Neutral Citation Number: [2008] IEHC 315

THE HIGH COURT

2002 No. 11853P

BETWEEN

PETER DUNNE

PLAINTIFF

AND

THE EASTERN REGIONAL HEALTH AUTHORITY, THE SOUTH WESTERN AREA HEALTH BOARD, JOHN O'BRIEN AND MATTHEW McHUGH

DEFENDANTS

Judgment of Mr. Justice Michael Peart delivered on the 17th day of October 2008

1. The plaintiff issued a Plenary Summons herein on the 9th September 2002 in which he claims damages for personal injuries arising from the allegedly negligent manner in which an injury to his left middle finger was treated at St. James's Hospital on the 2nd November, 1997. An issue arises for determination in relation to the Statute of Limitations, 1957, as amended ("the Statute"). However, no order has been made that this issue should be determined as a preliminary issue. Accordingly I intend to determine the case both on its merits and on the basis of that claim under the Statute.

2. The background to the surgery to address the injury to his finger is that some days previously on the 28th October, 1997 in the early hours of the morning he was returning home on foot after a night out. It was apparently raining at the time and he has stated that as he was running along the road he tripped, and in doing so caught his finger on some strapping which was attached to a pole which was beside a fence at the side of the road. When pulling his finger out from that strapping he tore off all the skin on the underside of his finger. He was in pain and bleeding profusely, and he made his way to Naas General Hospital where the wound was treated with iodine and bandaged. He was sent home and asked to return on the following day for an x-ray. He did so, and having had the finger x-rayed, he was referred to St. James's Hospital for an operation. He was admitted to St. James's Hospital, according to the hospital admission record at 4.30pm on the 1st November, 1997 and came under the care of Consultant, Mr. Matt McHugh, though it was not he who actually performed the operation about which the plaintiff complains. That operation was performed by a trainee surgeon, Mr. Ciarán McDonnell on the following day, the 2nd November, 1997.

3. On arrival at the St. James's Hospital the plaintiff was interviewed by a Mr. Mehdi. As the bandaging had adhered to the finger it could not be removed other than under general anaesthetic, and accordingly the wound could not be assessed at that time. Prior to the general anaesthetic being administered the plaintiff signed a consent form on the 2nd November, 1997 in which he consented to an operation for "*exploration and repair and a split skin graft, plus terminalisation*". The plaintiff does not recall those procedures being explained to him before he signed that consent. But he accepts that he would have understood that the wound would be looked at under general anaesthetic. The plaintiff accepts that following this injury there was a small piece of the nail remaining on his finger, though he was unable to confirm, when it was put to him, that there was in fact about one third of the nail remaining.

4. The Operation Sheet dated 2nd November, 1997 shows Mr. McDonnell as the treating surgeon, and describes the proposed operation as "*Terminalisation of distal phalanx and SSG*" [split skin graft]. Under the heading "Procedure" this Operation Sheet states:

> *"Nail avulsed – Bone trimmed – soft tissue approximated over bone – SSG harvested from (L) forearm and held in situ on finger tip."*

5. The plaintiff was discharged from hospital on the 3rd November, 1997 and returned home. His progress was monitored from time to time thereafter by Mr. McHugh on an out-patient basis. He has stated that in time the portion of nail which remained after this surgery grew round the top of the finger and back into the tissue. He was unable to cut the nail, and if anything touched against it he would experience a shooting pain. He states that at his out-patient appointments with Mr. McHugh he complained that "something is not right", but that Mr. McHugh told him that it was "grand" and should give it time. The out-patient notes appear to confirm that Mr. McHugh was happy that the finger was progressing well. The last out-patient note dated 11th May 1998 prior to 11th October 1999 states "*well – good range of movement – due to go back to work soon – troubled occasionally by nail going into tip – advised that avulsion and excision of nail-bed an option – not anxious for same – discharge – see as required*".

6. In fact the plaintiff's general practitioner, Dr. John Kehoe, did not feel able to certify the plaintiff fit for work, and was giving the plaintiff weekly certificates to that effect. The plaintiff describes himself as a utility worker involving the moving and sorting of rear-view car mirrors. This work means that the full use of his hands is vital to him. At the plaintiff's request, Dr. Kehoe gave him a letter for Mr. McHugh dated 28th May, 1999. In that letter, Dr. Kehoe seeks a review of the injury, explaining that the plaintiff was having common, recurrent and tingling in his finger, and stating also that he cannot use the hand, and is unable to straighten the finger. He stated that the plaintiff was making "no progress" and was "very anxious to return to work". He describes the finger as being tender and that the distal phalanx was deformed. Under "plan of action", Dr. Kehoe suggests referral to hospital and queries if there is a need for further surgery.

7. A further operation was performed on the 2nd September, 1999 which resulted in the amputation of the tip of the finger. That surgery enabled the plaintiff to return to work after a few months, and has been able to work satisfactorily since that date.

8. No complaint is made in relation to this second operation. His complaint is that he was negligently treated on 2nd November, 1997, whereby the nail subsequently grew in a "parrot beak" manner, curving down into the tissue of the finger causing him pain and discomfort and preventing him from returning to work, and that the amputation of the tip of his finger which was performed on the 2nd September, 1999 should have been done in November 1997.

Medical evidence

Mr. Ronald Alexander Evans

9. Mr. Evans is a Fellow of the Royal College of Surgeons in Edinburgh since 1981 and obtained a Masters Degree in orthopaedic surgery in 1984. He has stated that he has examined the plaintiff's medical records and has had the opportunity of examining the plaintiff's finger and interviewing him. His first medical report is dated 23rd September, 2001, and was prepared before he had met the plaintiff and actually seen the finger. He had been sent the plaintiff's medical records and photographs of the plaintiff's finger as it was prior to the second operation, and which showed the plaintiff's residual nail curling over the end of the finger. He describes the end of the finger being "*ugly because of the nail growth and also because of the contour of the skin*". He states in this report that he "*could not find any proper description of the initial injury in the contemporary medical records, and cannot therefore confirm that the operation undertaken was appropriate. There is no record of any x-ray examination of the finger before the operation*".

