Neutral Citation Number: [2006] IEHC 398

THE HIGH COURT

2003 No. 7267 P

BETWEEN

ALAN O'GORMAN

PLAINTIFF

AND

NICHOLAS JERMYN, RITU GUAI KAPUR, ROBERT GERAGHTY, BERNIE CURRAN, JOHN HARFORD, DANIEL K. SHEAHAN, JUSTIN GEOGHEGAN

DEFENDANTS

Judgment of The Honourable Mr. Justice Lavan delivered the 5th day of December, 2006.

Factual Background

1. On 14th February, 2002, the plaintiff was admitted through the accident and emergency department of St. Vincent's University Hospital and was operated on for a suspected appendicitis on the 15th February, 2002, by a senior registrar in surgery, Ms. Bridget Egan. During the course of the operation Ms. Egan took a biopsy from an area in or near the stomach and sent the sample to the hospital's pathology lab for a frozen section analysis. During the course of preparing the biopsy for frozen section analysis, the tissue sample of the plaintiff was mixed up with tissue sample of another patient whose tissue sample was sent down to the lab from another operating theatre at about the same time. That other patient was subsequently diagnosed with cancer. Because of the mix-up, the plaintiff was diagnosed as having the other patient's cancer by the sixth-named defendant, consultant histopathologist Daniel K. Sheahan. Based on that mistaken diagnosis, the plaintiff eventually underwent an unnecessary total gastrectomy operation, which was performed by the seventh-named defendant, consultant surgeon Mr. Justin Geoghegan on 19th March, 2002. Analysis of the removed stomach, which showed no cancer, led to an investigation that discovered the error.

2. In the proceedings, the plaintiff brought actions against all of the named defendants, alleging negligence and breach of duty against all of them. Also in the proceedings the first to fifth named defendants claimed an indemnity and/or contribution against the sixth and seventh named defendants, alleging negligence and breach of duty against each. Before trial, the claim by the first to fifth named defendants against the sixth named defendant was withdrawn.

3. During the course of the trial, the parties agreed the plaintiff's damages at €450,000.00, subject to findings being made on the issues of liability. On the fourth day of the trial, after discussions between counsel for the plaintiff and for the sixth-named and seventh-named defendants, the Court dismissed the plaintiff's claim against the sixth-named defendant. On the fifth day of trial, after discussions between counsel for the plaintiff and for the sixth-named and seventh-named defendants, the Court dismissed the plaintiffs claim against the seventh-named defendant. The Court ruled that the first to fifth named defendants could rely on the evidence of the plaintiff and witnesses called on his behalf, in its claim for indemnity and contribution against the seventh-named defendant. Consequently, the plaintiffs claim against the sixth and seventh-named defendants now stand dismissed and the issues that remain for the determination of the Court are the plaintiffs claim against the hospital defendants, the claim of the hospital defendants for contribution or indemnity against Mr. Geoghegan and the claim by Mr. Geoghegan for contribution or indemnity against the hospital defendants.

Plaintiff's statement of claim

4. A question arises as to whether the hospital was negligent. The plaintiffs claim that this should be resolved in accordance with the ordinary principles of the law of negligence and that it is not a case of "professional negligence". The Court is to consider whether the persons working in the hospitals pathology laboratory owed a duty of care to the plaintiff; if they did whether they were in breach of that duty; and finally whether that breach caused the plaintiffs injury and loss. It is submitted that in the circumstances of the present case, there is clearly a relationship of proximity between the parties, sufficient to give rise to a duty of care. There are furthermore, no conceivable considerations, which negative, reduce, or limit the scope of the duty. It is also submitted that that it is just and reasonable that the law should impose a duty of care on the hospitals employees.

5. It is submitted that the hospital and its employees did not exercise the requisite standard of care. The evidence establishes that hospital staff, in the course of dealing with the plaintiffs' tissue sample, made an error which was variously described as "elementary" or "fundamental". The hospital, it is contended, failed to ensure that operating procedures were in place in the pathology laboratory for the processing of frozen sections and thus it is submitted that negligence has been established as against the hospital.

6. With regard to the issue of causation, the hospital contends that the acts or omission of the surgeon, Mr. Geoghegan, breaks the chain of causation, so as to exonerate it from liability. It is submitted that regardless of the test applied, that the negligence of the hospitals employees, in mixing up the plaintiff's tissue sample with that of another patient, "caused" the plaintiffs injury, i.e., the unnecessary removal of his stomach. Under the "but for" test, it is clear that the plaintiffs injury would not have been caused "but for" the mix-up in tissue samples. The mix-up therefore "caused" the injury.

