Neutral Citation: [2015] IEHC 275

THE HIGH COURT

[2012 No. 8972 P.]

BETWEEN

LINDA FARRELL

PLAINTIFF

AND

JOHN RYAN

DEFENDANT

JUDGMENT of Mr. Justice Cross delivered on the 1st day of May, 2015

1. Introduction

1.1 The plaintiff was born on 9th January, 1939 and claims damages against the defendant as secretary and general manager of the Coombe Hospital, Dublin and as the representative of the hospital. The plaintiff's claim is that on 25th September, 1963, some twelve days prior to the delivery of her first child, the defendants carried out a non-emergency unnecessary symphysiotomy.

1.2 The plaintiff claims that the said procedure was in the circumstances negligent and that as a result thereof, she has sustained significant personal injuries.

1.3 The case proceeded for fifteen days of evidence. I was greatly assisted by all the witnesses I heard and I entirely accept that every witness gave their evidence truthfully and I also accept the independent expertise of those witnesses called as experts. I recognise that this issue is one that has generated much emotional controversy which at times has filtered through to some of the experts. While the independence of one of the defendant's experts was called into question due to alleged remarks made to another patient, I fully accept that this person gave independent expert evidence. Similarly, while one of the plaintiff's expert witness unfortunately in her report described what occurred to the plaintiff as "abuse". I also accept her evidence as being independent expert evidence.

1.4 The plaintiff who has worked for the vast majority of her life in various factories and as a waitress and homemaker, was married to a painter in May 1961. On 18th September, 1963, she was admitted to the Coombe Hospital on her first pregnancy with a believed estimated date of delivery of 7th September, 1963. Subsequent events clearly indicated that the estimated date of delivery calculated on the basis of the last stated menstrual period was an error.

1.5 The plaintiff signed a form stating:-

> "I gave my consent for any operation or anaesthetic which may be necessary."

1.6 The plaintiff was examined on admission and it was noted that the "Vx Eng" (head engaged in maternal pelvis) and x-ray pelvimetery was ordered. In the light of subsequent events, it seems probable that the notation that baby's head was engaged was, in fact, incorrect. Nothing materially turns upon that inaccuracy.

1.7 The x-ray pelvimetery was reported as showing a: "generally contracted anthropoid, sub-pubic narrow. T.C.10.8. T.10.5. The foetus is small but there is some disproportion, also outlet is diminished." "T.C." which refers to the True Conjugate was stated in evidence to be "normally" 11.5cm and the plaintiff's measurement was 10.8. The T. refers to transverse diameter which is stated as "normally" being 13.5cm but in the plaintiff's case was 10.5cm. The sub-pubic arch was described as "narrow".

1.8 It appears that on 20th September, 1963, there was an episode of regular uterine contractions for which the plaintiff was admitted to the labour ward but labour did not continue. There is some doubt expressed that the date, September 20th in the hospital notes might be a misreading of September 30th but this is on balance unlikely.

1.9 On 25th September, 1963, an examination under anaesthesia (EUA) was performed and at this examination it was noted "the head could not be made to engage in the pelvis. Symphysiotomy performed. Minimal bleeding. No difficulty. Good one inch gap obtained between symphysis."

1.10 At the conclusion of the EUA, the symphysiotomy was performed by the Master of the Coombe at the time. The gap in the symphysis was stated to be one inch. I believe that the Master may have anticipated the possibility of performing a symphysiotomy based upon the pelvimetry prior to the EUA as the plaintiff recalls him saying something to the effect that they were going to help her deliver the baby. However, I find that the decision to perform the procedure was not made until the EUA was completed.

2 The Symphysiotomy Procedure and its Aftermath

2.1 The pelvic girdle is made up of three parts. At the back is the sacrum which connects with at its low end with the coccyx (the tailbone of the spine) and that at its upper most end with the 5th lumbar vertebra. At each side the sacrum articulates with an ipselateral innominate bone which, in turn, articulate with each other anteriorally at the symphysis pubis. The symphysis pubis is a strong ligament which is at the front of the pelvis between the ends of the innomiates.

2.2 Symphysiotomy involves an incision being made in length above the upper boarder of the symphysis pubis and the tissues are divided to allow a gap to facilitate vaginal delivery. The history of the procedure will be described further below.

2.3 The plaintiff says, and I accept, that she did not know that a symphysiotomy was going to be performed. She expected that her baby would be delivered. When she woke in some considerable pain, she was not told for some time that the baby had still not been delivered. She had a band around her waist and had to be assisted by a fellow patient to go to the toilet. While there, she had a very frightening experience in which she recounted and I accept that she felt the sensation of being "split apart". The plaintiff was encouraged to walk the corridor after the symphysiotomy which she did though with difficulty.

2.4 On 3rd October, 1963, there is a note in the records documenting that the plaintiff had not started labour and it was questioned that she was "near term now". Her abdomen was noted to be difficult to palpate and the question of whether the baby was breached was raised.

2.5 The plaintiff was readmitted to the labour ward on 6th October, at 6:.30pm, there were strong and regular contractions and she was given an injection for pain relief and at 5:45am on 7th October, 1963, she was delivered by mid-forceps delivery due to "failure to advance". At this stage, a gap of half an inch was noted in the symphysis and the tight fit under the pubic arch was noted and it was documented that the pelvis "otherwise felt adequate". Accordingly, assuming that the hospital notes are correct, the gap in the symphysis had reduced from one inch to half an inch by the time of the birth.

2.6 The delivery was conducted under general anaesthetic and the plaintiff delivered herself of a baby girl who was noted to be slow to revive and was transferred to the paediatric unit.

2.7 On 17th October, 1963, the plaintiff was discharged home having had her nylon sutures removed. There was a slight discharge from her symphysiotomy scar noted.

2.8 Every year, the Coombe Hospital published a detailed clinical report as to the births in that year. The report for 1963 indicated that in that year, symphysiotomy was carried out in five cases, four times on a primigravida (first birth) and ones on a multiparae. The operation was performed on three patients during labour and was followed by "easy delivery". One patient had a caesarean section because of a breach presentation and a small pelvis. Symphysiotomy was done following the section. The plaintiff's procedure is described as follows:-

> "One patient had the operation two weeks before term. She had an easy low forceps delivery."

2.9 In the notes to the report, the plaintiff's case is summarised as follows:-

> "Generally contracted anthropoid pelvis. T.C.10.8 T.10.5. Narrow sub-pubic angle. Symphysiotomy two weeks before term. Low forceps delivery without difficulty at term."

2.10 It was also noted in the 1963 report that one of the five Symphysiotomies was a stillbirth which occurred in the case of a failed forceps delivery. This was in the case of a patient with a previous spontaneously delivery of a baby.

3 The effects of the procedure on the plaintiff

3.1 The plaintiff's evidence and hospital notes confirmed that the plaintiff had one further pregnancy in 1968 and on 1st December, 1968, at 42 weeks gestation, she had a forceps delivery under general anaesthetic. The delivery was described as "easy, low forceps after preliminary episiotomy. Infant in good condition".

3.2 The defendants contend that the symphysiotomy procedure does not result in any significant adverse effects. In particular, it was contended by Dr. Peter Boylan and Prof. Bonner that the performance of symphysiotomy is not associated with high rates of mortality or morbidity and that at the time of the plaintiff's procedure it was safer than caesarean section from a maternal point of view and there was no difference in outcome from the foetal point of view.