10. However, he goes on to state:

> *"The operation note indicates that the nail was removed by avulsion. There is no written evidence that any attempt was made to excise the nail-forming tissue.*
>
> *Failing to remove the nail-forming tissue makes it inevitable that the nail will grow back, and that the growth of the nail will be abnormal: the lack of support from the excised tissues typically causes the nail to curl around the residual finger end, as in this case…… .*
>
> *On the basis of the evidence which has been provided, I feel that the surgical management of the injury of April 1997 has fallen below the expected standard, and that proceedings for medical negligence are justified."*

11. It is worth noting at this point, and I will return to this aspect of the case later in relation to the Statute issue, that it is clear that the plaintiff had consulted his solicitor about making a claim for negligence at least by the 30th March, 1999 because that solicitor wrote to the Eastern Health Board on the 30th March, 1999 seeking the plaintiff's medical records, noting also that the plaintiff had been already seeking those medical records, albeit without any success. The plaintiff had spoken to Dr. Kehoe in May 1998 when the possibility of a second operation was obviously discussed, as I have already referred to. Dr. Evans's first report was obtained in September 2001, but it was not until almost a year later on the 9th September, 2002 that the plaintiff actually commenced these proceedings. That is three years and six months after his solicitor first wrote to the Eastern Health Board seeking medical records, four years and four months after he discussed a second operation with Dr. Kehoe on the 11th May, 1998. Much is made by the defendants about this delay, as it is pleaded that at least by the 11th May, 1998, and at worst by 30th March, 1999 the plaintiff must be deemed to have the necessary knowledge for the purposes of ss. 2 and 3 of the Statute of Limitations (Amendment) Act 1991. I will return to these matters in due course. Mr. Fleck has emphasised, however, that even though the Statute has been pleaded, the defendants rely principally on the issue of liability, and say that a case of negligence is not made out.

12. Mr. Evans prepared a second, and much longer report dated 29th November, 2001. It appears that by the time this report was prepared Mr. Evans had had an opportunity of actually interviewing the plaintiff. He refers to being told by the plaintiff that while x-rays had been taken of the finger at Naas Hospital on the 28th October, 1998, he had left them at home and did not have them with him on the 2nd November, 1998 when he was admitted for surgery at St. James's Hospital, and that while the doctor who examined him at St. James's Hospital told him that another x-ray would be taken, this did not occur and was not available to the surgeon who carried out that operation. He goes on to refer*, inter alia*, to the complaints of pain and sensitivity experienced by the plaintiff post-operation, and to his being told by Mr. McHugh that this would improve with time. He refers to the second operation and its outcome and has no criticism of that. But he deals at some length with the procedure adopted for the first operation, and the outcome of that operation, including by reference to relevant hospital notes and photographs of the finger taken prior to 9th September, 1999, showing the abnormal re-growth of the nail curling around the end of the finger. He has not seen the x-rays taken at Naas General Hospital.

13. Relevant to the allegation of negligence, Mr. Evans states in his report:

> *"8. The treatment decided upon at St. James's Hospital was to "terminalise" the end of the finger. The operation does not appear to have been performed in a proper way.*
>
> *9. A terminalisation procedure is an operation in which the end of the finger is stabilised, so that the residual wound will heal either by primary or secondary intent, resulting in a formal finger end. One difficulty in treating finger tip injuries is the necessity of providing proper support for the nail and the nail forming tissue. If there is inadequate support for the nail, then the nail will tend to grow in a curved fashion around the end of the finger.*
>
> *10. In this case it appears that no support was provided for the nail forming tissue, because the nail forming tissue appears to have been avulsed as part of the original injury. Maintaining the length of the finger tip by the application of skin graft does not provide support for nail forming tissue, particularly after "trimming of bone end", as was performed in the primary operation.*
>
> *11. If a reasonable length of the nail-bed is not provided, it is inevitable that marked deformity of the growing nail will occur.*
>
> *12. If a large enough portion of the nail-bed cannot be retained, then it is necessary to amputate the end of the finger in such a way as the nail forming tissue is removed, so that no further nail growth will occur. That is, the injured finger should no longer have a nail.*
>
> *13. It is apparent from the treatment provided that the original operation was not the appropriate procedure. The operation which should have been performed primarily was the operation which was performed on the second occasion.*
>
> *14– 21 ……*
>
> *22. It is my opinion that the operation performed at St. James's Hospital on the 2nd November, 1997 was improperly performed and the deficient standard of the first operation resulted in the need for the second operation. The second operation is the operation which should have been performed at initial presentation. If a proper operation had been performed at the initial presentation, there would not have been any need for a second operation."*

14. In this report, Mr. Evans referred to what he describes as "*the standard hand surgery text in this country*" as well as in the United Kingdom, namely Green's Operative Handbook Surgery.

15. In his oral evidence Mr. Evans is critical of aspects of the Operation Notes in relation to the first operation in that they do not describe the nature of the injury being treated. But he was able to say that the surgery performed involved closing a hole, albeit that he described it as having been carried out in "a non-expert manner". He then explained this procedure in some more detail (T.1, Q. 174) as follows:

> *"Basically, without using medical terms, they pinched the end of the finger as tight as they can, they couldn't shut that completely so they have taken a piece of skin from the left forearm to put it on the end of the finger."*

16. He confirmed also that in the course of this procedure the finger nail was pulled off (avulsed), and that the skin graft harvested

from the left forearm was wrapped around the tip of the finger. He also confirmed that from the notes it is clear that some bone-trimming of the finger tip was carried out, but that the notes do not state how much of the tip was removed in that process.