7. Under the "material contribution test", it is clear beyond reasonable doubt that the mix-up in tissues samples "materially contributed" to the removal of the plaintiff's stomach and therefore, in that sense "caused" the injury. It is submitted that causation has been established in this case irrespective of the test applied.

8. It is submitted that there was no *novus actus interveniens* in the present case. The evidence indicates that Mr. Geoghegans reliance on the pathology report was intended or "as good as programmed" by the hospital; at the least, it was entirely foreseeable that Mr. Geoghegan would rely on it. Since Mr. Geoghegans reliance on the pathology report was, at least, foreseeable, then the question is whether his intervention, at that point, was criminal or reckless. It was, it is submitted, neither. It is submitted that even if a contribution is required from Mr. Geoghegan, that does not exonerate the hospital from its liability to the plaintiff, since Mr. Geoghegans intervention cannot, in law, amount to a *novus actus interveniens*.

Defence of the first to fifth named Defendants

9. The first-to-fifth named defendants (hereafter these defendants) have at all material times accepted the basic facts alleged by the plaintiff, namely, that a tissue sample of the plaintiff, sent for frozen section analysis during the course of the plaintiffs operation on 15th February, 2002, was mixed up with a tissue sample of another patient who was suffering from cancer, with the result that the plaintiff's frozen section biopsy indicated that the plaintiff was suffering from cancer, when this was not the case. These defendants did not and do not, contest the evidence tendered by or on behalf of the plaintiff. These defendants also accept the conclusions, reached by the report, into the circumstances of the mix-up commissioned by St. Vincent's Hospital. These defendants submit that it is a matter for the Court to decide whether the facts and circumstances of the tissue mix-up, as established by the

evidence, constituted negligence and breach of duty of these defendants as alleged by the plaintiff. These defendants accept that the Court is entitled to take account of all of the evidence adduced at the hearing of the plaintiffs' claim, against these defendants, in making its determination on the causation issue. These defendants submit that on the basis of that evidence, the only determination that can be made, is that the party that caused the plaintiff's injury was the seventh named defendant. As these defendants did not cause the injury to the plaintiff, scope does not exist for a finding that their negligence and breach of duty (if there is a finding to such effect) was causative. It is, accordingly submitted that the plaintiffs claim against them should be dismissed. The plaintiff in consenting to the dismissal of his claim against the seventh name defendant did not exercise the option open to him to rely upon the expert evidence that was to be tendered on behalf of these defendants. See *Hetherington v. Ultra Tyre Services* [1993] 2 IR 535, *O'Toole v. Heavey* [1993] 2 IR 544 and *Cranny v. Kelly* [1998] 1 IR 54.

10. These defendants contend that the causative negligence that resulted in the unnecessary removal of the plaintiffs stomach was that of the seventh-named defendant. It is submitted that if the seventh-named defendant had acted with ordinary care in the performance of his duties that the plaintiff would not have suffered any injury as a result of such prior actions or omissions of these defendants is as may be held to constitute negligence and breach of duty on their part. The plaintiff was only twenty-one years of age. Prof. Elder gave uncontested evidence that he had only come across one patient of that age with stomach cancer in his thirty-three year career, during which, he had seen 6,000 patients with stomach cancer. Mr. Johnson gave uncontested evidence that in his eighteen year career, he had come across no cases of stomach cancer in persons aged twenty-one years or less. Prof. Elder estimates that the risk of gastric cancer in any persons in their early twenty's is in the region of 1 in "hundreds of thousands." Counsel for Mr. Geoghegan and Prof. Reynolds attempted to discredit this incidence rate, by stating that the incidence of stomach cancer in patients in their twenty's was one per cent, based on the fact that about one per cent of the 1,100 stomach cancer cases treated at St. James Hospital over a fifteen year period involved patients between the ages of twenty and thirty. In fact the experience of St. James actually bolsters Mr. Elder estimate that the incidence rate of stomach cancer among all twenty one year olds is one in hundreds of thousands. The plaintiff's family had no history of gastric cancer and there is no evidence to suggest that anyone, including the seventh-named defendant, ever believed that the family had such a predisposition. The plaintiff had the symptom of pain, inconsistent with his type of stomach cancer, and no symptoms consistent with his diagnosis of stomach cancer. Prof. Elder gave evidence that a person, whose stomach cancer had progressed so far as to penetrate the stomach wall and to leak cancer cells into the peritoneal cavity would be expected to exhibit some symptoms, such as the vomiting of food that has been ingested the day before, weight loss or early satiety. "It is seldom painful until the very terminal stages and it is not typical of the history that this your man clearly gave on more than one occasion."

