Neutral Citation: [2013] IEHC 461

THE HIGH COURT

[2003 No. 11186 P]

BETWEEN

HUGH O'NEILL

PLAINTIFF

AND

DANIEL RAWLUK

DEFENDANT

JUDGMENT of Mr. Justice Michael Moriarty delivered on the 31st day of July, 2013

1. These proceedings arise out of the performance of a surgical procedure by the defendant on the plaintiff on 12th January, 2001; namely, a cervical discectomy. The plaintiff alleges that there was no reasonable basis for this procedure to have been deemed appropriate in his case, and claims to have suffered adverse sequelae as a result of its having been performed.

2. The plaintiff is a forty eight year old man, who was by profession an IT consultant. Following diagnosis of early onset Parkinson's disease in 2002, his capacity to work diminished towards virtual retirement in early 2004. A final attempted resumption of his working life in 2007 proved abortive. Diagnosis of that incurable and progressive disease is independent of the matters in issue in these proceedings, and no complaint in that regard is made against the defendant. Nor is it contended for the plaintiff that the surgical procedure itself was carried out other than competently. Rather, the plaintiff's case is that the procedure should never, in all the circumstances, have been undertaken.

3. In or around 2000, the plaintiff began to experience problems relating to his manual dexterity, a tremor and general weakness in his left arm, and particularly weakness in his grip with his left hand. The plaintiff also suffered neck stiffness, including an episode of "slight discomfort" over the course of two to three days during the summer of 2000, but did not suffer any significant pain at this time. These symptoms were particularly noticeable to him when he attempted to operate computer keyboards, which was an essential element of his working life. The plaintiff also experienced difficulties in such tasks as reaching for coins in his pocket. The plaintiff accordingly attended his GP, Dr. Cahill, who initially suggested that his complaints could have a carpal tunnel problem as their cause.

4. Dr. Cahill referred the plaintiff to an orthopaedic surgeon, Mr. McGoldrick, who subsequently referred the plaintiff to a neurologist, Dr. Moorhouse. After an initial consultation, Dr. Moorhouse performed nerve conduction studies on the plaintiff. Mr. Moorehouse synopsised his findings in a letter to Mr. McGoldrick dated 27th November, 2000, as follows:-

> *"Clinical examination ... reveals an upper motor neurone pattern of weakness in his left upper extremity. There is associated hyper-reflexia and rigidity. There also appears to be a mild decrease in the left nasal labial fold. His left toe was also equivocal.*
>
> *This man has upper motor neurone pathology involving his left arm. He does give a history of neck discomfort for 3 weeks in the middle of the summer and the problem is either his left neck region or in his right hemisphere. In view of this feel that he needs an urgent MRI scan of his neck which has been arranged for Friday, if this is normal he then needs a CT scan of his brain."*

5. On foot of these consultations, Dr. Moorhouse arranged for the Plaintiff to undergo an MRI of his spinal cord on 1st December, 2000. In the clinical information endorsed on the request for an MRI Scan, Dr. Moorhouse had requested that the scan should be undertaken with a view to "rul[ing] out cord compression". Dr. Brennan, the consultant neuroradiologist who performed the scan, stated in his report dated 4th December, 2000:-

> *"Standard MR cervical spine was performed showing degenerative change at C5/6. Axial scans through this region show evidence of a large central and left sided disc herniation compressing the left C6 nerve root. There are no other features of note."*

6. On 4th December, 2000, Dr. Moorhouse wrote to Mr. McGoldrick enclosing the result of the MRI scan, enquiring as to whether he, "*still [does] the occasional cervical discectomy*", and offering in the alternative to arrange a neurosurgical consultation for the plaintiff.

7. Dr. Moorhouse requested a CT scan of the head on 5th December, with his requisition indicating that that, "*MRI of neck, large disc [left] sided but no cord involvement*", and indicating the "*need to [rule out space occupying lesion right hemisphere*." The CT scan was performed on 14th December, 2000 and disclosed no abnormalities.