17. He summarised the procedure again at T.1, Q. 192, as follows:

> *"…means that what they did was they pulled the nail off, removed bone from the end of the finger and then pulled the soft tissues together to cover the bone and then stitched it, and they used the split skin graft to cover the hole."*

18. By way of further explanation for the fact that the plaintiff's nail grew in a curved fashion downwards over the end of the finger and into the tissue underneath, Mr. Evans stated at T.1, Q.:

> *"The normal stretch of the fingernail is not well known to most people, the bit that people call the nail is actually the nail plate, underneath that is the nail-bed, which is the tissue that both supports and nourishes the nail plate, it also contributes to the thickness of it. At the very root of the nail is the germadine matrix, which is the tissue which forms the nail in the first place, that is the bit that hides underneath the nail where you cannot see it. To get a nail that is growing straight the nail plate has to be supported by the nail-bed, so basically they have to grow parallel to each other, and that will give you a straight nail. What I think happened in this case is that the nail-bed has been curved over to close the end of the finger and because of that the nail plate which is adherent to this tissue has followed the nail-bed and therefore curved round the finger, it had no other option, it had to go round, and that is why you end up with a parrot beaked nail." (my emphasis)*

19. He went on to state that in order to address the deformed terminal phalanx it was necessary to perform the second operation in order to stop the nail growing in this particular way, by removing the end of the finger, which is what happened on the 2nd September, 1999. Mr. Evans believes that the appropriate procedure to be performed on the first occasion was what was done in the second operation. But he stated also that an alternative would have been to stop the nail-bed being able to produce a curved nail by foreshortening the nail-bed or removing all the nail forming tissue. He stated that it was not appropriate to imbed the nail-bed around the tip "*because it makes it inevitable that the nail is growing in that deformed way and it is inevitable that the patient is going to require a further operation to deal with the situation. This was something that was easy to see was going to happen at the time of the first operation*." (T.1, Q. 215)

20. When asked if he had any criticism of the first operation, he stated (T.1, Q. 216):

> *"I think the first operation that was carried out was not a definitive operative procedure. In my view it was a rough cobbling together of tissues paying no regard to the growth that was going to occur in the tissues that were left behind. It was inevitable that this was going to cause problems for the patient in the long term."*

21. When asked whether it would have been known to the plaintiff, a trainee surgeon, that the nail-bed should not be bent around the tip of the finger, Mr. Evans stated:

> *"I think whoever did the surgery, trainee or not, the surgeon is obligated to perform a proper procedure. If the doctor who inspected the wound saw that it was beyond his knowledge and skill to deal with it he should have called for further and expert help to deal with the situation" (T.1, Q. 217).*

22. Mr. Evans was asked how many operations of this particular kind he has carried out over his years of practice as a hand surgeon since 1992, and he thought about 90 such operations, though he has carried out about 3500 hand operations generally over that period. He stated that his own strategy for dealing with this particular type of injury is that:

> *"[he] leave[s] tissue behind without trying to pull the thing shut. You get quite a good result by secondary intention. I would also try and leave as much bone behind as was possible as part of that. It is actually quite unusual to be radical in the removal of the bone. Each individual's finger tip injury is an individual injury because there is no set pattern of which tissues are involved, the different plains, the degree of tissue damage that has taken place …… If you get a distorted nail growth that stops the patient being able to use their finger or they complain about the nail's remnants catching on items, it is a very important part of the finger to get right." (T.1, Qs. 229-230)*

23. Mr. Evans was cross-examined by Kieran Fleck SC for the defendants. He was asked whether his criticism of the first operation is that it was a mistake not to have amputated the end of the distal portion of the finger. In reply, Mr. Evans stated that the error was in using the nail-bed to close the wound by pulling the nail-bed into an abnormal position, and that it is from that error that the plaintiff's subsequent problems stem (T.1, Q. 244). When asked whether it is important to maintain the functional length of the finger, Mr. Evans stated that "*it is reasonable to maintain as much length as is possible providing the end of the finger is left in a reasonable condition*" (T.1, Q. 247). Mr. Fleck asked him whether it is only after an operation is performed that one will find out if there are any problems arising, to which Mr. Evans responded that "*at the time of surgery you will have a good idea of what the likely outcome from that surgery should be*" (T.1, Q. 249). He accepted that there are procedures carried out to fingers which result in difficulties with the nail which may require further operative procedures, and confirmed that he regards the first operation as having been negligent "*because of the manner in which the nail-bed was dealt with at the time of surgery*" (T.1, Qs. 251-252).

24. It was put to him that since the plaintiff is a manual worker it would be important for him to have as much use of the hand and fingers as reasonably possible, and that only as much of the finger would be amputated as was absolutely necessary. Mr. Evans stated that as much would be amputated as would be necessary to leave the finger with as much use as possible, and this would take into account the condition of the nail and the likely possibility of pain. He agreed that reasonable practitioners would make judgments in order to save tissue which in hindsight have been seen to be unsuccessful, and that this would not be negligent or inappropriate "*if the procedure is done in a reasonable and responsible manner*" (T.1, Qs. 259-264).

25. Mr. Evans agreed that he had never seen the plaintiff's finger prior to the second operation carried out in September 1999.

26. Mr. Fleck referred to the fact that Mr. Evans in his report had referred to Green's Operative Hand Surgery, which Mr. Evans stated is the most widely used textbook by hand surgeons. That text states on p. 48, *inter alia*, that *"… the goals of amputation surgery in the upper extremity should be (1) preservation of functional length ….."*. Mr. Evans agreed with that Mr. Fleck referred to the following passage on p. 49:

> *"Tip amputation is the most common type of amputation seen in the upper extremity and at the same time provokes the greatest controversy. Although it is generally agreed that the length of the thumb should be maintained by*

reasonable means, there is less agreement about the wisdom or necessity of maintaining length of the other digits. Multiple, ingenious techniques have been developed to advance local skin or transfer skin from an adjacent digit to ensure coverage of an area where bone is exposed. No set of rules can be laid down that will serve as a satisfactory guide to the application of each of these techniques. Every surgeon, in consultation with each patient, must choose the type of coverage that appears to be most appropriate for that individual's needs."

27. Mr. Evans agreed with this statement. Mr. Fleck referred to a liability report dated 7th October, 2004 provided by Mr. Michael J. Earley, Consultant Plastic Surgeon on behalf of the defendants and in which Mr. Earley states in the opening paragraph thereof:

"It is my opinion that it was not unreasonable to have attempted to maintain the length of the finger tip by application of a skin graft. It may not have been the procedure carried out by all hand surgeons but there would be many who would be of the opinion that normal practice [is] to attempt to maintain length, especially in a 27 year old manual worker. In an emergency situation, it would not be unusual to leave the nail-bed having avulsed the nail, as recorded in the notes."