11. The Court is referred to the tests as set out in the judgement of Finlay C.J. *Dunne v. The National Maternity Hospital* [1989] I.R. 91 at p.109: -

> "1. The true test for establishing medical 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, 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 that 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 qualification.
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> 3. If a medical practitioner charged with negligence, defends his conduct by establishing that he followed a practise 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 practise has inherent defects which ought to be obvious to any person giving the matter due consideration."

12. These defendants contend that the seventh named defendant was in breach of the first of the tests, laid out in *Dunne v. The National Maternity Hospital* in that he did not act with ordinary care in connection with (a) the diagnosis of the plaintiffs' condition and (b) the management and treatment of the plaintiff. They also contend that the seventh named defendant was in breach of the third test laid out in *Dunne v. The National Maternity Hospital*, in that the practice of accepting, without question, biopsy results was a practice that had inherent defects, that should have been obvious to any person giving the matter due consideration. It is submitted that, with regard to the criticisms of Professor Elder, that the "absolutely closed mind" of the seventh named defendant to "the possibility of any alternative diagnosis", is evidence *per se* of a lack of ordinary care on the part of a treating doctor and that the Court should so find. If the seventh named defendant was acting with ordinary care, it is submitted that his mind would be open to all possibilities and to the need to investigate them, if only for the purposes of informing himself fully prior to surgery. An alternative explanation is, of course, that he failed to appreciate the significance of the unique factors of the case, which of itself would be evidence of a breach of a duty of ordinary care. In response to the questions raised by the plaintiff and the defendants, the seventh named defendant had an absolute right to trust the diagnosis of stomach cancer, because a surgical biopsy is the best possible means by which to diagnose stomach cancer. While these defendants do not contest the fact that a surgical biopsy is a critical tool in the diagnosis of stomach cancer, it is not the only method by which a diagnosis any be made. Further these defendants do not accept that the seventh named defendant had, in this case, having regard to all the factors "an absolute right" to trust the diagnosis based upon the biopsy, particularly when the other factors did not support such a diagnosis. In addition to failing to take into account the patients' age, diagnosis, history and medical notes, Mr. Geoghegan was negligent in failing to undertake a gastroscopy or endoscopy of the inside on the patients stomach. Further, because of the manner in which the surgery was carried out, it is common sense that the plaintiffs' stomach was removed, without the seventh named defendant having inspected the interior of it. These defendants also contend that the seventh defendant was negligent for carrying out a gastrectomy, when the tissue sample relied upon indicated that the plaintiff cancer was probably terminal. The operation note of the surgery carried out on 19th March, 2006, contains no record of the fact that the seventh named defendant made a visual assessment of the stomach or that he palpated the stomach with his fingers to ascertain the extent of cancer. These defendants also submit that the seventh named defendant was negligent for failing to consult widely enough with his colleagues about the diagnosis and management of Mr. O'Gorman. Had the seventh named defendant been open to the possibility of error, the said additional tests and procedures would have, it is submitted led to the discovery of the error and to the making of the correct diagnosis, thereby rendering surgery unnecessary. It is also submitted that the seventh named defendant failed to carry out a proper examination of the plaintiffs' stomach. On this basis, it is submitted that the seventh named defendant failed the first *Dunne* test. It is also submitted that the seventh named defendant was also in breach of the third *Dunne* test in failing to exhibit ordinary care in failing to question the tissue biopsy, and failure to question the diagnosis represented an inherent defect. In this regard, it is submitted that the seventh named defendant was therefore negligent on this account also.