8. Dr. Moorhouse then referred the Plaintiff to the Defendant, Mr. Rawluk. The defendant is a consultant neurologist, practising at the Blackrock Clinic and Beaumont Private Clinic. The defendant first met the Plaintiff at the former institution on 14th December, 2000, on which occasion the defendant advised the plaintiff to undergo surgery. This is evidenced by a letter written by the defendant to Dr. Moorhouse on 19th December, 2000, wherein he stated:-

> *"I saw Hugh in my rooms noting his problems with weakness of his left hand associated with some neck stiffness since the Summer of this year.*
>
> *He feels that the dexterity has been very troublesome since September and October which has affected him when typing on a keyboard.*
>
> *On examination, his neck movements were satisfactory and he did have a tremor affecting his left arm on performing*

formal examination with a general weakness, but in particular, a significantly reduced grip in his left hand.

His MRI scan has revealed a sizeable disc prolapse on the left side at C5/6 giving rise to nerve root compression.

I advised him that surgery was an option, however, this would be dictated by his appreciation of the severity of his symptoms.

While people with more radiculopathy [nerve root compression] usually show some improvement following a surgical decompression, a proportion of patients might fail to show such a recovery and I advised him of this possibility.

Essentially, he wished some time to consider our interview and said that he would get back to me once he has decided whether he wished to proceed to surgery or not."

9. The Plaintiff travelled to Waterford on 18th December 2000 to see a Dr. Cormac McNamara to get advice as to whether or not it was advisable to proceed with the surgery. There is a measure of disagreement between the plaintiff and the defendant as to whether the defendant conveyed the impression that this type of surgery was the only viable option in attempting to alleviate the dexterity problems suffered by the plaintiff.

10. The surgery was performed by the defendant at the Blackrock Clinic on 12th January 2001. The Plaintiff was subsequently discharged on 12th January, 2001. In the immediate aftermath of the surgery, the Plaintiff complained of pain in his neck. He was prescribed painkillers for 3 weeks and attended physiotherapy, which was also noted as having caused pain.

11. The plaintiff returned to work in a limited capacity two and a half weeks after the surgery. Upon his return to work, the plaintiff submits that he suffered neck pain, as well as a "clicking" sensation in his neck. He claims that no improvement was evident in the symptoms affecting his left hand.

12. The plaintiff attended two post-operative appointments with the Defendant, respectively on 14th March, 2001, and 11th July, 2001. At the first of these consultations, the Plaintiff noted an ache in his neck and left shoulder. The possibility that he may have been suffering the onset of Parkinson's disease was not raised with the plaintiff until subsequent consultation with Dr. Moorhouse around March 2002.

13. The plaintiff claims that, as a result of the surgery performed by the defendant, any activities which involve neck rotation now cause him pain. By way of example, the plaintiff's evidence was that he was precluded from riding a motorbike due to the difficulty of rotating his neck to observe traffic, dealing with a helmet, and encountering "speed bumps". Similarly, the plaintiff's evidence is that swimming also induced notable pain. The plaintiff experienced pains in his neck when looking at computer screens. Furthermore, the plaintiff suffered sleep disturbance arising from neck pain.

14. The plaintiff was subsequently diagnosed as suffering from early onset Parkinson 's disease, a progressive degenerative neurological disease. This condition has specifically manifested itself in the form of bradykinesia, or pronounced slowness of movement, and it would appear, in retrospect, that the symptoms with which the plaintiff had presented in 2000 were attributable to Parkinson's disease, although, as previously stated, the defendant is not faulted for diagnostic failure in this regard. The plaintiff is now and presented throughout the hearing as wheelchair-bound, depending on the support of family members and other carers.

The Proceedings

15. Proceedings issued by way of Plenary Summons on 7th October, 2003. Dr. Moorhouse was named as a defendant in the proceedings as initiated, in respect of his alleged failure to diagnose the plaintiffs Parkinson's disease. The plaintiff subsequently elected not to pursue the latter cause, with a Notice of Discontinuance being delivered on 15th September 2005 in respect of that element of the claim.