3.3 In particular, the defendants contend that the plaintiff herself suffered no injuries. The plaintiff did not mention any problems that could be associated with symphysiotomy to her GP between January 1997 (when the records presently available begin) and August 2014. Indeed, her GP was unaware until around the time of this litigation that the plaintiff ever had a symphysiotomy. She attended at the Adelaide Hospital in 1988 for gynaecological problems which resulted in a hysterectomy being performed and did not make any reference to urinary incontinence. The plaintiff was in attendance in the Mater Private Hospital at the physiotherapy department in 1993 because of a road traffic accident and reported historic four year problems with her hip and in 2007, she also attended a surgery complaining of discomfort in her left hip.

3.4 However, I accept the plaintiff's evidence of a lifetime of some physical instability. Some six months after the birth in 1963, the plaintiff developed a neurogenital prolapse. The plaintiff also developed incontinence. This incontinence is correctly dated back to the time of the catheter was removed after delivery. While some incontinence is associated with the aftermath of many births and while some of the plaintiff's present incontinence may be age related, I accept the evidence of Prof. Cardozo that on the balance of probabilities, the incontinence was, at least, exacerbated by the symphysiotomy.

3.5 Ms. Alison Bourne, Chartered Physiotherapist on behalf of the plaintiff gave evidence various tests and found that while she had some fairly mild hip and back pain consistent with a woman of her age, that she does struggle to maintain stability in her pelvis and that she tested positively for pelvic pain tests.

3.6 Prof. McElwain, Orthopaedic Surgeon, who gave evidence for the defendant, vigorously contested the evidence of Ms. Bourne and insisted that the plaintiff had no instability. I note that the gap in the symphysis which was originally one inch after the procedure had narrowed to half an inch by the time of the birth and is now clinically within normal limits. Having heard all the evidence, I accept that in the plaintiff's case, she is suffering from functional pelvic instability and has so suffered throughout her life since the first birth which I associate with the symphysiotomy but which the plaintiff believed, historically, was her "lot" following the first birth. It would be very easy, in view of the present normal measurements, to dismiss the plaintiff's evidence as retrospective, but the plaintiff made her "complaints" about mild but continuing disabilities after her first birth to her friends at work, long before any question of legal proceedings arose. Indeed, it was only because that she remembered these complaints that Ms. Teeling was able to associate what she saw on the television programme with the plaintiff.

3.7 The validity or efficacy of the various follow up tests on persons who have undergone a symphysiotomy has been called into question. Indeed, one eminent surgeon in the Coombe, Dr. Feeney, at that time noted the fact that it is mostly satisfied patients who return to their doctor and tried to set in place a more objective system of monitoring the effects of symphysiotomy on his patients. I am not deciding on any general safety or the generally alleged possible harmful effect of symphysiotomy. What I am deciding upon is the effect this procedure had on this plaintiff. The procedure was carried out twelve days prior to birth and post operation, the plaintiff was required to walk up and down the corridor after the symphysiotomy had been performed, and experienced significant pain as a result prior to delivery.

3.8 Whether the plaintiff's injuries are a general example of persons who undergo symphysiotomy or are particular to the plaintiff due to the timing of her symphysiotomy and what occurred thereafter is not for me to decide. However, I do accept that the plaintiff has suffered physically in the manner outlined above.

3.9 In addition, to the physical trauma, the plaintiff also suffered mental health sequelae. The plaintiff spoke graphically of the event when she went to the toilet in the hospital after the procedure and before the birth and felt that the two sides of her body were "on the floor". She was also told after birth that she could not see her baby for some four days. She was unable to look after the baby

after discharge and had to get relatives and friends to assist her. She did not bond or "attach" to baby as she had a right to expect and this was, at least, contributed to by reason of her inability to look after her baby after discharge. The plaintiff gave evidence, which I accept, of a lifetime of some distance from this child in contradistinction to her experience with her second child who was born in 1968.

3.10 I also accept that the plaintiff was traumatised by her experience and that she suffered flashbacks due to the event in the toilet. Whether this amounts to a Post Traumatic Stress Disorder as suggested by the plaintiff's expert, Prof. Veronica O'Keane or should be classified as another psychiatric disorder, as contended by the defendants, is not really material.

3.11 After the symphysiotomy, the plaintiff suffered distress and anxiety and was very fearful of becoming pregnant. Her husband was even more fearful of this and resolved that their sexual activity should preclude pregnancy and in effect, the plaintiff says that she "tricked" her husband so that she could become pregnant again. Again, it would be easy to be somewhat cynical and associate these complaints with a retrospective belief fostered by associating with the "survivors of symphysiotomy". However, this is another matter that was also raised long before these proceedings were contemplated by the plaintiff in her chats to her fellow workers in the cafeteria.

3.12 Notwithstanding what I accept was her lifetime distress the plaintiff, entirely untypical for her age and for the times, was obliged to return to work when her husband was unemployed due to an industrial dispute in the building trade in the mid 1960s. In essence, the plaintiff has been in regular and constant employment since she returned to work in 1964.

3.13 The plaintiff originally worked since the age of approximately 15, in a textile factory in Tullamore near where she then lived. She moved to Dublin and worked in the Urney's Chocolate Factory and continued working therein, after her marriage, until the smell of the chocolates affected her adversely during the latter part of her pregnancy. When an industrial dispute in the building industry occurred in the summer of 1964, the plaintiff got a job as a textile supervisor and continued working until approximately six months prior to the birth of her second child in December 1968. After the birth of her second child, she returned to work with the factory until it closed in 1974 and then worked part time in the Green Isle Hotel until 1979 and from 1979 she worked in Jury's as a waitress. She says allowances were made for her as she could not lean over with heavy trays at work.

3.14 With the closure of Jury's Hotel, she is still working, elsewhere as a waitress, notwithstanding her age. As the eminent historian, Prof. Mary Daly, who gave evidence on behalf of the defendant stated:-

> "She has a very interesting employment history, which would have been atypical at the time and I find it quite remarkable. We need to record stories of people like her because it is a working career that would have been untypical at the time."

With that opinion, I respectfully agree.

4 Issues

4.1 The defendants plead there has been a prejudice due to the lapse of time between the instant and the bringing of the proceedings, that the proceedings are barred by virtue of the statute of limitations and that there was no negligence on behalf of the defendant.

4.2 Accordingly, the issues that have to be addressed on liability are:-

> (a) prejudice;
>
> (b) statute of limitations; and
>
> (c) liability.

5 Prejudice

5.1 The defendant contends that the proceedings should be dismissed on the inherent jurisdiction of the court to dismiss proceedings the court concludes would be unfair or unjust to require a defendant to meet. I accept that this jurisdiction which was recognised in *O'Domhnaill v. Merrick* [1984] I.R. 151 and *Toal v. Duignan (No. 2)* [1991] ILRM 135, is separate from the line of authorities stemming from *Primor Plc v. Stokes Kennedy Crowley* [1996] 2 I.R. 459 which involves an examination of whether any delay is inordinate, inexcusable and whether assuming it is both inordinate and inexcusable that the balance of justice favours dismissal.

5.2 Hogan J. stating in *Donnellan v. Westport Textiles* [2011] IEHC 11:-

> "the speedy and efficient dispatch of civil litigation is of necessity an inherent feature of the court's jurisdiction under Article 34.1."