28. When asked if he agreed with this statement, Mr. Evans referred to another extract from page from Green's Operative Hand Surgery where the author refers to studies carried out the effectiveness of split skin grafting as a method for covering exposed pulp, and which showed this method as offering no advantages for finger tip coverage over healing by what is described as secondary intention, and that there was often either increased sensitivity or diminished sensibility. A number of studies are referred to in this regard. The author's preferred method for dealing with tip amputation is for healing by secondary intention rather than by skin graft, thus "*converting a wound with exposed bone to one without exposed bone*". In this regard, Mr. Evans stated:

"…. You will see that there is a rather scathing discussion about the use of skin grafts. The author of the text says that split skin grafts in general increase the patient's degrees of complaints after that surgery. So there is a generalisation and there is no tablet of stone. There is a generalisation that the use of skin grafts, as suggested, is not the appropriate thing to do. The author implies that the application of a full thickness skin graft would be probably better, but the best results of treatment for many patients are by not putting the graft there at all, by leaving the wound to heal by secondary intention." (T.1, Q. 287)

29. Mr. Fleck asked him to agree however that many respected surgeons still use the procedure which he was criticising, to which Mr. Evans responded by stating that "*if respected surgeons frequently perform the wrong procedure, that does not make it correct*". Mr. Evans himself favours allowing the wound to heal by secondary intention.

30. Mr. Fleck asked also in relation to what Mr. Earley had stated in his report to which I have referred whether it was not reasonable in the first operation to have attempted to maintain the length of the finger tip by the application of a skin graft. Mr. Evans answered by stating:

"It is not unreasonable to attempt to maintain the length of the finger, and a skin graft being used to assist – that is an understandable way of dealing with it. It is not the best way, but it is understandable. The difficulty in this case is what was done to the nail-bed. The skin graft is a small part of the cause of the ultimate outcome." (T.1, Q. 293) (my emphasis)

31. He agreed however that normal practice would be to try and maintain the length of the finger, especially in the case of a 27 year old man, such as the plaintiff (T.1, Q. 296-297). But he stated also that where there was about one third of the nail-bed remaining on the injured finger after this injury occurred "*the treatment of that would be to bring the tissues on the palm side of the finger up to that level and not to pull the nail-bed tissue around the corner to meet the palm*". (T.1, Q. 301)

32. Mr. Evans feels that in the plaintiff's case it would have been appropriate to amputate the finger tip back to the end of the joint, as occurred with the second operation, if the patient wanted the fastest possible healing time and was prepared to accept the fact that his finger would be foreshortened by more than the injury produced. It would depend on the patient. Mr. Fleck characterised this as a choice between trying to maintain length against trying to maintain function, and that one could amputate more of the finger in order to minimise complications. Mr. Evans agreed with this, but was of the view that there was no point in maintaining the length of the finger if it was not going to be a functional finger, since at the end of the day the finger is there to be used.

33. In relation to Mr. Earley's conclusion that the first operation was a reasonable attempt to maintain length with options of further treatment, Mr. Evans stated that this opinion *appears to ignore what was done with the nail-bed* (i.e. pulling it forward around the tip causing the nail plate to grow around the tip also). He accepted that if the Court were to accept that there was about one third of the nail-bed left after the injury, then it would be appropriate to try and save as much of the finger as possible, but "*provided that the nail-bed was not curved around the end of the finger*" (T.1, Qs. 312-313).

34. When Mr. Evans was re-examined by Colm Smith SC for the plaintiff, he was referred to another passage from Green's Operative Hand Surgery at p. 50 thereof which addresses how to avoid a hooked nail development. That passage states:

"The development of a hooked nail is avoided by careful attention to wound closure of a fingertip amputation and avoiding the loss of bony support for the nail-bed. Closure of a fingertip amputation by pulling the nail-bed over the distal phalanx should be avoided. If a satisfactory amount of distal phalanx is absent, the nail-bed must be trimmed back to the same level at the end of the bone so that it does not curve over the end of the bone and subsequently lead to the development of a hooked nail. If a hooked nail develops, we recommend revision with shortening of the phalanx and nail-bed to a comparable level……".

35. The plaintiff's General Practitioner, Dr. Kehoe also gave evidence, but it is not of assistance in relation to the issue of negligence in this case.

Evidence of Mr. Ciarán McDonnell

36. On the 2nd November, 1997 Mr. McDonnell was working at St. James's Hospital as a trainee surgeon under the direction of the fourth named defendant, Mr. McHugh. Prior to that position he had worked as a Senior House Officer in general surgery at Waterford Regional Hospital. By that time he had achieved in 1995 an Honours Degree from the National University of Ireland in medicine, surgery, obstetrics and gynaecology, and was a member of the Royal College of Surgeons in Ireland and Royal College of Physicians in Ireland. Since that date he has obtained further qualifications, and is currently employed as a consultant general and vascular surgeon at the Mater Hospital, Dublin.

37. Mr. McDonnell explained that he had no specific recollection of this first operation in November 1997 but stated that the plaintiff would have been examined under general anaesthetic because the bandages would have adhered, and it would have been too painful for that examination to have been done other than under anaesthesia. That examination would be carried out by a Registrar or a Consultant, whereupon a decision would be made as to what operation was thought to be appropriate and who would perform it. He stated that he never carried out any operation without the authority or direction of his superior, until he himself obtained a consultant post in July 2007. He stated that before operating on the plaintiff he would have been involved in twenty five such procedures. He performed thirteen of these himself, and assisted in the other twelve.

38. He gave his evidence of the operation which he performed on the plaintiff by reference to his operation notes, as he cannot specifically recall that operation at this stage. But he states that his goal would have been to maintain the functional length of the finger, though functionality would be difficult to assess where the finger tip is swollen and bruised and the patient is under general anaesthetic. He believes that he adopted what he called a 'minimalist approach', taking away no more than necessary, and stated in that regard that "*the price one pays for that is you may have to go back and do a second operation. But you can always take more away - you can never put back what you have taken away. That remains my practice today as a vascular surgeon*." (T.2, Q. 99) He stated also that this approach would have been part of his training or instruction while at St. James's Hospital.