16. In his Statement of Claim, delivered on 1st September, 2005, the defendant alleges that the defendant was negligent and in breach of duty *inter alia* on the following basis:-

(a) In misdiagnosing nerve root compression I prolapsed disc as being causative of the plaintiff's symptoms;

(b) In attributing the plaintiff's symptoms of weakness, tremor and loss of dexterity in his left hand to a prolapsed disc with nerve root compression;

(c) In failing to have any or any adequate regard to the inconsistency between the presentation of the plaintiff's symptoms and the clinical findings on the MRI scan;

(d) In carrying out a cervical discectomy upon the plaintiff that was unnecessary in all of the prevailing circumstances;

(e) In failing to have regard to the fact that the MRI scan of the plaintiffs cervical spine showed no evidence of cord compression;

(f) In misdiagnosing the cause of the plaintiff's symptoms and failing to consult, further, with the plaintiffs referring neurologist prior to performing surgery upon the plaintiff;

(g) In failing to consider in any or any reasonable manner other potential causes of the plaintiffs symptoms;

(h) In failing to recognise that the symptoms with which the plaintiff presented in December 2000 were not typical of a peripheral nerve lesion or a trapped nerve in the neck or arm;

(i) In failing to proceed cautiously in circumstances where the MRI scan showed evidence only of nerve root compression but no evidence of cord compression;

g) In failing to have due regard to the neurological symptoms with which the plaintiff presented;

(k) In failing to recognise that the plaintiff's clinical presentation and physical symptoms were not consistent with the diagnosis of left sided C5/6 root compression;

(l) In failing to investigate more fully the cause of the plaintiffs symptoms prior to conducting cervical disc surgery;

(m) In failing to understand or appreciate the significance of the plaintiff's history upon presentation;

(n) In failing to note that clinical signs usually associated with a disc herniation of nerve root compression were not present in the plaintiffs case; and

(o) In negligently misdiagnosing the plaintiffs condition and thereby subjecting him to an unnecessary surgical intervention.

17. The plaintiff asserts that, in an all the circumstances, the defendant failed to act with all due or reasonable care, skill, competence, diligence or judgment in his assessment, diagnosis, management and treatment of the plaintiff.

18. Specifically, the claim against the Defendant is that the injuries complained of by the Plaintiff were caused and occasioned by reason of the negligence and breach of duty on the part of Mr. Rawluk in or about his failure to use reasonable care, skill, competence, diligence and judgment in his assessment, diagnosis, management and treatment of the Plaintiff.

19. In his defence, delivered on 29th November, 2007, the defendant asserts that the plaintiff was advised that cervical discectomy was an option in light of the defendant 's assessment of the his MRI scan, and was adequately apprised of the risk that the surgery may not be successful in alleviating his symptoms.

20. The defendant further submits that his interpretation of the MRI scan was an accurate one and that the scan did show evidence of indentation and compression of the spinal cord. The defendant claims that all appropriate investigations had been carried out prior to surgery and that the probable cause of the plaintiff's symptoms had been similarly identified as cervical disc herniation by the plaintiff's consultant neurologist.

Summary of the Evidence

21. The court heard evidence from Mr. Tom Russell, a consultant neurosurgeon of some 25 years standing, specialising in trauma and spinal problems. Mr. Russell addressed in detail the issues arising out of herniation of C5/C6 vertebrae. His evidence was that the... cervical discectomy procedure gives rise to a one in two hundred chance of the patient's becoming quadriplegic as a result.