Hogan J. found support for that proposition in Article 6 ECHR and added:-

> "One might add that this duty also extends to protecting the public interest in ensuring the timely and effective administration of justice."

5.3 The test in *O'Domhnaill v. Merrick* can be summarised under two headings: (a) is there by reason of the lapse of time a real and serious risk of an unfair trial; and (b) is there by reason of a lapse of time a clear and patent unfairness in asking the defendant to defend the action.

5.4 I do not believe that the inherent jurisdiction of the court to dismiss proceedings for delay which is a clearly draconian measure is properly exercised outside the *O'Domhnaill v. Merrick* principles.

5.5 In other words the defendants must show that there is a real and serious risk of an unfair trial or a clear and patent unfairness in asking them to defend the action. The right to a speedy trial, as identified by Hogan J. in *Donnellan v. Westport Textiles* (above), must, I believe, be subordinate to the right to a trial in the first place.

5.6 The symphysiotomy complained of, occurred in September 1963. The personal injuries summons was issued on 6th September,

2012, some 51 years after the event. It is clear that none of the characters present on behalf of the hospital at the time is alive or available to give evidence of the defendant.

5.7 By letter dated 10th October, 2014, the plaintiff's solicitor wrote to the defendants advising that the case was being reformulated and was proceeding on a single basis, namely:-

> "That there was no justification whatsoever in any circumstances for the performance of a symphysiotomy on the plaintiff at the time it was performed."

5.8 I will discuss the implications of that plea later under the issue of liability but notwithstanding that plea, the defendant contends that they are prejudiced in establishing that there was justification for the procedure. I do not accept that contention it is not for the defendant to establish justification, it is for the plaintiff to establish "no justification". This is a very onerous burden indeed. In any event, the defendant had the benefit of a number of experts, at least one of whom was in practice at the time of the operation and I do not believe they have been in any way prejudiced in resisting the plaintiff on this point.

5.9 The defendants also contend that there is a general prejudice, given the absence of records, because of lack of knowledge of all the parties as to the development of the plaintiff's complaints. I accept that the plaintiff did not make any complaints of symptoms related to symphysiotomy to her doctors but as I have indicated above, I also accept that her present complaints are genuine. Accordingly, I do not accept that there is any real prejudice to the defendant due to the absence of records or due to the lack of contemporaneous evidence of the development of the plaintiff's complaints.

5.10 The plaintiff's reformulation of her case by letter of 10th October, 2014, as discussed above, followed the reformulation by the plaintiff appellant in *Kearney v. McQuillan & North Eastern Health Board* [2010] 3 I.R. 576, Hardiman J. on behalf of the Supreme Court stated at p. 580 – 581:-

> *"(15) This formulation appears wholly to prescind from any complaint about the manner in which the symphysiotomy was carried out, as opposed to the decision to carry it out at all. It also seems to render irrelevant the matter of any contemporary records said to be missing, and the reason for their disappearance.*
>
> *(16) This reformulation of the case was done in order to meet what would otherwise be a very strong claim on the part of the first defendant to have the action dismissed against it on the grounds of prejudice arising from prejudice arising from delay…*
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> *(17) …Counsel for the plaintiff conceded that the case, reformulated as it was, would be defeated if the first defendant could establish any circumstances in which in the circumstances prevailing in Ireland in the year 1969, and in the circumstances of this case, a symphysiotomy could have been justified by a consultant gynaecologist. In other words, the first defendant may, if the action is permitted to proceed, defeats the plaintiff's claim on a hypothetical basis and will not be itself defeated because its defence by reason of the absence of Dr. Connelly and his consulting colleagues of the time can only be hypothetical.*
>
> *(18) In those circumstances, it appears to the court that no remaining prejudice accrues to the first defendant by reason of the death of Dr. Connolly and the other doctors mentioned. In particular, the court is satisfied that the first defendant will continue to have available to it the defence suggested by the second of the principles laid down by Finlay C.J., in Dunne (an infant) v. National Maternity Hospital [1989] I.R. 91, at p. 109. This is as follows:-*
>
> > *'If the allegation of negligence against a medical practitioner is based on proof that he deviated from a general and approved practice, that will not establish negligence unless it is also proved that the course he did take was one which no medical practitioner of like specialisation and skill would have followed had he been taking the ordinary care required from a person of his qualifications.'*
>
> *(19) It appears to the court that, by reason of the reformulation of the case, the first defendant is relieved of the necessity to establish specific indications, perceived by Dr. Connolly, and justifying the carrying out of the symphysiotomy. It is enabled to defend the case by establishing in credible evidence some realistic reason for the procedure in the circumstances actually prevailing in relation to the plaintiff in 1969…."*

5.11 Following the above decision of the Supreme Court, I have no doubt but that there is no prejudice to the defendant in defending the trial given the extremely difficult task that the plaintiff accepts.

5.12 In the absence of the reformulation of the plaintiff's case of October 2014, I believe that the defendant would have had a strong, if not unanswerable case on prejudice.

5.13 The defendant makes one further plea in relation to prejudice that due to the delay and the relative paucity of records and the difficulty in establishing the plaintiff's state of mind, insofar as that may be necessary, and in particular the plaintiff's knowledge of whether or not she was ever aware that a procedure called symphysiotomy had been performed that the issue of the Statute of Limitations cannot be fairly decided. I will turn to the issue of the statute of limitations in the next section but given the basis of my decision on the statute, I do not see any merit in the defendant's submissions to dismiss the proceedings by reason of delay on this point.

6 Statute of Limitations

6.1 On 24th September, 1963, the Master of the Coombe Hospital informed the plaintiff that the hospital would help her to have her baby. An EUA was performed and a symphysiotomy was then performed. Initially, the plaintiff believed she had delivered her baby and was confused when she realised that this was not so. The plaintiff states that she did not know that the procedure that was conducted was called "symphysiotomy" until around the time of the broadcast of one or either of a television programme, either *Primetime or Tonight with Vincent Browne*.

6.2 She did state over the years that she informed various doctors at various hospitals that she was "cut across the end of my stomach" before the birth of her first born. She says that she was not aware of any procedure to her pelvis. The plaintiff put her post birth symptoms down to the normal complications of pregnancy and the birth with the aid of a forceps. In particular, she put down her incontinence to the pregnancy and birth and associated her psychological problems more with post-natal depression or general post birth problems than any specifically due to the procedure that was performed upon her.

6.3 It must be said, however, that a number of hospital notes in relation to examination of the plaintiff in the years following the

symphysiotomy do refer to the fact of symphysiotomy, by name. The plaintiff believes that she merely told the doctors or staff that she had a procedure "down there" and submits that they must have concluded what was done was a symphysiotomy. The record keepers in the various hospitals do not, obviously, recall the plaintiff or what the plaintiff said in person but the witnesses do not believe that they would have recorded the word "symphysiotomy" without being told of it by the plaintiff. Indeed, one of the doctors said that at the time he would not have known what a symphysiotomy was. However, I prefer and accept the direct evidence of the plaintiff on this point that she did not use the word "symphysiotomy", rather than the hypothetical recollection of what various witnesses believe they would or would not have done. I do not believe that the use or non-use, or knowledge or non-knowledge of the word "symphysiotomy" is material to the issue of the statute of limitations.