The conflict in expert evidence

13. The Court has the difficult task to resolve the conflict in the expert evidence tendered, by deciding which evidence is to be

preferred. These defendants submit that the Court should prefer the evidence of Professor Elder (supported in material respects by the evidence of Mr. Johnson), to that of Mr. Broe and Professor O'Sullivan and Reynolds. It is submitted that the Court, in assessing the reliability of the evidence of the witnesses in question, should examine all aspects of their evidence for the purposes of seeing whether or not any aspect of it was unreliable, in which case a question mark would have to be placed over the remainder. It is submitted that the Court should also critically examine the extent to which the witnesses can be said to be truly independent in the sense that their judgment (and in consequence their evidence), was not affected by prior association with the seventh named defendant. Professor Reynolds, in the course of his evidence acknowledged that he is a friend of the seventh named defendant and thus cannot be regarded as a detached, independent witness. The fact the Professor Reynolds was armed with all of the experts reports in the case, before being presented as a witness as a fact, indicates a defence strategy, thus it is submitted that the Court should regard his evidence with suspicion, where it conflicts with that of Professor Elder, a truly independent witness.

14. Mr. Patrick Broe, presented as an expert witness on behalf of the seventh named defendant, had trained with the seventh named defendant. It is submitted that the independence and detachment of Mr. Broe, as an independent witness is therefore questionable. It is submitted that such a degree or prior proximity to the seventh named defendant makes the evidence of Mr. Broe, less than reliable, where it conflicts with that of Professor Elder. Additionally, regard should be had to the change made (in his report dated 20th August, 2006) to a critical sentence that appeared in his report of 30th April, 2004. It is submitted that the only conclusion the Court should draw from this action on the part of Mr. Broe is that he was, at best ignorant of the true medical position or, at worst, seeking to mislead readers of his report as to the correct medical position. On either view of evidence on this issue, it is submitted that it is the effect of rendering the remainder of his evidence unreliable, particularly where that evidence seeks to exonerate the seventh named defendant. With regard to the second independent expert tendered whose evidence was tendered on behalf of the seventh named defendant, Professor O'Sullivan, it is submitted that the fact that this witness did not give accurate evidence, renders the remainder of his evidence unreliable, where it conflicts with that given by Professor Elder. Professor O'Sullivans medical opinion puts him at variance with all of the other medical witnesses in the case and on this basis, it is submitted that there has to be a question mark over his evidence, on the question of the adequacy of the performance of the seventh named defendant of his duties, where the plaintiff was concerned. Whilst Professor Thomas Walsh was withdrawn as a witness, a portion of his Report of 21st February, 2006, was put into evidence and the Court is entitled to have regard to it. It is submitted that if the Court does have regard to it, on the issue as to whether an endoscopy should have been carried out, it should take the view that the opinion of Professor Elder and of Mr. Johnson, is to be preferred to that of the other witnesses referred to above.

The right of the first to fifth named defendants to an indemnity or contribution in the event of a finding of negligence and breach of duty against the seventh named defendant

15. It is submitted that as the negligence of the seventh named defendant was causative of the plaintiffs' injury, these defendants, notwithstanding any finding of negligence and breach of duty that may be made against them, should be entitled to a full indemnity from the seventh named defendant. It was the subsequent and intervening negligence and breach of duty of the seventh named defendant that caused the damage complained of. In the alternative, it is submitted that the Courts finding as to the appropriate level of contribution that the seventh named defendant should make, will depend upon the nature of any finding that the Court may make, as to the negligence and breach of duty of these defendants.

Defence of the seventh named defendant

16. It is understood that the hospital defendants intend to rely on the authority of *Conole v. Redbank Oyster Company* [1976] I.R. 191, in support of an argument that the chain of causation between their own negligence, in mixing up the plaintiffs tissue sample and the injury suffered by the plaintiff was broken by Mr. Geoghegans alleged negligence. This argument cannot arise unless the hospital defendants succeed in satisfying the Court that Mr. Geoghegan was in fact negligent. Having regard to the decision of *Connolly v. South of Ireland Asphalt Company Limited* [1977] I.R. 99, and the test to be applied in considering whether or not the acts or omission of the seventh named defendant negatived the causal connection between the plaintiffs ultimate injury and the undoubted negligence on the part of the first five defendants, it is submitted that the decision in *Conole v. Redbank Oyster Company* has no application to the case whatsoever. The hospitals submission based on this authority ignores that fact that Mr. Geoghegan was proceeding on his belief in the histological diagnosis and also ignores the fact that there is no evidence upon which the Court could base a finding of "recklessness" on the part of Mr. Geoghegan. The argument of the hospital defendants that no responsibility of any kind attaches to any of the hospital defendants and that full responsibility for the plaintiffs' injury should be attributed to Mr. Geoghegan, it is submitted, is devoid of credibility. In view of the fact that the plaintiffs' case against Mr. Geoghegan has been dismissed, the implication of their argument is that the plaintiffs claim should fail altogether. The seventh name defendants did not call any evidence whatsoever, in rebuttal of the plaintiffs claim in negligence against them. The Court has heard that a mix-up of an elementary nature occurred, whether it was made by a registrar or by a laboratory scientist. It is submitted that, in making this error, the hospital, its servants or agents, were in breach of their duty of care to the plaintiff and the plaintiff is entitled to succeed in full against the hospital defendants.