22. Mr. Russell very firmly took the view that the symptoms with which the plaintiff had presented should not have been seen as warranting surgery by reference to ordinary professional standards, and that a cervical discectomy should not, in the circumstances, have been presented to the plaintiff as an option. Having considered the MRI scans of the plaintiff taken in December of 2000, the witness stated that the scan revealed:-

> *"... no abnormality of the spinal cord which can be linked with any of the symptoms experienced by Mr. O' Neill or with any of the signs elicited by Mr. Rawluk during his pre-operative examination of Mr. O'Neill. "*

23. Dr. Sanjiv Chawda, a senior consultant neuroradiologist based at Queen 's University Hospital at Romford in the United Kingdom, gave evidence that the defendant 's MRI scan did not disclose that the neural foramen, described as "*the tunnel [in the vertebra] that the nerve goes through*" was significantly narrowed, such as to cause compression. Dr. Chawda was of the view that such evidence of a prolapsed disc as may have been gleaned from the MRI scan could not properly be interpreted, particularly having regard to the particular characteristics of the "T1" and "T2" weighted imaging techniques of scanning, as showing sufficiently obvious spinal cord flattening ("myelopathy"). The witness was of the view that the degree of flattening evident in the scans "*would not have been capable of producing clinical signs and symptoms in Mr. O'Neill*."

24. Mr. Robert Maurice-Williams, a widely published emeritus consultant neurosurgeon based at the Royal Free Hospital at Hampstead, London, in his report put the view that:-

> *" Mr. O'Neill's pre and postoperative neurological problems as described in Dr. Moorhouse 's letters could not possibly have been caused by the disc protrusion shown on the preoperative scan and this being so I agree with Mr. Russell that there were no indications for carrying out an anterior cervical discectomy at that level"*

25. Mr. Maurice-Williams was quite clear in his evidence that:-

> *" I don 't think there is any body of neuro-surgical opinion, reasonable body, which would have advocated surgery. I mean, there are differences of opinion about spinal surgery as to whether symptoms are sufficiently severe to warrant surgery, if there are indications, and also there are different surgical approaches, but in this case there was no clinical evidence of nerve root compression. In fact, the symptoms simply could not be explained by the radiological abnormality...*
>
> *... But what one can say is that the upper motor neurone pattern of weakness with hyper-reflexia and rigidity in the left arm cannot be explained by root compression.*
>
> *... neck stiffness by itself will not help one decide whether nerve root compression was causing the symptoms in the arm ...*
>
> *... The weakness as described was not consistent with a compression of the C6 nerve root ... But more importantly, compression of the C6 nerve root was excluded by the rigidity of the arm and the brisk reflexes. "*

26. Mr. Maurice-Williams expressed his opinion that while the risk of, "*a complete signal cord lesion, tetraplegia or quadriplegia, is very low, probably of the order of one in every 200 or 300 cases*", the cervical discectomy is a quite complex and invasive procedure, performed under operating microscope and close to the spinal cord and nerve root. The witness stated that there is a risk in the order of 1-2% that the patient's condition will be "*made worse in some way*" by the surgery.

27. Mr. Istvan Nagy, senior lecturer in neuronal processing at Imperial College London, considered in his evidence the standard of the assessment by the defendant of the plaintiffs condition, putting the view that a distinction must be drawn between "compression" in the colloquial sense of any apparent impingement upon the nerve root, which may be asymptomatic, and "*pathological compression*", where the degree of intrusion upon the nerve root or spinal cord will produce clinical signs or symptoms.

28. Mr. Nagy stated that the defendant must have been operating under the assumption that there was a pathological compression of one or both of the left C6 nerve roots, in having formed the view that cervical discectomy represented an appropriate intervention. However, the witness was of the opinion that the there was no basis upon which to form this view, based upon the symptoms with which the plaintiff presented:-

> *" First ... pathological compression of the dorsal nerve root induces pain and loss of sensation of the C6 dermatome. Mr. 0'Neill did not complain of pain or loss of sensation referred to in the C6 dermatome. Hence, there could have been no pathological compression of the C6 nerve root.*
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> *Second, the C6 ventral root does not innervate the muscles which are involved in gripping with the hand. Muscles involved in gripping with the hand were significantly weakened in Mr. O'Neill's left hand, but that cannot be caused by pathological compression of the C6 ventral nerve root Third, compression of the ventral root results in reduced, not increased, reflexes. Mr. 0'Neill had been found on examination to have hyper-relexia (noted on 27th November, 2000, by Dr. Moorhouse) and brisk reflexes (noted by Mr. Rawluk on 19th December, 2000). Increased reflexes are inconsistent with pathological compression of the C6 nerve root.*
>
> *Accordingly, there was no neuroanatomical or physiological basis for believing that decompression of the C6 nerve roots would have relieved the signs or symptoms suffered by Mr. O'Neill when examined by Mr. Rawluk on 14th December, 2000. "*