6.4 However, it is clear that in discussions with her fellow waitresses, the plaintiff did relate various injuries and woes to the circumstances of the birth of her first child. Her friend, Ms. Teeling was informed, at least on one occasion that the plaintiff after birth could not walk her baby, had difficulty in walking, had pain in her back, but the plaintiff stated that she thought that these symptoms were as a result of a forceps delivery or the like.

6.5 It is clear that Ms. Teeling, having been told on at least one occasion of the plaintiff's post birth difficulties was in a position having watched a television programme in 2010 or 2011, to contact the plaintiff and suggest that she obtain her birth record and associate the stress of persons who had undergone symphysiotomy with what the plaintiff had told her. There was a *Primetime* programme on RTE about symphysiotomy in 2010. There was a programme on TV3 on *Tonight with Vincent Browne* in June 2011 which also dealt with the symphysiotomy issue. The plaintiff and Ms. Teeling both say that it was as a result of this programme not *Primetime* that Ms. Teeling rang, the plaintiff looked at the end of the programme at the time the credits were being rung, saw an address of a solicitor to contact and was advised by Ms. Teeling to get her hospital records. The plaintiff was also given a book about symphysiotomy in Ireland, "*Bodily Harm*" in 2011.

6.6 On other occasions when being examined by Prof. Keane, for the purposes of these proceedings, the plaintiff said that she was notified by Ms. Teeling following the programme which she referred to as *Primetime*.

6.7 As a matter of probability, I believe that the plaintiff was contacted by Ms. Teeling after the *Primetime* programme because by letter dated 20th February, 2010, shortly after the *Primetime* programme, the plaintiff first sought her medical records from the Coombe. This letter was received by the Coombe on 26th February, 2010.

6.8 The plaintiff, however, was not furnished with any records following the requests in February 2010. The defendant states that this was because the information furnished was not sufficient, in point of fact they were subsequently able to find the plaintiff's records without all the information that they contend they ought to have been given. In any event, the defendants wrote to the plaintiff by letter of 23rd April, 2010, seeking further details including her date of birth and address at the time of confinement. The plaintiff received this letter but does not seem to have replied to it. In July 2011, after the TV3 programme, the plaintiff sent a second letter of request of her records and the plaintiff was then telephoned by Ms. Farrell on behalf of the defendants requesting further information and the records were furnished to the plaintiff in August 2011. The plaintiff then contacted the solicitor whose phone number appeared at the end of the *Vincent Browne* broadcast and attended a meeting of "survivors" and the proceedings herein were issued by personal injuries summons dated 6th September, 2012.

6.9 I find as a fact that as a matter of probability the plaintiff was not aware of the word "symphysiotomy" until around the time she was contacted by Ms. Teeling. I do not, however, believe that the plaintiff's knowledge that the procedure she had undertaken was called "symphysiotomy" is of relevance to the issue of the statute of limitations. It is for that reason that I rejected the defendant's claim of prejudice due to the inability to establish what the plaintiff did or did not tell various doctors as to the name of the procedure she underwent or her knowledge that she had undergone the procedure. What is of relevance to establishing the plaintiff's date of knowledge is the provisions of s. 2 of the Statute of Limitations (Amendment) Act 1991.

6.10 I also find as a fact that contrary to the plaintiff's own recollection now and contrary to the recollection of Ms. Teeling that Ms. Teeling probably had watched the *Primetime* broadcast in 2010. This must be the reason for the 2010 request for her records. The plaintiff has no explanation as to why she made her first request in 2010 but the coincidence with "*Primetime*" is too great in the circumstances.

6.11 I do not believe that the plaintiff or indeed Ms. Teeling are in any way trying to deceive the court in their evidence on this matter, I fully accept that the plaintiff does not normally watch either Mr. Browne's programme or indeed *Primetime*.

6.12 The defendants plead that the plaintiff's case is statute barred. It is common case that a two year time period now is the relevant period at present for commencing personal injury proceedings after the "date of knowledge". A person's date of knowledge is the date in which the plaintiff first had knowledge of certain facts as set out in s. 2(1) of the Statute of Limitations (Amendment) Act 1991, as follows:-

> *"(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"*

6.13 Section 2(2) of the 1991 Act provides:-

> *"(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."

6.14 It is clear, and I accept, that a plaintiff relying on the provisions of s. 2 of the 1991 Act, has the burden of establishing that he or she falls within the ambit of that section.

6.15 The correct approach to the provisions of s. 2 of the 1991 Act has been established by the Supreme Court in *Gough v. Neary* [2003] 3 I.R. 92 and in subsequent cases. In *Gough*, Geoghegan J. quoted with approval the judgment of the English Court of Appeal in *Spargo v. North Essex Health Authority* [1997] 8 MDLR p. 125 as follows:-

"(1) The knowledge required to satisfy s. 14(1)(b) is a broad knowledge of the essence of the causally relevant act or omission to which the injury is attributable;

(2) 'attributable' in this context means 'capable of being attributed to', in the sense of being a real possibility;

(3) a plaintiff has the requisite knowledge when she knows enough to make it reasonable for her to begin to investigate whether or not she has a case against the defendant. Another way of putting this is to say that she will have such knowledge if she so firmly believes that her condition is capable of being attributed to an act or omission which she can identify (in broad terms) that she goes to a solicitor to seek advice about making a claim for compensation;

(4) on the other hand, she will not have the requisite knowledge if she thinks she knows the acts or omissions she should investigate but in fact is barking up the wrong tree: or if her knowledge of what the defendant did or did not do is so vague or general that she cannot fairly be expected to know what she should investigate; or if her state of mind is such that she thinks her condition is capable of being attributed to the act or omission alleged to constitute negligence, but she is not sure about this, and would need to check with an expert before she could be properly said to know that it was."

6.16 Irvine J. in *Naessens v. Jermyn* [2010] IEHC 102, indicated that the issue was to "ascertain the point at which it could be said that the plaintiff had sufficient knowledge" to "*justify embarking on the preliminary to issue a writ*".

6.17 The plaintiff's claim against the defendant is that she was subjected to an unnecessary symphysiotomy and indeed after the reformulation of her case that there was "no justification" at the time for the procedure. By accepting the authority of the Supreme Court in *Gough v. Neary* which I must, and of Irvine J. in *Naessens v. Jermyn* which I readily do, I conclude that the plaintiff's date of knowledge did not start to run until she had actually received the records from the hospital. I believe that when her friend rang her as I found in 2010 this caused her to seek the records. At that stage, the plaintiff did not and could not have had the requisite knowledge, as defined in s. 2 above. It is only when the plaintiff had available to her the records to show that the symphysiotomy was indeed carried out twelve days prior to the birth of her eldest child and which also set out the circumstances of her confinement that potentially gave rise to the symphysiotomy that she could properly have been advised that she had a possible case against the defendants. It was only at that stage when she had the hospital notes that the plaintiff could be said to have knowledge to "*justifying embarking on the preliminary to issue a writ*". I believe that up to her obtaining the requisite notes from the hospital, the plaintiff's position was as in sub-paragraph (4) of the judgment in *Spargo* i.e. she may have thought that she knew the acts or omissions that she should investigate but it was quite possible that she was barking up the wrong tree. She may have been aware by that stage, in 2010, that the procedure carried on her was indeed a symphysiotomy but she was not armed with any information that could have justified her issuing proceedings against the defendants or going to a solicitor to instruct that solicitor to issue proceedings, until the furnishing of the records. The plaintiff's date of knowledge commences in August 2011 when she was furnished the records is inside the two year period and accordingly, the defendant's plea under the statute of limitations must fail.