39. In relation to Mr. Evans's criticism that he ought to have amputated the finger back to the end of the joint, Mr. McDonnell in summary stated that as the plaintiff was a young man, he was acutely aware of the importance of the hand, and that while amputation would have healed without complication, his first goal was to maintain functional length, even if this involved a further procedure at some later stage.

40. In relation to Mr. Evans's criticism about the use of the split skin graft procedure and the pulling of the nail-bed around the tip of the finger, Mr. McDonnell stated:

> *"I think it is intuitively obvious that if you pull forward the nail-bed the nail is going to curve forward. From reading my notes, I would imagine that the reason we put a skin graft there was to interpose it between the volar surface of the hand, which is the palm surface of the finger tip, and the dorsal surface … so that approximation of the two sides over the tip of the finger didn't have to take place." (T.2, Q. 111).*

41. He stated also that his training in relation to skin grafts was that it would have been a reasonable treatment to have performed at that time to cover the defect, and that the medical purpose of the graft is to close the defect in the finger in order to try and maintain as good a functional length as possible (T.2, Qs. 112-113).

42. In relation to the outcome of that operation about which the plaintiff complains, Mr. McDonnell stated that the curving of the nail was "*because the finger has been foreshortened and there is nothing to support the nail – when it grows further it tends to curve over the tip of the fingers*", and that further procedures are available to deal with that if required, and that this is a price one pays for a minimalist approach. He also stated that any decision as to what operation was to be performed on that day would be made by a senior colleague, but he went on to state that if he was faced today with the same injury he would carry out the same procedure "*in the knowledge that this may not be the definitive operation and you may have to come back again*" (T.2, Qs. 123-127).

43. Having regard to the fact that it was evident from the evidence of Mr. Evans that his criticism of the first operation was not so much that an amputation ought to have been performed at the first operation (albeit that he considered that such a procedure would have been appropriate), but rather that the nail-bed had been pulled forward over the tip of the finger into an abnormal position, Mr. Smyth asked Mr. McDonnell if he had a difficulty with that criticism. Mr. McDonnell stated that he could only base his answer on the operation notes as he has no direct recollection of the operation, and went on:

> *"… I don't believe the nail-bed was pulled into an abnormal position. I used the skin graft to interpose between the finger tip on the palm or surface of the hand and the back of the hand, so that the nail-bed would not be pulled into an abnormal position" (T.2, Q. 248)*

44. However Mr. Smyth referred to the evidence of Mr. Evans that the nail-bed had to have been pulled into an abnormal position because the nail could only have grown in a parrot beak way if the nail-bed had been pulled into an abnormal position. Mr. McDonnell stated that he did not agree with this evidence and stated that this sort of deformity can occur without the nail-bed being pulled into an abnormal position (T.2, Q. 249). Mr. Smyth commented that this had never been suggested to Mr. Evans in cross-examination by Mr. Fleck, and referred Mr. McDonnell to the extract from Green's Operative Hand Surgery which referred to the necessity to trim back the nail-bed to the same level of the end of the bone so that it does not curve over the end of the bone and subsequently lead to the development of a hooked nail. He put it to Mr. McDonnell that if such a procedure is not carried out it follows that a hooked nail will develop. To this Mr. McDonnell responded as follows:

> *"If the nail is pulled into an abnormal position, the hooked, this parrot-beak like nail will develop. As I have said to you, the notes will suggest … that I put a skin graft on to prevent the nail-bed being pulled into an abnormal position." (T.2, Q.252)*

45. Mr. Smyth repeated that Mr. Evans had not been challenged on his evidence that the nail-bed had been pulled into an abnormal position resulting in the curving of the nail, and that it was too late now to be advancing another reason for that occurrence. But Mr. McDonnell stated that he was not advancing another reason but was stating that even though the nail-bed is not pulled into an abnormal position, it is still his understanding that a parrot beak can take place. Mr. Fleck interrupted at this point to say that after Mr. Evans had been re-examined by Mr. Smyth following his cross-examination, he had referred to the final sentence in the paragraph in Green's text book referred to where the author, having stated that the nail-bed must be trimmed to the same level of the bone so that it does not curve over the end of the bone causing a hooked nail, goes on to state "if a hooked nail develops, we recommend revision with shortening of the phalanx and nail-bed to comparable level". Mr. Fleck submitted that the author himself contemplates a situation where, even though the nail-bed is shortened a curved nail may develop requiring subsequent revision. However, Mr. Fleck went on to say that Mr. Earley would be giving evidence for the defendants and would deal with this question.

46. But Mr. McDonnell stated again in answer to certain questions put to him by me that he did not believe that he had in fact pulled the nail-bed forward, and that if he had done so it would not have been necessary to put a skin graft on the finger (T.2 between Qs. 255-256). He repeated this in answer to Mr. Smyth later at T.2, Q. 301.

Evidence of Mr. Michael Earley, Consultant Plastic Surgeon

47. In his evidence Mr. Earley described the operation which was performed, and which has already been set forth. Mr. Fleck asked him his opinion as to the appropriateness of that first operation. Mr. Early stated in response that there is a large range of methods

that are used, such as doing nothing at all with the finger tip other than applying a dressing, which he stated is referred to in Green's Operative Hand Surgery, and that there was also the possibility of applying a split skin graft to prevent any pulling together or abnormal displacing any of the tissues, which would also act as a biological dressing and allow the wound to heal. He also referred to what he called more complex methods by the application of flaps or other techniques of skin cover which he stated were by and large not recommended nowadays. He stated that there was a lack of evidence as to which may or may not be the best method. He stated that Green has made an effort to draw all of these different methods, comment on them, and does not condemn any of them out of hand, and presents the evidence for the correctness of using them or not, as the case may be.

48. As to the goal of preserving the functional limb, Mr. Earley stated that in the plaintiff's case every effort was made to preserve the length of the finger, and that it is better to try and preserve finger length. As to Mr. Evans's stated view that the first operation performed in this case was "inappropriate", Mr. Earley stated that he would not use that word in the present case, and that the choice of operation in this case was "*a reasonable choice given the wide spectrum of choices that exist with poor evidence base to show that any particular one is better than the other*". He stated also that the second operation that was performed in September 1999 would have been one that would be more appropriate to a more experienced hand surgeon and would be done where it would be clearer as to what the function of the hand was going to be (T.2, Q. 345).