29. The plaintiff gave evidence that he had been advised by the defendant that there was a good possibility of a positive outcome from the surgery. His evidence was that the defendant had told him of a previous patient, a keen darts player, who had developed similar difficulty with weakness and dexterity, with the cervical discectomy performed on that patient having led to a full recovery, to the point that he could play darts again. Furthermore, the plaintiff gave evidence that, upon enquiring as to whether there was a possibility that he might be left disabled by the procedure, the defendant replied, "*you are disabled already*". His testimony was that there was little or no discussion of a potential "downside" to the procedure.

30. The plaintiff gave evidence of his recovery from the procedure and the difficulties experienced by him. He stated that he had suffered severe pain in the immediate aftermath of the operation, with his neck feeling "stiff and rigid". The plaintiff gave evidence of having been seen by the defendant while in hospital after his surgery and having been asked by him "*has the pain gone*" to which the plaintiff replied,"*I never had any pain*". The plaintiffs summary of the outcome of the procedure is that he was left with, "*a painful neck and a hand that didn't work still*".

31. Turning to the defence evidence, Professor Robin Sellar, consultant neuroradiologist at Glasgow Institute of Neruosciences considered that the MRI scan revealed, *"[a] large central disc prolapse, you are highlighting to the referring physician in this case the possibility in certain positions of the neck that he could get compression." The witness noted "a little button coming out of the C5/6 disc into the spinal canal ... [t]hat is disc material, a prolapsed intervertebral disc*."

32. Mr. Sellar pointed to flattening of the spinal cord evident from the MRI scan, as well as a 50% constriction of the neural foramen, which, in disagreement with Dr. Chawda, he regarded as being very significant. His view is that he would have expected such a degree of constriction to have produced pathological compression, that is to have evidenced itself by way of clinical symptoms.

33. Mr. Robert McFarlane consultant neurosurgeon at the Department of Neurological Surgery in Addenbrooke's Hospital in Cambridge gave evidence that:-

> *"[I]f Mr. O'Neill had been suffering from spinal cord compression (myelopathy) then I think that the indication for surgery would have been strong.*
>
> *The reason for that is that we know that patients who have myelopathy, who don't have their myelopathy relieved, their chances of getting a good outcome are reduced because the spinal cord, being central nervous tissue, has no capacity to recover. So that, in fact, if he had thought that Mr. O'Neill was suffering from myelopathy, then I think the indication for surgery would have been almost overwhelming in a man of 35, whose upper limb was becoming weak, because the likelihood is that he would have become progressively disabled without surgery. "*

34. Referring to nerve root compression ("radiculopathy"), the witness stated:-

> *"I think that it is harder and requires more consideration to think about the indication for radiculopathy because radiculopathy is much more a case of quality of life; that there is no absolute indication for surgery in radiculopathy. Most patients will have their surgery to try and relieve pain. We know that sensory disturbance often does not recover even if you take the pressure off the nerve root. So, a patient who presents with numbness, we would often say to them if the pain is gone that actually they are unlikely to benefit from surgery. Motor weakness on the whole is second to pain in terms of recovery of function. So that someone who you think has radiculopathy, with weakness as a consequence of nerve root compression, that will be an indication."*

35. David Moorhouse, consultant neurosurgeon based at Bon Secours Private Hospital in Glasnevin, Dublin 9, confirmed that the plaintiff had presented with, "weakness involving his left upper extremity, also stiffness and increased reflexes". Mr. Moorhouse was formerly the second named defendant to these proceedings. While acknowledging that typically radiculopathy would result in, "sensory symptoms including pain and numbness, [as well as] motor symptoms, which would be weakness", Mr. Moorhouse gave evidence that disc prolapse causing nerve root compression may in certain cases manifest itself without sensory symptoms. The witness declined to give an estimate as to the proportion of cases in which this may occur.