17. It is submitted that the theory, of the single witness, Mr. Brown Elder, has been comprehensively rebutted and also that the evidence of this witness is unreliable. It is submitted that the criticisms made by Mr. Brown Elder of Mr. Geoghegan are criticisms made retrospectively and with the benefit of hindsight. In order to succeed in establishing a case in negligence against Mr. Geoghegan, the hospital defendants must discharge the onus of satisfying the Court that Mr. Geoghegan was "guilty of such failure as no other practitioner of equal specialist or general status and skill would be guilty of if acting with ordinary care." The evidence that the Court heard establishes the contrary and consequently, the test of no other medical practitioner having failed to do what Mr. Geoghegan failed to do (i.e. disbelieve the histological diagnosis) is not met and the hospital have thereby failed to discharge the onus of proof. If the Court considers that it was reasonable for Mr. Geoghegan to rely on the histopathogical diagnosis, it follows that the criticism of Mr. Geoghegan for not having performed a gastroscopy, in advance of the gastrectomy is rebutted. The Court has heard the evidence of Mr. Geoghegan (which the Court is entitled to accept) as to reasons for saying that a finding of negative biopsies on gastroscopy would not change his management plan on the basis that they would not negative the presence of cancer based on the earlier histopathological diagnosis of the full thickness sample taken at the plaintiffs earlier surgery. The Court also heard evidence of two experienced Irish consultant surgeons called on behalf of Mr. Geoghegan, both of whom gave evidence to the effect that a gastroscopy would not have advanced matters, in that the purpose of gastroscopy is to make a diagnosis by visualisation and by taking histological samples for analysis. In this case, both of these objectives had already been achieved and a diagnosis had already been made. Judges (and juries) are reliant on the evidence of medical experts to enable them to decide whether the relevant legal benchmark for determining medical negligence had been met and thus it is submitted that the evidence of Mr. Brown Elder is unreliable and should be approached by the Court with a high degree of circumspection. The evidence, given by Mr. Brown Elder, it is submitted raises a serious question mark over the reliability of not only the evidence of Mr. Brown Elder on these particular issues, but over all of his evidence. It is thus submitted, that the hospital defendants have not discharged the onus of proving that Mr. Geoghegan failed in his duty of care to the plaintiff.

Evidence

18. The hospital has admitted that its employees, working in the pathology laboratory, caused the plaintiffs sample to be mixed-up

with that of another patient. These defendants did not, and do not contest the evidence tendered by and on behalf of the plaintiff in relation to this issue. Following the incident, the hospital commissioned an investigation, which was conducted by Mr. Fergus Clancy of Healthcare Risk Consulting Ireland. Mr. Clancy reported that a person referred to as "registrar A" carried out a gross examination of the plaintiff's tissue sample. She did not, however, place the sample on the chuck (a holding device). This was left to be done by "technician A". However, neither Registrar A nor Technician A have any recollection as to how precisely this handover took place. Thereafter a slide, supposedly containing the plaintiff's tissue sample, was prepared. This slide was prepared by Technician A and taken to registrar B. In the words of Mr. Clancy, "It is now known that by this time the sample on the slide marked as belonging to (the plaintiff) had been mixed up and actually belonged to the previous frozen section patient." In his findings, Mr. Clancy said that "In these circumstances it must be assumed that some of the first patients tissue sample had been left out of its container and in the same work area in which (the plaintiffs) tissue sample was grossly examined and cut by Registrar A and that the communication between Registrar A and Technician A was incomplete, resulting in the wrong tissue sample being placed on the chuck for the purposes of completing the second frozen section."