49. Referring to the fact that Mr. McDonnell had carried out the first operation having discussed it first with the Registrar (Mr. Mehdi), whereby a decision was reached that there should be minimal amputation and a trimming of the bone, Mr. Earley stated that this was a "*very reasonable decision to make with that type of injury*" (T.2, Q. 346).

50. Regarding the suggestion by Mr. Evans that the nail-bed had been pulled forward and distorted during closure, being the cause of the development of the curved nail growth, Mr. Earley stated:

> *"I would argue that the split skin graft was applied to prevent this very thing happening and due concern was displayed by [Mr. McDonnell] in trying to avoid distorting the nail-bed. One of the common or long-term causes of distortion of the nail, which is called gryposis … is the lack of boney support and damage to the germinal matrix of the nail itself (T.2, Q. 347).*

51. He added that the development of a curved nail is not wholly or exclusively the result of the nail-bed being bent down (T.2, Q. 348)

52. As to the prevalence of a beak or hooked nail he stated, albeit based on his own "anecdotal impression" in the absence of hard scientifically based figures, the development of a hooked nail is a common occurrence where there is a partial shortening of the finger tip, and that it will be allowed to occur and can then be dealt with later if it is a problem for the patient, but that "*in many instances patients are not troubled by the beaked nail and do not seek further treatment*." (T.2, Q.354)

53. Mr. Earley confirmed also that he would still be of the opinion as expressed in his opinion dated 7th October, 2004, and as already set forth above, namely:

> *"It is my opinion that it was not unreasonable to have attempted to maintain the length of the finger tip by application of a skin graft. It may not have been the procedure carried out by all hand surgeons but there would be many who would be of the opinion that normal practice [is] to attempt to maintain length, especially in a 27 year old manual worker." (T.2, Q. 355)*

54. Mr. Earley was not cross-examined to any great extent about the operation which was actually performed. Most of his cross-examination was directed to the question of supervision which I will come to in due course. But in relation to the operation itself, Mr. Earley confirmed to Mr. Smyth that if he was carrying out this operation himself he would be careful to close the wound in order to avoid as far as possible the loss of any boney support for the nail-bed, and that the nail-bed would not be distorted or wrapped round the tip of the finger, and finally that if Mr. McDonnell had been one of his students he would ensure that the operation would be carried out in a way that avoided the distortion of the nail-bed. (T.2, Qs. 385-387)

Supervision

55. Apart from the operation itself, I want to deal with the evidence given by Mr. McDonnell in relation to the circumstances in which Mr. McDonnell, being a trainee surgeon at the relevant time, performed this operation without a Registrar or Consultant actually being present in the operating theatre with him, and the appropriateness of that. As I have already stated he was working during his training, and at the time of this operation, under the general direction of Mr. McHugh. Again, as has already been referred to, the decision as to what particular procedure would be performed on the plaintiff on the 2nd November, 1997 was taken by the Registrar available on that date, Mr. Mehdi. But the latter was not actually present during the operation. He would never perform any operation other than after that decision had been made by his superior.

56. Under cross-examination there was some discussion between Mr. Smyth and Mr. McDonnell as to exactly what is meant by supervision. From that questioning and answering the position appears to be that in relation to operations which were performed by him during his period of training, he would never have performed any of these operations, including that on the plaintiff, without having first discussed with either a Registrar or Consultant what procedure should be carried out. That Registrar or Consultant may not be actually present in the operating theatre or even in the hospital, and the discussion could take place on the telephone. Mr. McDonnell would not agree with Mr. Smyth when he suggested that a consultant could only train a trainee if he/she was actually present at the operation. He believes that of the thirteen operations which he performed, about half would have been done when no supervisor was actually present. He could not recall whether on the 2nd November, 1997 a supervisor was present in the operating theatre, but there is no reference on the Operation Note to any being present. It appears that a trainee surgeon keeps a log book in which all operations are detailed. Mr. McDonnell did not have his Log Book with him in court, and he agreed that the log might normally show who was or was not present at the operation, but he stated also that having consulted this Log Book on the night prior to giving his evidence, this particular operation was not recorded at all. It was suggested by Mr. Smyth that this absence of any record in the Log Book was indicative perhaps of him not being "best pleased" with the operation which he performed, but he denied this.

57. In his cross-examination of Mr. Earley, Mr. Smyth first of all explored the question of the appropriateness of Mr. McDonnell performing the first operation without supervision by a Registrar or Consultant being present in the operating theatre. It was suggested to him by Mr. Smyth that this operation had not been carried out by a hand surgeon and that as a manual worker, the plaintiff was entitled to have had it carried out by a hand surgeon. Mr. Earley of course confirmed that Mr. McDonnell was not a hand surgeon but stated that the operation had been carried out by a qualified person, and that it was good practice that Mr. McDonnell should have carried it out, and that there was no entitlement to have it carried out by a hand surgeon as such, and that it was normal and common practice that it be carried out by a trainee surgeon. Mr. Earley stated that Mr. McDonnell was supervised in

relation to the operation since he had the advice of a senior surgeon available to him and had taken advice, even if that person was not actually 'scrubbed up' and present in the theatre at the time. This, he stated, is normal practice (T.2, Qs. 359-384).

58. Mr. Earley agreed with Mr. Smyth that if he himself had been performing this operation he would have at all times have been trying to preserve as much bone as possible, and would be careful to ensure that "the nail bed would not be distorted or wrapped round the tip of the finger", and also that if he had been present assisting when Mr. McDonnell was doing this operation he would ensure that the operation was carried out in a way that would have avoided the distortion of the nail bed (T.2, Qs. 385-387).

Liability conclusions

59. While Mr. Evans himself does not favour the use of a split skin graft to close the wound, this is not his primary criticism of the manner in which Mr. McDonnell performed the first operation on the plaintiff's injured finger. His principal criticism is that the nail bed was pulled forward over the end of the finger making it inevitable that the nail would grow in a parrot-peak fashion. He has referred to this both in his reports and in his evidence in court. This criticism is fundamental to Mr. Evans's evidence and the plaintiff's allegation of negligence in relation to the first operation. I have already set out that evidence in detail above and it is unnecessary to do so again. It is clear from that evidence that Mr. Evans is of the view that the tip of the finger should have been partially amputated at the first operation, as it was in the second operation in order to avoid the abnormal growth of the nail which occurred.