36. Mr. Moorhouse was questioned regarding his letter to Mr. McGoldrick dated 2ih November, 2000, wherein he stated, "*[c]linical examination however reveals an upper motor neurone pattern of weakness in his left upper extremity*". His evidence was that an upper motor neurone pathology relates to dysfunction in the brain or in the spinal cord, while lower motor neurone pathology includes nerve root compression. The witness was robustly questioned on this issue, with his evidence being that upon receipt of the MRI scan together with Dr. Brennan's report, the presence of a disc prolapse on the left C5/C6 vertebra, where the relevant nerve root "*innovates muscles in this man's left upper extremity*" , represented a very important piece of diagnostic evidence, notwithstanding the inconsistency of the plaintiffs symptoms with nerve root compression.

37. The defendant in his evidence confirmed his contemporaneous note of the plaintiffs having presented with "*no pain, but arm feels tired/fatigued*" and "*brisk reflexes in arms and legs*", notwithstanding "*tremor and weak left arm, with reduced grip*" at his

consultation on 19th December, 2000. That same note concludes, "*surgery an option, await decision*".

38. The defendant acknowledged that:-

> *"First of all I thought his presenting symptoms were not typical for a cervical disc prolapse in that he did not report definite brachialgia, which is pain in the arm. He did not report any numbness or pins and needles in the arm but, nevertheless, he did have obvious weakness in his arm ... "*

39. In his evidence, the defendant maintained that this was not a straightforward case:-

> *" He presented in an unusual manner. As I mentioned he did not have the usual associated symptoms of pain, numbness and pins and needles which goes with brachycardia due to a disc prolapse but he did appear to have weakness which could have been attributed to the disc prolapse at C5/6 level. "*

40. The defendant also acknowledged having mentioned the case of a previous patient, who had suffered a weakness in his arm, where a cervical discectomy had restored the use of his arm, including his ability to play darts, but strenuously denied having put any pressure on the plaintiff to undergo the procedure. The defendant's recollection was that:-

> *" My assessment was that we were very much in a 50/50 situation, that given the findings on examination which could have been relevant to the disc prolapse that surgery was an option, that there was a chance that he might improve but I hope I didn't mislead him to believe that this was a definite guarantee that it would help his arm and I certainly would not have led him to believe that. "*

Conclusion on Liability

41. This is a case of some antiquity, with the procedure in question having been performed more than 12 years ago. This presents difficulties for both plaintiff and defendant. Pleadings were exchanged in the "old" form, preceding the currently operating regime under the Courts and Court Officers Act, 2004. The vast majority of expert witnesses in this matter travelled from the United Kingdom, which contrasts with more recent practice in medical negligence litigation.

42. While there are certain differences between the parties on this matter, the plaintiff does not seek to base his case on a lack of informed consent. The unique experience of the plaintiff is likely to be more indelible than the recollection of one of many procedures undertaken by a busy neurological surgeon, with a clinical case load exceeding, on the defendant 's own evidence, 350 patients per year. However, the defendant 's practice of maintaining handwritten notes also gives a more reliable picture. I accept that that a cervical discectomy was offered to the plaintiff as an option, but was not specifically advised, but also that the defendant indicated a reasonable expectation of significant improvement, referring to an earlier patient, a darts player. I accept that in response to a question from the plaintiff in relation to the possibility of becoming disabled as a result of the procedure, the defendant commented, "*you already are disabled*". I also accept the plaintiffs evidence that he was asked by the defendant at a post-operative conference whether the pain was gone, to which he responded that he had not suffered any pain in the first instance.