19. Mr. Clancy identified a number of "root causes" and "underlying causes" for the incident. "Root causes" included the fact that "no formal and specific training had been provided in relation to how two sets of frozen section tissue samples to be processed simultaneously should be managed". In relation to "underlying causes", Mr. Clancy pointed out that, at the time of the incident, the hospitals pathology laboratory was engaged in preparation for CPA accreditation. This involved the preparation of standard operating procedures (SOPs) for all main work processes. At the time of the incident, however, the SOP for frozen sections was still in draft and did not, in any event, deal with the procedure for the handling of two samples, which arrive for frozen section in close time proximity to each other. Mr. Clancy commented that "Policies to cover activities such as these (i.e., the arrival of two frozen sections in the laboratory) should also have included particular reference to the absolute need for continuity throughout the process, i.e. that the pathology registrar who begins the process by carrying out the gross inspection ands cutting of the tissue sample should remain involved throughout and should concluded the process by reviewing the slides". A second "underlying cause" identified by Mr. Clancy was that of "communication". In this regard he said "Clearly the lack of effective communication between Registrar A and Technician A, was central to this incident occurring. Mr. Clancy agreed that the effect of the error was to expose the patient, whose sample was involved in the mix-up, to a serious risk. He agreed that the risk was obvious. He characterised the error itself as being an elementary one of the most fundamental kind and stated "Something like that clearly should not happen."

20. Ms. Maria Dineen is a director of a company known as Consequence UK Ltd., which is engaged both in the investigation of medical accidents and in teaching medical professionals how to investigate such accidents. She expressed the opinion that the error in the case occurred when the previous patient's tissue sample had not been cleared away and the cut-up area had not been sufficiently cleaned. From a management perspective, she thought it "astounding" that there were no standard operating procedures for the pathology laboratory. Elaborating she said "All managers, be they clinical or otherwise, have a responsibility to make sure that they provide a safe system of work and it is part of good management and safe practise to make sure that there are essential standard operating procedures in place, functional and audited for their effectiveness…" Her evidence was that if there had been procedures in place in the laboratory, it would have dealt with the area of error in this case. Ms. Dineen acknowledged that the error, which occurred in this case, was a fundamental one. She could not disagree that, whether or not there were procedures in place, an experienced registrar and/or medical scientist should know better than to leave samples from two different patients on the bench at the same time.

21. It should be noted that Mr. Jermyn, in evidence, said that the hospital took responsibility for the employees involved in the mix-up of the tissue samples. Furthermore, the plaintiffs uncontroverted evidence was that, at a meeting held in April 2002, he got the "most sincere apology from Dr. Oscar Traynor (under whom he had first been admitted to St. Vincent's) on behalf of the hospital for what had happened …"

Submissions on behalf of the plaintiff
22. The plaintiffs claim against the hospital is in essence that an employee or employees of the hospital caused or permitted a tissue sample from the plaintiff to be mixed up with that of another patient, who did indeed have cancer, with the result that cancer was wrongly diagnosed in the plaintiff, a diagnosis which led to an unnecessary operation for the removal of his stomach. The act of the employee or employees is alleged to constitute negligence. As regards the defendants, other than Mr. Jermyn, Dr. Sheahan and Mr. Geoghegan, it would appear that they were employees of the hospital. Since it has not been possible to establish which individual employee was responsible for the mix-up, it must be conceded that there can be no decree against any of those defendants. The plaintiff must succeed against Mr. Jermyn.

Submissions on behalf of the First-named, Second-named, Third-named, Fourth named and Fifth named defendants
23. These defendants submit that on the basis of the evidence the only determination that can be made is that the party that caused the plaintiffs injury was the seventh-named defendant. As these defendants did not cause the injury to the plaintiff, scope does not exist for a finding that their negligence and breach of duty, if there is a finding to such effect, was causative. Accordingly, it is submitted that the plaintiffs claim against then should be dismissed

24. In the event that the Court finds that there was negligence and breach of duty on the part of these defendants, and that such negligence and breach of duty was causative where the plaintiff's injury is concerned, the plaintiff will be entitled to an Order for payment of the agreed damages against these defendants. In those circumstances, the Court will then have to determine the claim of these defendants for an indemnity and/or contribution, in respect of any such Order, against the seventh named defendant. In that regard, if the Court finds that there was a negligence and breach of duty on the part of the seventh named defendant, it will then proceed to determine the nature of the Order that it should make on the claim for indemnity and contribution.