7 Symphysiotomy and the "Dublin School"

7.1 The first successful symphysiotomy was performed in Paris in 1777 on a woman with "dwarfism" who had lost three previous children. Both mother and child survived the operation but the mother suffered significant after effects, difficulty in walking and urinary incontinence. The operation persisted only in small numbers in the ninetieth century but at the beginning of the twentieth century, a different and less invasive technique was perfected so that the symphysis fibres were not completely severed to reduce the chance of long term pelvic instability. Local anaesthesia replaced general anaesthesia and this was the technique used in Ireland in the mid-twentieth century.

7.2 Mr. A.W. Spain, Master of the National Maternity Hospital (1942 – 1948) introduced symphysiotomy to Dublin together with his successor A.P. Barry (Master, 1949 – 1955). Spain wrote in the *Journal of Obstetrics and Gynaecology of the British Empire* (1949) at p. 576 on "Symphysiotomy and Pubiotomy" and gave a history of symphysiotomy describing the paper as "Apologia based on the study of 41 cases". In this Apologia, Spain wrote of the justifications or indications for the operation as being:-

(i) In the case in which the head enters the true pelvis but becomes arrested in mid-straight or at the outlet and cannot be delivered vaginally without the use of undue force or craniotomy.

(ii) In the case of a young woman in whom both clinical judgment and radiological knowledge of the pelvis advises "a little more room is required the whole way through, especially in the transverse diameter, to vaginal delivery. This latter indication would become operative in primigravida only when a Trial of Labour has failed to bring the head into the true pelvis or when the decision has been forced by premature ruptures of the membranes without the onset of labour in a reasonable time.

(iii) "Occasionally it may be justifiable to perform the operation in a mutligravidae before labour has set in.

7.3 Symphysiotomies became more popular in Ireland, especially in Dublin, because more and more births were taking place in hospitals after the end of the Second World War and because there was still a belief that caesarean sections were dangerous, especially repeat caesarean sections. This belief was being challenged by experts, especially from the United Kingdom but it undoubtedly is the

case that the prejudice against repeat sections remained.

7.4 Dr. Barry, in the Irish Journal of Medical Science in February 1952, deals with the question as to when symphysiotomy should be performed and states:-

> *"The answer to this is comparatively simple. The operation should be carried out:-*
>
> *(a) in all young primigravida with pelvic contraction undergoing trial labour when the natural powers are failing to overcome the obstruction;*
>
> *(b) in all multigravidae with disproportion sufficient to cause obstruction;*
>
> *(c) in all cases of failed forceps due to contracted outlet if the child is alive;*
>
> *(d) in the face of presentation with a chin posterior and in brow presentation were efforts that corrections have failed;*
>
> *(e) in all young primigravida with contracted pelvis selected for trial labour in whom early rupture of the membranes are inertia occurs. In such cases it is better to do the operation too early than too late, as delay may result in loss of the baby…"*

Barry went on and subsequently controversially to add:-

> *"Again it must be emphasised that the real value of this procedure is that it does not have to be repeated as does the caesarean treatment of contracted pelvis. It may be argued that no woman needs to have more sections than she freely desires, but in many countries, and especially in those countries containing a high percentage of Roman Catholics, sterilisation and contraception are repugnant to the patients…"*

7.5 It is clear that the operation as performed on the plaintiff does not fall into any of the categories or indications for symphysiotomy as set out by Barry or Spain above. What was performed was known as a prophylactic symphysiotomy and it is important to consider how the original indications as set out by Spain and Barry were expanded upon to a certain extent, at least, in the Dublin hospitals.

7.6 In the Coombe Hospital between 1959 and 1962, a total of 42 symphysiotomies were performed and 17 of these were described as "prophylactic" (i.e. before labour). In the National Maternity Hospital between 1960 and 1962, 47 symphysiotomies were performed and of these 15 were elective pre-labour and 7 "on the way out". In the Rotunda Hospital, uniquely, the procedure was used almost always "on the way out" only after a caesarean section in the anticipation of the next pregnancy where obstruction had been discovered.

7.7 Up to the mid-1960s, the maternity hospitals all over Britain and Ireland used pelvimetry x-rays extensively to determine the size and shape of the pelvis. The practice of pelvimetry was discontinued in Dublin from the mid-1960s. The new Master of the National Maternity Hospital, Dr. O'Driscoll (1963 – 1969) introduced "active management of labour" in which trial labour was persisted and it was discovered that many cases previously diagnosed as disproportion were, in reality, ineffective, inefficient uterine action. Pelvimetry was, in effect, "banned" by the Master in the Dublin hospitals. The National Maternity Hospital led the way in Britain and Ireland advocating "active management of labour" with the result that symphysiotomies rapidly declined to the extraordinarily rare occasions in which they would be utilised now. This rapid decline in pelvimetry and of symphysiotomies was followed in the other Dublin maternity hospitals.

7.8 I have already indicated that each of the Dublin maternity hospitals published annual reports and these annual reports were each year subject to frequently extremely robust discussion by obstetricians at meetings of the Royal Academy of Medicine. At these meetings, visiting experts usually from the Great Britain discussed, and commented upon and sometimes criticised the Annual Transactions of the Dublin Hospitals. The visitor's comments were answered equally, if not more robustly, by Irish consultants. The full papers and the responses were then published. This whole procedure is one that must be welcomed and applauded as it gave active review and intellectual and practical challenge to the practices and procedures of the Dublin Hospitals. And this open discussion had, I accept, a mutual advantage to both native and visiting consultants.

7.9 I have read a number of these Annual Transactions which were published in the Irish Journal of Medical Science and indeed to borrow from Nietzsche, the consultants were philosophising with a hammer and testing concepts and conclusions by striking them to see if they were hollow.

7.10 These discussions as to the practices in the Dublin maternity hospitals took place on an annual basis. Following its re-emergence in Dublin, the role of symphysiotomy was acknowledged and referred to in the various English leading textbooks and references were made to the "Dublin School". There is evidence that British experts who had been entirely dismissive of symphysiotomy and who contributed to the Dublin proceedings, did modify their view and acknowledged that symphysiotomy had a role, if a limited role, in childbirth. In the British textbooks, the indications for symphysiotomy never varied from the initial indications as set out in Spain and Barry above. Donald in *Practical Obstetric Problems* (1959), a leading Scottish obstetrician refers to symphysiotomy and states as follows:-

> "One of the great advantages of symphysiotomy is that the pelvis is permanently enlarged, so that subsequent deliveries are likely to be much easier. In a city like Dublin where high degrees of parity are common, this is a factor of some importance as it helps to eliminate the needs for repetitive caesarean section with all its penalty."

7.11 The indications for symphysiotomy in the Dublin hospitals expanded and developed from the initial strictures as set out in Spain and Barry and the practice of "prophylactic" symphysiotomy (symphysiotomy performed without any Trial of Labour because a conclusion had been reached that normal delivery would not be reasonably possible) started to develop in limited cases. The reason for this development is that the consultants believed that a combination of pelvimetry and a EUA could predict that vaginal delivery would not be either possible or easy in a number of limited cases and that on certain occasions a symphysiotomy was preferable to a caesarean section.

7.12 Feeney, the Master of the Coombe, stated in the 1954 report:-

> "My experience of prophylactic symphysiotomy is limited to six cases which worked out satisfactorily, but I do not recommend it. The patient should have the benefit of carefully supervised Trial of Labour."