60. It is significant in this case that Mr. McDonnell's evidence is that he did not in fact pull forward the nail bed in the manner which Mr. Evans states must have happened, and that if he had done that it would not have been necessary to apply a split skin graft. Mr. Evans's evidence that this must have occurred since the nail grew abnormally thereafter is put into doubt given the reference in Green's Operative Hand Surgery to the fact that even where the nail bed is trimmed back to the level of the nail plate problems may develop in relation to a hooked nail which will have to be addressed by further surgery. That reference has been set forth already. It does seem to follow that there can be circumstances where, even if the first operation was carried out as Mr. Evans states it ought to have been, a hooked nail can develop nevertheless. It is significant also that Mr. Evans had no opportunity of seeing the plaintiff's finger before the second operation was performed. He has had to rely on what he has been told by the plaintiff and by reviewing the operation notes. In this regard I note his criticism of the lack of complete detail in those notes as to the precise details of what was actually done.

61. Mr. McDonnell has stated, as I have said, that he does not believe that he did in fact pull he nail bed forward. He has explained why he is of that belief. I do not consider, given this conflict of evidence, that the plaintiff has established as a matter of probability, that the nail bed was pulled forward over the end of the finger tip.

62. I am not satisfied that the fact that a split skin graft was applied is of itself negligent, given the evidence both from Mr. Earley and from the statements contained in Green's Operative Hand Surgery at p. 49 that grafting of skin onto the finger to close the wound is something which some surgeons do. While not all surgeons may on all occasions use this method of closing the end of the finger, it seems clear that it is nevertheless a method which is recognised as a reasonable method of achieving closure of the wound. Mr. Earley considers that it was reasonable in this case that this method was adopted. I cannot regard that procedure as having been negligent.

63. I accept from the evidence given that it was reasonable, particularly for this plaintiff, a manual worker, that Mr. McDonnell would have attempted by the procedure adopted, to have maintained as much functional length as possible for the finger. It seems obvious that this would be the case, even if this turns out eventually to lead to further surgery to address any adverse sequelae which may appear at some later stage. It seems clear from what is stated in Green's Operative Hand Surgery and from the evidence given in this case that hand injuries and finger injuries in particular are problematical, and that the treating surgeon must make decisions as to which procedure, from a range of possible procedures available, is appropriate in the particular case. Mr. McDonnell took relevant advice from his senior. I am not satisfied from the evidence that there was negligence from the fact that this senior person was not physically present in the theatre when the operation was performed. Mr. Earley has made it abundantly clear that it is accepted practice that a trainee surgeon would take advice in the way Mr. McDonnell did on this occasion.

64. Clearly Mr. McDonnell might have been advised that the appropriate procedure would have been to perform the partial amputation which was done on the second operation, but that advice was not given. One could even imagine that a person such as the plaintiff, a manual worker, who discovered that the finger tip had been amputated, might have some cause for concern that a sufficient effort had not been made to preserve full or near full finger length, and claim negligence in that event also. That demonstrates the difficulty facing surgeons who are dealing with an injury of this kind when making choices as to what procedure to adopt. It seems prudent in my view to make a decision to perform in the first instance a more conservative surgical procedure which could preserve length, rather than opt for the more radical procedure by way of amputation. In the latter case no subsequent surgery could restore length, whereas in the former case, as in the present case, a second operation can deal with any residual difficulties in the light of how the nail may grow over time.

65. I am satisfied therefore that the operation which was carried out by Mr. McDonnell has not been established by the plaintiff as having been a negligent one, even if the outcome achieved was one which required further surgery to address. For this reason the plaintiff's action must fail.

The Statute of Limitations issue

66. This issue is very much a secondary one being pursued by the defendants, and that is understandable, especially in an action for professional negligence. Nevertheless it has been raised and pursued by the evidence adduced and submissions made by the defendants, and the Court must reach a conclusion on it for the sake of completeness, in case my findings on liability are found elsewhere to have been incorrect.

67. It is quite clear that over the course of a few months after the first operation was performed in November 1997 the plaintiff was experiencing difficulties with how the nail was growing, and was dissatisfied with the outcome of the first operation. He attended Mr. McHugh for review on a number of occasions and was advised that he needed to be patient and that given time the difficulty may resolve. These assurances by Mr. McHugh did not reassure the plaintiff who, in his evidence, stated that he kept saying to Mr. McHugh that his finger was not "grand" and that there was "something not right" (T.1, Q. 45). He was unable to go back to work, as his GP, Dr. Kehoe could not certify him as being fit for work. As it happens, Dr. Kehoe was also the company doctor for the plaintiff's employer. Nothing turns on that. The plaintiff has stated in his evidence that Dr. Kehoe was "never satisfied with the finger whatsoever." (T.1, Q. 51)

68. The plaintiff was asked by Mr. Fleck if Dr. Kehoe had told him in the months after the first operation that there was something wrong with the first operation. The plaintiff stated that he had told him there was something wrong, not in the immediate aftermath of the operation, but "it would have been a matter of months after it … anywhere within five or six months after" (T.2, Qs. 124-125).

That would be around April/May 1998. The plaintiff does not accept that at the meeting with Mr. McHugh, the latter told him that an excision of the nail bed was a possible option at that stage. He denies also that he was reluctant to undergo a second operation, and says that it was he who went to Mr. McHugh seeking a further operation to try and sort out the problems he was having with his nail. He knew however, at least in his own mind, that there was something seriously wrong with his finger and that he needed a further operation (T.1, Q. 154). He went on to say, when asked if Dr. Kehoe suggested within months of the operation that there was something wrong with it: "*He did, absolutely*" (T.1, Q. 157). Mr. Fleck asked him if he could explain why, following the meeting with Mr. McHugh in May 1998, his proceedings were not commenced until the 9th September, 2002. The plaintiff stated in response "*I was dealing long before that with my solicitor about this*" (T.1, Q. 160). I note in passing that his solicitor wrote a letter to the Eastern Health Board at Dr. Stevens' Hospital on the 30th March, 1999, seeking medical records since the plaintiff's own efforts to obtain them had failed up to that point.