25. These defendants contend that the causative negligence that resulted in the unnecessary removal of the plaintiff's stomach was that of the seventh-named defendant. On that basis, these defendants contend that, in the event of a finding of negligence and breach of duty (with consequential order for damages) against them, they are entitled to a full indemnity from the seventh-named defendant in respect of any such decree. Alternatively they submit, that they are entitled to an Order requiring the seventh-named defendant to make a contribution to any such decree to such extent as the Court considers appropriate. The basis for the claim by these defendants is set out in a Notice of Indemnity and Contribution served on the seventh-named defendant pursuant to the terms of ss.21 and 27 of the Civil Liability Act, 1961 and pursuant to O. 16, r. 12 of the Rules of the Superior Courts. If the Court makes a finding of negligence and breach of duty against the seventh-named defendant, the Court should further find that, notwithstanding any finding of prior negligence and breach of duty on the part of these defendants, the negligence and breach of duty of the seventh-named defendant was the causative negligence where the injury to the plaintiff is concerned. It is submitted that if the seventh-named defendant, had acted with ordinary care in the performance of his duties, that the plaintiff would not have suffered any injury as a result of such prior actions or omissions of these defendants is, as may be held to constitute negligence and breach of duty on their part.

Submissions on behalf of the Seventh Named Defendant
26. The primary submission on behalf of the seventh-named defendant is that there is no basis for a finding of negligence against him. The hospital defendants are seeking to attribute blame for the plaintiffs' injury to Mr. Geoghegan. It is the intention of the hospital defendants, in reliance on the authority of *Canole v. Redbank Oyster Company* [1976] I.R. 191 that no responsibility of any kind should attach to any of the hospital defendants and that full responsibility for the plaintiffs' injury should be attributed to Mr. Geoghegan. It is submitted by the seventh-named defendant, that the position adopted by the hospital defendants, both in relation to Mr. Geoghegan and to the plaintiff is utterly devoid of credibility. It is submitted that in establishing a case in negligence against Mr. Geoghegan, the hospital defendants have failed to, discharge the onus of proof, satisfying the Court that Mr. Geoghegan was "guilty of such failure as no other practitioner of equal specialist or general status and skill would be guilty of if acting with ordinary care." If the Court considers that it was reasonable for Mr. Geoghegan to rely on the histopathological diagnosis, it follows, it is submitted, that the criticism of Mr. Geoghegan for not having performed a gastroscopy in advance of the gastrectomy is rebutted. It is submitted that the evidence of Mr. Brown Elder is unreliable and that the criticisms made by Mr. Brown Elder of Mr. Geoghegan are criticisms made retrospectively and with the benefit of hindsight. Having regard to the decision of *Connolly v. South of Ireland Asphalt Company Limited* [1977] I.R. 99 and the tests to be applied, in considering whether or not the acts or omissions of the seventh-named defendant negatived the causal connection between the plaintiffs ultimate injury and the undoubted negligence on the part of the first five named defendants (the hospital), and also having regard to the evidence that the court has heard, it is submitted that the decision in *Canole v. Redbank Oyster Company* [1976] I.R. 19, has no application to this case.

27. The claims for contribution and indemnity will only arise if the Court makes a finding of negligence against Mr. Geoghegan, as per s. 21 of the Civil Liability Act 1961, regarding contribution between concurrent wrongdoers. It is submitted that the comparative blameworthiness of the defendants is such that the "just and equitable" course that the Court should adopt under the section, is to either exempt Mr. Geoghegan from liability to make contribution to the hospital defendants or to grant Mr. Geoghegan contribution from the hospital defendants amounting to a complete indemnity.

The Issues
28. The Hospital agrees with the report on the findings of a Critical Incident Analysis, prepared upon their instructions.

29. Whilst the facts of that report were admitted in evidence, none of the defendants was called in evidence in relation to the events which occurred in the pathology laboratory leading to the dreadful error which occurred.

30. This, in my view, was unsatisfactory as there was no judicial determination of what actually occurred in the mislabelling of the plaintiff's frozen section with that of a 70-year old man.

31. Of the defendants, two are innocent and two are responsible.

32. Because the defendants were not called in evidence this Court cannot come to a conclusion as to who was responsible for the mislabelling. It can and does conclude on the evidence that the error occurred in the Pathology Department.

33. It is clear that there must be a major distinction between the findings of an unsworn investigation as conducted by Mr. Clancy, and of which I make no criticism, and a full examination in chief and cross-examination in a court of law. This proper form of investigation has been precluded by virtue of a decision, tactical or strategic, taken by the Hospital.