7.13 Dr. Feeney was Dr. Stewart's predecessor and he stated, one year later, in the 1955 report:-

> "My experience of prophylactic symphysiotomy is limited to seven cases which worked out satisfactorily, but I do not ordinarily (emphasis added) recommend it. The average (emphasis added) patient should have the benefit of a carefully supervised Trial of Labour."

7.14 The practice and use of symphysiotomy including prophylactic symphysiotomy was carefully recorded and subject to open and transparent review at the annual transactions as referred to above.

7.15 In 1956, Dr. Barry from the National Maternity Hospital stated "equally we believe that there is a small place for the elective operation…in the management of contracted pelvis in the young primagravida where the success of Trial of Labour seems at the outset to be a very unlikely proposition".

7.16 The Rotunda Hospital which was most clearly not under the control of either a Catholic religious order or subject to the control of the Roman Catholic Archbishop of Dublin, symphysiotomies were performed "on the way out" after a caesarean section for prophylactic reasons in order to facilitate further vaginal deliveries.

7.17 I believe that the truth of the conflict between the British and Irish experts, specially in the 1951 transactions, was as stated in evidence in this trial, though couched in religious and biblical terms, more a question of a clash between native obstetricians defending Irish practices and visitors from the old colonial power.

7.18 In any event, what is at issue in this case is whether there was any justification for the procedure that was carried out on the plaintiff, twelve days prior to birth and without Trial of Labour.

7.19 I accept that medical practice evolves in the manner that Dr. Boylan indicated. There will always be a first time when any particular procedure is undertaken. It may be justified or not justified. In a trial for negligence, that issue is one for the judge to resolve on the evidence. The procedure may ultimately be proved to be successful and valid or be discontinued as unsuccessful and possibly dangerous but even if a procedure is subsequently discontinued or subsequently out ruled, it does not necessarily mean that that procedure could be described as negligent. I accept that medical science could not advance if such strictures were applied. Where any practice is a general one, of course, the defendants after the principles laid down in the Dunne case (below) cannot escape liability if the plaintiff should establish that the practice has inherent defects which ought to be obvious to any person giving the matter due consideration subject to the plaintiff also establishing the case as reformulated.

7.20 It is clear that this operation would not have been performed at the start of the introduction of symphysiotomy in Dublin by Spain and Barry as it did not fulfil any of the criteria set out by them and it would also not have been performed within a year or two, after 1963, as the ultimately extremely successful practice of "Active Management of Labour" had been established in Dublin.

8 The Plaintiff's Case

8.1 The plaintiff's case is that there was no justification for the carrying out of the procedure on the plaintiff some twelve days prior to birth without any Trial of Labour. The plaintiff contends that there is no support in the literature for antenatal symphysiotomy as a general and approved practice and that such references that they are merely the reports by those who performed them in the annual records of the hospital. It is further submitted if it were a general or approved practice that it was inherently defective as an approach and failed to meet a test of rational scrutiny and is indefensible.

8.2 Dr. Peter Bohan Simpkins who gave evidence on behalf of the plaintiff states that in his practice, he had never heard or seen a symphysiotomy being performed and that it was and remains an operation of last resort. Mr. Gareth Thomas stated that symphysiotomy was limited to an unforeseen crisis of outlet obstruction but a Trial of Labour is also required. The leading textbook at the time (*Monroe Kerr's Operative Obstetrics, Chassar Moir* (Ed. 6th) was referred to in which Chassar Moir stated:-

> "I cannot stress too strongly the importance of recognising the limitations of symphysiotomy. Pressed beyond its scope it has grave potential dangers."

8.3 The plaintiff's expert strongly disputed that there was any or any sufficient evidence of cephalopelvic disproportion which both Bohan Simpkins and Thomas insisted could only manifest itself in labour and this was a functional diagnosis which was not interchangeable with and could not be confused with a contracted pelvis which was merely an anatomical description.

8.4 Both of the plaintiff's experts were of the view that a Trial of Labour was always indicated when there was a suspicion of CPD and essentially that a diagnosis cannot be made until a Trial of Labour occurs.

8.5 The plaintiff's experts also contended that in a case of absolute disproportion of the pelvis, a caesarean section is always indicated and for moderate contraction the options are either Trial of Labour, induction of premature labour and caesarean section. It was submitted that a contracted pelvis or a small pelvis has no bearing on CPD whatsoever. Accepting the x-ray evidence as suggesting a moderately contracted pelvis and some disproportion, this would only give rise to a suspicion of CPD and not a diagnosis and therefore a Trial of Labour was the only reasonable option. If it was decided that the plaintiff could never deliver vaginally (a case of absolute disproportion) then a planned caesarean section was always required as symphysiotomy is never recommended for absolute disproportion.

8.6 Dealing with the argument that there was a "development" or expansion in the indications for symphysiotomy in Dublin during the late 1950s and early 1960s, and that prophylactic symphysiotomy without labour came to be accepted, the plaintiff contends that in her case, there was no basis for such a decision. The records indicate there is no evidence that could lead any reasonable doctor to conclude that there was absolute disproportion and therefore she could not have been delivered vaginally.

8.7 Further, the plaintiff submits that even if it was determined that she could not deliver vaginally and that there was absolute disproportion that the only reasonable course available in the literature was a planned caesarean section. It was further argued that CPD could not have been diagnosed prior to the onset of labour and that other alternatives e.g. forceps of vacuum extraction could have been available to deal with any difficulties in labour. The plaintiff further disputes that by 1963 repeated caesarean sections were or could be reasonable regarded as dangerous. The practice of prophylactic symphysiotomy was disapproved of by Chassar Moir in 1965 as a failure to "grasp the principles surrounding the treatment of disproportion". The plaintiff also relies on the report of Dr. Hugo McVey (*Treatment of Disproportion by Combined Lower Segment Section with Symphysiotomy*, Irish Journal of Medical Science 1957) in which he refers to a case in which prophylactic symphysiotomy was performed:-

"Another point bears condemnation the patient was not allowed a Trial of Labour prior to symphysiotomy. If the plaintiff did have a vaginal delivery on her next confinement, the justifiable question could be asked: how do you know she could not have done it the first time? A question to which there is no answer because she was not allowed a Trial of Labour.

This brings us to the question as to whether there is any place for prophylactic symphysiotomy i.e. symphysiotomy before the onset of labour. It is unanimously agreed that the place of the operation is a minor or medium degrees of disproportion. Admitted that this minor degree of disproportion is clinically and radiologically proved can even the most expert obstetrician state that the disproportion will not be overcome by asynclitism and moulding of a foetal head. Only a Trial of Labour with concurrent assessment of uterine forces, moulding, asynclitism and lateral deviation of the foetal head to the sacral base will prove if the disproportion is insurmountable.

It is easy to diagnose a minor degree of disproportion at 38 weeks, perform an immediate symphysiotomy and await vaginal delivery two weeks later. If the patient then has a vaginal delivery, what is being proved? Precisely nothing. The question would be asked "how do you know she could not have had a vaginal delivery without a symphysiotomy?" The question to which there is no answer because there has been no Trial of Labour."