69. Dr. Kehoe's own evidence under cross-examination was that he had no recollection of ever specifically telling the plaintiff that there was something wrong about the manner in which the operation had been performed, and that he is experienced enough not to have actually criticised it (T.2, Q. 59). He went on to say that he would probably have indicated that he did not think that the finger was progressing satisfactorily but that this would not have been a criticism of the surgery (T.1, Qs. 59-60).

70. I am inclined to accept Dr. Kehoe's evidence in that regard. After all, as a general practitioner, he would not be likely to express a professional opinion in relation to a matter which is of a specialist nature. The plaintiff is likely to be referring instead to the comments made by Dr. Kehoe about the lack of satisfactory progress post-operation, rather than any attribution of negligence or other blame on the surgeon who carried it out. But clearly the plaintiff had become so concerned about it that he was intent at that stage on seeking out information from the medical records in order to see if in fact the operation might have been carried out improperly or negligently. It would not be correct in my view to regard the plaintiff as being possessed of the necessary information at that stage to justify the commencement of proceedings for medical negligence, given the lack of any expert opinion on the issue of negligence, especially in the absence of any medical records having been made available to the plaintiff at that point. It was perfectly reasonable, and indeed necessary, for the plaintiff's solicitor to seek those records before going further to seek an expert independent opinion on that issue.

71. Equally, the fact that both the plaintiff and Mr. McHugh may have been of the view by May 1998 that a second operation should be performed, cannot be equated with fixing the plaintiff with the necessary knowledge at that point to require that proceedings be commenced within three years thereafter. It was not until about September 2001 that Mr. Evans was consulted for the purpose of advising on the question of negligence. I accept that there has been considerable delay between the date of the second operation and the seeking of Mr. Evans's opinion – a delay of nearly two years. Mr. Fleck is of course correct that an expert could have been provided with an opportunity to examine the finger before the second operation was performed. In other words, Mr. Evans, or some other expert could have been consulted before November 2001. But I have no information on how long it took to first of all obtain the plaintiff's medical records from the defendants following the plaintiff's solicitor's letter to the Eastern Health Board in March 1999.

72. Even though it might well have been prudent for a solicitor perhaps to issue the Plenary Summons on a precautionary basis within three years of the date of the first operation, i.e. before November 2000, and then hold them in abeyance while marshalling the necessary expert evidence ahead of actually serving the defendants, it ought not to be regarded as fatal to the plaintiff's claim that they did not do so, and chose instead to delay the issue of the proceedings until they had obtained the necessary expert medical opinion on negligence, provided that the delay in question can be seen as justified. The plaintiff is entitled to have relied upon his solicitor's expertise in that matter. I do not believe that the plaintiff has been in any way at fault in that regard.

73. The relevant provisions of the Statute of Limitations (Amendment) Act 1991 are:-

> *"2.—(1) For the purposes of any provision of this Act whereby the time within which an action in respect of an injury may be brought depends on a person's date of knowledge (whether he is the person injured or a personal representative or dependant of the person injured) references to that person's date of knowledge are references to the date on which he first had knowledge of the following facts:*
>
> > *(a) that the person alleged to have been injured had been injured,*
> >
> > *(b) that the injury in question was significant,*
> >
> > *(c) that the injury was attributable in whole or in part to the act or omission which is alleged to constitute negligence, nuisance or breach of duty,*
> >
> > *(d) the identity of the defendant, and*
> >
> > *(e) if it is alleged that the act or omission was that of a person other than the defendant, the identity of that person and the additional facts supporting the bringing of an action against the defendant; and knowledge that any acts or omissions did or did not, as a matter of law, involve negligence, nuisance or breach of duty is irrelevant.*
>
> *(2) For the purposes of this section, a person's knowledge includes knowledge which he might reasonably have been expected to acquire—*
>
> > *(a) from facts observable or ascertainable by him, or*
> >
> > *(b) from facts ascertainable by him with the help of medical or other appropriate expert advice which it is reasonable for him to seek.*
>
> *(3) Notwithstanding subsection (2) of this section—*
>
> > *(a) a person shall not be fixed under this section with knowledge of a fact ascertainable only with the help of expert advice so long as he has taken all reasonable steps to obtain (and, where appropriate, to act on) that advice; and*
> >
> > *(b) a person injured shall not be fixed under this section with knowledge of a fact relevant to the injury which he*

has failed to acquire as a result of that injury.

3.—(1) An action, other than one to which section 6 of this Act applies, claiming damages in respect of personal injuries to a person caused by negligence, nuisance or breach of duty (whether the duty exists by virtue of a contract or of a provision made by or under a statute or independently of any contract or any such provision) shall not be brought after the expiration of three years from the date on which the cause of action accrued or the date of knowledge (if later) of the person injured."

74. I have underlined the parts of s. 2 of the Act which need to be considered on the facts of this case, the other parts being matters which are not in dispute.

75. As far as s. 2(1)(c) of the Act is concerned, and in so far as the allegation of negligence concerns whether or not the nail bed was pulled forward inappropriately, and the application of a split skin graft, it was certainly not until Mr. Evans's report arrived that any allegation of negligence could be thought to exist. The mere fact that the finger turned out to require a further operation would not have justified the commencement of proceedings.

76. As far as s. 2(2) is concerned, the plaintiff could not come within these provisions unless I was to conclude that there had been unexplained and unreasonable delay in seeking out the opinion of Mr. Evans or some other expert. I am not so satisfied. As I have said, there appears to have been some delay on the part of the defendants in providing the plaintiff with his medical records, and it was necessary for his solicitor to write for these in March 1999. I have no evidence as to when these records were provided. It would be incumbent upon the defendants to satisfy me that they were provided in a timely fashion thereafter before I could bar the plaintiff on this ground, and the defendants have not sought to adduce that evidence. In fairness, Mr. Fleck was at pains to point out that while the issue was in the case, the defendants were principally relying on the failure by the plaintiff to prove any negligence in the manner in which the first operation was carried out.

77. The plaintiff has failed in these proceedings to satisfy me that the first operation was carried out negligently as pleaded, and I will accordingly dismiss same against all the defendants.