertex of the infant's head was at station 0/+1, and that 'low cavity' for Holles Street at least, begins at that point. Further confusion arose about the interpretation of certain passages in the "*Active Management of Labour*" (Mosby, 2003), which defines the principles and practice of the care and labour developed by the defendant hospital. For example, Dr. Boylan seemed to feel that the vertex of the infant's skull did not necessarily mean the point of the skull furthest descended, and equally offered a different view of the definition and the term "pelvic floor" in the context of foetal head descent.

Dr. Strachan, whose evidence I found particularly helpful, explained that the guidelines published by the Royal College are constantly evolving and the more recent guidelines were not those in operation in 2004. She stressed they were guidelines only. She told the Court that the 2005 guidelines appear to have been informed to a significant degree by practice and theory developed in the U.S.

I altogether resile from any commission type finding as to whether the practices and philosophy adopted and followed in Holles Street are consonant, or should be consonant with the latest Royal College Guidelines. The defendant hospital does not carry out its work in ignorance of those guidelines and its practices in relation to instrumental deliveries appear to be consistent with those pursued in other maternity hospitals in Ireland. I, therefore, reject any suggestion in this case that the defendant hospital pursues practices or philosophies which are idiosyncratic or fall short per se in providing an appropriate level of medical care to either mothers or their babies.

This brings me finally to the question of the caesarean section. It is of course the case that the plaintiff would not have sustained the anal sphincter injury if Dr Sheehan had, at 8.30 pm on the 20th July 2004, opted to elect for this procedure. In that context I find as a fact that the CTG was showing variable and late decelerations which, whilst not of themselves indicative of any major crisis or emergency, nonetheless indicated that delivery had to effected expeditiously. However, as regards the decision made by Dr Sheehan to proceed with an instrumental delivery one cannot simply assess whether that decision was in breach of her duty of care because of the distressing injury suffered by the plaintiff. Both Dr Sheehan and the other obstetric witnesses called on behalf of the defendant were adamant in their evidence that a caesarean section, carried out when the infant's head is well descended at the level of the ischial spines, carries a significant risk of haemorrhage for the mother. There is a common misconception that a caesarean section is a 'risk-free' procedure but it must be remembered that this would not have been an elective caesarean but an emergency operation. Professor Morrison spoke of an 'equivalence of risk' or even higher degree of risk attaching to a caesarean carried out in the late stages of labour. His evidence on those risks, which I accept, was not challenged nor were those risks canvassed or dealt with in any detail by the plaintiff's obstetric experts. Dr Strachan further posited that if a caesarean had been pursued and the plaintiff had haemorrhaged as a result, would Dr Sheehan be equally facing a claim that she should not have opted for that course and should have applied forceps instead?

It is all too easy to apply the wisdom of hindsight when an adverse outcome occurs, but I am of the view that a medical practitioner in the position that Dr Sheehan was in should not be damnified for the sole reason that the option chosen in a particular set of circumstances had unfortunate adverse consequences - unless the decision was one which no reasonable practitioner, exercising ordinary care, would have made in her situation. I do not believe Dr Sheehan fails the test of negligence laid down in *Dunne v National Maternity Hospital* [1989] I.R. 91 in this respect. She was not operating outside the protocols operating in the defendant hospital and in other maternity hospitals in this jurisdiction. Given that there were equal or even higher risks associated with a caesarean section at that stage of the labour, she was in my view was acting within the reasonable parameters of professional discretion in opting to proceed with an operative delivery. I would therefore hold against the plaintiff on issues (a) – (e).

As the plaintiff has succeeded in her claim to the extent already detailed, that is to say ground (g), I will proceed to assess damages for the failure to discover the plaintiff's injuries and to provide prompt and appropriate treatment for them.