43. Turning to the expert evidence, much of the defendant's evidence seemed to me to involve a recasting of events with a level of detail and particularity far in excess of that typically operating in day-to-day practice at the time of the surgery. It seems clear to me that while I must carefully consider all the evidence adduced on both sides, and have done, I should primarily have regard on the defendant's side to all the relevant information that was assembled and made available to him at the time, whether from medical colleagues or his consultation with the plaintiff, before proceeding to perform the surgery. Reconstructions and hypotheses devised long subsequent to the events in issue, of particularity and detail far in excess of the defendant's notes, described by Mr. Maurice-Williams as "limited, to say the least", fall to be considered, but lack the cogency of what was disclosed to the defendant at the material time.

44. I similarly approach with a degree of caution the often reiterated reference in much of the defence testimony to the unusual and atypical manner in which the plaintiff presented clinically. Whilst in no sense determinative, I found the mention by Mr. Maurice-Williams in evidence that 70% of his engagements in similar English litigation was on behalf of defendant insurers certainly did not diminish the weight of his forceful evidence.

45. Reference was made to a relatively recent online conference between the experts to be called on behalf or the defendant. My mention of this is not intended as a criticism, as the plaintiffs witnesses could properly have done likewise, although I note testimony from Mr. Maurice-Williams that he was unacquainted with Mr. Russell, and had at no stage discussed the case with him. Overall, I found the plaintiffs witnesses, in particular Mr. Russell and Mr. Maurice-Williams, to be more persuasive. It seems to me to be of greater assistance in assessing what was apparent to the defendant when he offered surgery to the plaintiff, from the available clinical, radiological and other data, rather than on the basis of inordinately conjectural assessments undertaken with significantly more particularity than may have been expected at the time.

46. I am satisfied that the cervical discectomy was offered to the plaintiff without due regard to the lack of clinical symptoms of signs supporting a diagnosis of nerve root compression. While the MRI scans of the plaintiff did disclose herniation to the C5/C6 vertebra, attendant nerve root compression could be expected to cause pain and impair reflexes. In fact, the plaintiff reported no significant pain and presented with increased reflex response. The symptoms exhibited by the plaintiff, being tremors and weakness in the left hand, could not have been attributable to nerve root compression at the C5/C6 vertebra. This was the central thesis of the plaintiff's case when opened by his Counsel, and for all the amount of the defendant's evidence and argument, I am not persuaded that it has been displaced.

47. Applying the test set out in Dunne v. National Maternity Hospital [1989] 1 I.R. 91, I am of the view that "*the course taken was one which no other medical practitioner of like specialisation and skill would have followed when taking the ordinary care required from a person of his qualifications*". I therefore hold the defendant liable in damages.

Damages

48. I turn finally to the question of damages, limited in the circumstances of the case to those that are general and compensatory. Counsel for the plaintiff inferred at the conclusion of the hearing that this issue might be viewed as subsidiary to the matters of principle involved in determining liability, but, however viewed, a finding for the plaintiff necessarily imports an entitlement to not inconsiderable relief. He was subjected to a serious and invasive neurosurgical procedure that has been found to be unnecessary and inappropriate, entailing what were admittedly reasonably remote risks of a catastrophic outcome, and more realistic hazards of lesser adverse effects. In the event, he derived no tangible benefit from the procedure, and was occasioned pain of initially considerable

intensity, but which lessened with time and medication. He also retains scarring from the operative incision, and it bears remembering that, although categorised by the defence as being less hazardous and invasive than much neurosurgery, nevertheless on the defendant's own detailed account the operation occupied a full hour.

49. The primary complication in assessing damages is in providing some demarcation between the considerable sequelae of the surgery and the regrettable later onset of Parkinson's disease that would in any event have befallen him. The combination of factors is unusual, and though I have consulted both, I have derived little assistance from either *McGregor on Damages* or the *PIAB Book of Quantum*.

50. Appraising matters as carefully as I can, I find that my overall appraisal tends to fall marginally either side of an aggregate €100,000. I shall accordingly assess that sum as the entirety of the plaintiffs claim. Given the complicating factors, and the length of time since the surgery, I do not consider it incumbent on me to divide this between pain and suffering to date and into the future, but were I compelled to do so, I feel the degree to which post- operative complaints have been have been subsumed into the more grievous related symptoms would dictate that the preponderance should be in the former category.