9 The Defendant's Case

9.1 The defendants contend that the decision to carry out the symphysiotomy appears from the notes to be based upon the pelvimetry and which revealed:-

> "Generally contracted anthropoid subpubic narrow, true conjugate 10.8 transverse diameter 10.5. Foetus is small but there is some disproportion. Also outlet is diminished."

9.2 As well as the pelvimetry, a clinical examination under anaesthetic (EUA) was undertaken and this EUA revealed "the head could not be made to engage in the pelvis".

9.3 The decision to proceed to symphysiotomy was not made on an abstract diagnosis of pelvic dimensions on the basis that the pelvis was contracted but after analysis of the pelvimetry and the clinical examination.

9.4 The defendants contend that at the time of this delivery, it was acceptable to make a decision in advance of labour, either that the pelvis was contracted to such an extent, or that disproportion was present to such an extent, that one could not anticipate a successful Trial of Labour.

9.5 The defendants concede that reliance of pelvimetry fell out of favour and indeed that this lack of favour was pioneered in Dublin with a development of "active management of labour". But, at the time of this birth, pelvimetry was widely used in Ireland and Britain to ascertain the viability or ease of vaginal delivery.

9.6 The defendant referred to the text of Donald (1960) as follows:-

> "It is naturally a part of good antenatal care that major degrees of contracted pelvis should be evaluated long before the patient reaches term. Nowadays the main problem is confined to the lesser degrees in borderline cases. A foetal head engaged within the pelvis within the last four weeks practically rules disproportion out of court, for there is no finer pelvimeter than the foetal head, but where satisfactory engagement of the head is not present, disproportion is one of the numerous diagnostic possibilities…the stature of the patient is relevant, and although quite small women have good obstetrical pelvis, any woman whose height is less than five feet should have an accurate assessment of the pelvis made during pregnancy, and if she is a primigravida, radiological pelvimetry is indicated."

9.7 X-ray pelvimetry continued to be used in 97% of UK maternity units up to 1995.

9.8 In Ireland, the use of x-ray pelvimetry was, in effect, "banned" in the National Maternity Hospital and active management of labour rapidly supplanted x-ray pelvimetry pre-labour as the 1960s progressed.

9.9 The defendants rely upon the evidence of Prof. Bonner who stated that the shape of the pelvis was anthropoid i.e. a pelvis in which the transverse diameter is reduced and Prof. Bonner, as well as Dr. Boylan, both stressed that the recorded features of the plaintiff's pelvis were consistent with not merely mild to moderate rim disproportion but also moderate outlet contractions.

9.10 Accordingly, the defendants rely upon Donald (1960) *Practical Obstetric Problems* at p. 340 that Trial of Labour is "definitely not applicable"…where there is outlet contraction.

9.11 During the course of the EUA, the Master performed what is known as the Muller Muno Kerr manoeuvre which involves a clinical assessment of the pelvis and foetus and assess whether the head would enter the pelvis. The head would not engage and the Master decided to perform a symphysiotomy to enable the subsequent delivery to be vaginal.

9.12 The defendants accordingly contend by the standards and knowledge of 1963 that a combination of EUA and an analysis of x-ray pelvimetry could justify intervention prior to labour and could have done so and should have done so in the plaintiff's case.

9.13 The defendants then contend that the practice in the Dublin Maternity Hospitals in 1963 was that symphysiotomy was an acceptable option in carefully selected cases even in advance of labour.

9.14 The plaintiff further contends that the records of the Dublin Maternity Hospitals indicate that the original strictures on confining symphysiotomy in cases in which a Trial of Labour failed had gradually been superseded by the belief that symphysiotomy could in certain cases be used rather than caesarean cases.

9.15 The defendants contend that the reason for the popularity of symphysiotomy was that there was still a fear as to the danger of multiple c-sections and that there was a large instance of multiparous women in the population, in that 30% of all births in the Republic were fifth births or higher. The belief was that disproportion/CPD was a problem which would reoccur on subsequent deliveries and that the patient as a whole rather than the instant pregnancy must be treated.

9.16 At the time the importation and sale of contraceptives was banned and the practice of sterilisation was prohibited or was not

available in the Dublin Maternity Hospitals (in this regard, Dr. Boylan is incorrect to say that sterilisation was unlawful or that use of artificial contraceptives was unlawful but that distinction is probably a legal rather than a practical one).

9.17 If a caesarean section was offered then the likelihood that future births would also have to be by caesarean section. There were certain dangers still associated with multiple sections but the option of sterilisation after two or three sections though it was routinely available in Britain was not available in Ireland.

9.18 Symphysiotomies were practised in the three Dublin maternity hospitals, one of which was not under any control of any Roman Catholic religious order or the Archbishop of Dublin. The Rotunda Hospital utilised symphysiotomy "on the way out" only after the first births by caesarean section where a Trial of Labour was not successful. In other words, in the Rotunda, the practice was that symphysiotomy might be considered after one successful delivery by c-section prophylactically in order to ease future births and obviate the need for repeat caesarean sections.

9.19 Dr. McVey of the Rotunda, upon whom the plaintiff also relies, wrote at the time of a caesarean section:-

> *"This decision while overcoming the difficulty of the present pregnancy makes no provision for any future pregnancy. The patient still has a contracted pelvis, and, further, a uterine scar…a future pregnancy will result in either another uterine scar or induction of premature labour with all its risks or hazards…in this country we have special circumstances of treating a population in which sterilisation and contraception are not practised plus a primagravida delivered by caesarean section for disproportion faces a lifetime with repeat operations with all the hazards of uterine ruptures, adhesions and bladder injury. In gross disproportion caesarean section is unquestionable correct, but in minor or medium degrees of disproportion, if symphysiotomy allows of vaginal delivery on this and all subsequent pregnancies it is surely the operation of choice."*

9.20 The defendant's hospital was aware of a maternal death a few months prior to the symphysiotomy, the mother in question had a repeat caesarean section with placenta acreta and placenta praevia. The defendant further referred to Monroe Kerr of *Operative Obstetrics* (1971) in a section dealing with the dangers of symphysiotomy, he concludes:-

> *"Employed in just the right case, it is one of the most satisfactory of obstetrical operations."*

9.21 The practice in relation to what is known as prophylactic symphysiotomy had developed in Dublin as the obstetricians were content with the good results and lack of complaints in relation to their patients and this was recognised by Feeney in the Coombe as early as 1955 and Barry in 1956, who stated:-

> *"Equally, we believe there is a small place for the elective operation…in the management of contracted pelvis in the young primagravida where the success of Trial of Labour seems at the outset a very unlikely proposition."*

9.22 Furthermore, Dr. Browne, Master of the Rotunda stated in 1962 in the *Irish Journal of Medical Science:-*

> *"It is interesting to note that the longer a man is Master of a Maternity Hospital the more he gets worried about sections and the more he tries to find a way of avoiding them. Symphysiotomy seems to be the answer and I quite agree that elective symphysiotomy must surely be a correct indication, rather than symphysiotomy done during labour."*

9.23 Accordingly, the defendants contend that it is impossible to legally propose that there was at the time no justification for the procedure that was carried out. It was contended therefore that in Ireland in 1963, symphysiotomy pre-labour had a role in the treatment of disproportion and this was carried out by an experienced practitioner and that though medical experts from Britain, and some in Ireland (e.g. McVey) disagreed with the level of symphysiotomy and in particular with the introduction of the practice of prophylactic symphysiotomies, this disagreement does not amount to a breach of the principles in the *Dunne* case and does not result in the plaintiff being able to establish her case as reformulated.

10 The Law

10.1 In *Dunne (an Infant) v. National Maternity Hospital* [1989] I.R. 91, Finlay C.J. stated that the principles laid down in relation to medical negligence and the liability of professionals could be summarised:-

> *"1. The true test for establishing negligence in diagnosis or treatment on the part of a medical practitioner is whether he has been proved to be guilty of such failure as no medical practitioner of equal specialist or general status and skill would be guilty of if acting with ordinary care.*
>
> *2. If the allegation of negligence against a medical practitioner is based on proof that he deviated from a general and approved practice, that will not establish negligence unless it is also proved that the course he did take was one which no medical practitioner of like specialisation and skill would have followed had he been taking the ordinary care required from a person of his qualifications.*
>
> *3. If a medical practitioner charged with negligence defends his conduct by establishing that he followed a practice which was general, and which was approved of by his colleagues of similar specialisation and skill, he cannot escape liability if in reply the plaintiff establishes that such practice has inherent defects which ought to be obvious to any person giving the matter due consideration.*
>
> *4. An honest difference of opinion between doctors as to which is the better of two ways of treating a patient does not provide any ground for leaving a question to the jury as to whether a person who has followed one course rather than the other has been negligent.*
>
> *5. It is not for a jury (or for a judge) to decide which of two alternative courses of treatment is in their (or his) opinion preferable, but their (or his) function is merely to decide whether the course of treatment followed, on the evidence, complied with the careful conduct of a medical practitioner of like specialisation and skill to that professed by the defendant…."*

10.2 As previously stated the plaintiff by letter of 10th October, 2014, reformulated her case to the effect that it would proceed on a single ground, namely:-

> *"That there was no justification whatsoever in any circumstances for the performance of a symphysiotomy on the*

plaintiff at the time it was performed."

10.3 This reformulation was done as in the case of *Kearney v. McQuillan and North Easter Health Board* in the Supreme Court in order to defeat a claim for prejudice. As Hardiman J. stated that in the *Kearney* case it was conceded by the plaintiff and in this case, I hold that the case reformulated would be defeated if the defendant could establish:-

> *"any circumstances in which, in the circumstances prevailing in Ireland in the year 1969, and in the circumstances of this case, a symphysiotomy could have been justified by a consultant gynaecologist. In other words, the first defendant may, if the action is permitted to proceed, defeat the plaintiff's claim on a hypothetical basis and will not be itself defeated simply because its defence, by reason of the absence of Dr. Connolly and his consultant colleagues of the time, can only be hypothetical."*

10.4 Hardiman J. specifically stated that the court is satisfied that the defendant will continue to have available to it the second principle laid down in *Dunne*, i.e. the allegation that a professional from a generally approved practice will not establish negligence "unless it is also proved that the course he did take was one which no medical practitioner of like specialisation and skill would have followed had he been taking the ordinary care required from a person of his qualifications".

10.5 The plaintiff contends that the second *Dunne* principle of necessity also requires the third principle which somewhat qualifies the second i.e. where the medical practitioner defends his conduct by establishing that he has followed a course of practice which was general and which was approved by his colleagues cannot escape liability if, in reply, the plaintiff establishes that such practice has inherent defects which ought to be obvious to any person giving the matter due consideration.

10.6 I accept the contention that the third *Dunne* principle must have application, however, it is, of course, applicable only within the case as reformulated i.e. that there was no justification "whatever, in any circumstances for the performance" of the operation. It does not follow as a matter of law that just because one expert says that a particular practice was reasonable that a court must follow that opinion. In medical negligence cases, it is always the obligation of the court to make its decision and a court can do so by accepting or rejecting some or all of the evidence of any particular expert or experts.

10.7 I reject any suggestion from the defendants that the plaintiff's case should, in any way, be judged less sympathetically due to the existence of a no fault scheme for "survivors of symphysiotomy".

11 Decision

11.1 There is no doubt but that this operation would not have been performed on the plaintiff today or indeed at any date after the introduction of "active management of labour" by Dr. O'Driscoll. It was only a matter of a few years after 1963 when active management of labour came into practice in Dublin. There is also little doubt but that at the start of the reintroduction of symphysiotomy into Dublin that symphysiotomy without Trial of Labour would not have been performed.

11.2 I have already held that the plaintiff has suffered during her life as a result of the effects of this operation. I do not make any general observations about the effects of symphysiotomy on patients. I am aware that there is still a limited place for symphysiotomy especially in countries with limited hospital facilities for mothers and where mothers have great distances to travel. I also accept that the contention that symphysiotomy produces generally significant adverse affects on mothers is hotly in dispute. In this case, the plaintiff, whether as a result of the timing of the symphysiotomy or otherwise did suffer and indeed continued to suffer consequences throughout her life.

11.3 I accept that medical practice develops and can only develop in the manner as suggested by Dr. Boylan. Every procedure, now common place must once have been "unprecedented" and indeed may well have been very controversial. A practice will not be condemned merely because it is not supported in any peer review literature. A practice can only be condemned if it fails the *Dunne* test, or in this case, the reformulation of the plaintiff's case against the defendant.

11.4 I have come to the conclusion that in 1963 in the Dublin Maternity Hospitals, it was accepted that Trial of Labour was not always required for a consultant to conclude that a vaginal delivery would not be possible and that in those cases prophylactic symphysiotomy without Trial of Labour was a reasonable though limited option. In this case the hospital notes indicate that pelvimetry and the EUA convinced the treating doctors that a vaginal delivery would not be possible and accordingly, they proceeded on a course of a symphysiotomy which at the time they had reason to believe was not generally adverse in its effect to the mother and it was safer as far as the child was concerned. I have further come to the conclusion that given the real fears of multiple caesarean sections and the perceived benign effects of symphysiotomy and also given the wide acceptance of this practice among the leading consultants in the Coombe and National Maternity Hospital, that the plaintiff has not established that this practice was one which such inherent defects that ought to have been obvious to any person giving the matter due consideration.

11.5 The practice of prophylactic symphysiotomy was vigorously and publicly defended by the professionals in the annals of their hospitals and was subject to combative peer review at the annual Proceedings of their Professional Society. The annual records of the maternity hospitals do not merely relate the circumstances of the births and indeed some cases the deaths of patients but also contain some frank admissions as to failures and errors of certain procedures in order to counsel against their repetition. There is no evidence of any peer criticism of the plaintiff's procedure.

11.6 The issue in this case is whether the plaintiff has established that there was "no justification whatsoever in any circumstances for the performance of a symphysiotomy on the plaintiff at the time it was performed". The fact that the procedure was carried out some twelve days before the birth may have been causative of a number of the plaintiff's injuries but the particular time delay involved is not, of itself, a factor which could be added to the plaintiff's case such as to establish liability. The defendants did not know at the time of the symphysiotomy when labour would commence and indeed the defendants at that stage still believe that the baby was overdue.

11.7 I find that the practice of prophylactic symphysiotomy in 1963 was not a practice without justification. It was, indeed, a controversial practice but it was also strongly defended. I find the strength of this defence is such that it is impossible to conclude that the plaintiff has proved her case. Though I would in the words of Sir Ranulph Crewe, Chief Justice of England, "take hold of a twig or twine-thread" to uphold the plaintiff's case, I must find that this remarkable lady whose story indeed deserves to be told must fail in her case against the defendants.