34. This unfortunate plaintiff must succeed against the first, second, third, fourth and fifth defendants (hereinafter called the defendants). It is to be noted that the first defendant is the nominee representing St. Vincent's University Hospital (hereinafter called the Hospital).

35. Damages were agreed in the sum of €450,000.

36. That then leaves the issues concerning the sixth and seventh defendants.

37. The claim by the plaintiff against the sixth and seventh defendants was withdrawn shortly before and at the conclusion of the plaintiff's case.

38. That then left an issue between the plaintiff and the seventh named defendant.

39. The essence of that was the alleged failure of the seventh defendant to carry out an endoscopy (otherwise a gastroscopy) on the plaintiff, before completing his diagnosis, that the plaintiff was suffering from malignant cancer. This issue was based on an opinion expressed by Professor Elder, who had been retained by Messrs. Arthur O'Higgin Solicitors (then acting on behalf of Dr. Kapur, the second named defendant). It seems clear that the Hospital then took over the defence of Dr. Kapur and the third, fourth and fifth defendants and relied on the above report.

40. I accept all of the evidence adduced on behalf of the plaintiff except that of Mr. Johnson.

41. Professor Elder was asked to report by way of letter dated 28th April, 2004. It is agreed that he furnished his report some six months later on 31st October, 2004.

42. I should record that Mr. Johnson gave expert evidence on behalf of the plaintiff. His first report, dated 20th November, 2005, completely exonerated the seventh defendant. However, he subsequently read the first report of Professor Elder and altered his view by report dated 20th June, 2006 to the effect that the seventh defendant was, now in his opinion, negligent.

43. I note that Mr. Johnson did not know the appropriate legal test applicable in this jurisdiction, as set out in Dunne v. Holles Street Hospital [1989] I.R. at p. 91. I also note that Professor Elder had learned of this test some six days before he gave evidence, after the case had opened, and some two years after he had furnished his report.

44. It was put to Mr. Johnson in evidence,

> "That the cause of everything that happened in this case was that there was a mix up in the laboratory and everybody was misled by it."

45. to which he replied,

"Certainly if there had been no mix up there would not have been the error."

46. I take the view that Mr. Johnson's evidence would not be sufficiently reliable to be accepted so as to ground a finding of negligence of the seventh defendant.

47. I then turn to the issue between the defendants and the seventh defendant. The case put forward was based on the opinion and word of Professor Elder.

Evidence of Professor Elder
48. Professor Elder gave evidence to the court on 1st and 2nd November, 2006. He is now Professor Emeritus of Surgery at the University of Keele and Honorary Consultant Surgeon at the University Hospital, North Staffordshire. This witness has an extensive academic and professional record of some thirty years' of service and I accept him fully as an expert.

49. He retired in September, 2003. Currently he gives opinions and writes reviews and he has published research papers and contributed to medical books, three of which have been published in 2006, and he also has a small medico-legal practice.

50. In relation to the case before the court he has seen one 21 year old in a personal experience of over 6,000 cases.

51. He firstly dealt with his view as to the steps that ought to be taken to confirm his diagnosis.

52. His basic criticism was that he thought the seventh named defendant should have taken an endoscopy.

53. Taking all of Professor Elder's evidence into account the essence of his opinion is that the rarity of the diagnosis in a 21 year old, of malignant cancer, would raise immediate doubts as to whether this,

(a) was a correct diagnosis, or

(b) was actually the material from the plaintiff

54. and he concludes that it is his firm opinion that an urgent endoscopy should have been performed as soon as [the plaintiff] was fit enough.

55. This is the issue that this case is about between the Hospital and the seventh named defendant.

56. He was then asked taking the matters into account what in his view should the seventh named defendant have done and he replied:

> "Well I think he was a bit gullible in believing the diagnosis from the biopsy. I think he should have looked at the whole picture, the history of the boy [the plaintiff], the findings at operation, the background knowledge of a surgeon with regard to prepyloric ulceration during laceration and while I firmly believe that he was convinced of the diagnosis that there was a cancer, I think there should be alarm bells ringing at that stage. They would in me and I would have wanted every possible safe method of investigation applied to try and provide some corroboration evidentially for his biopsy report and in addition and perhaps, equally important to map the stomach to obtain very valuable information that would have guided him later in the performance of any gastric resection. He also, I think, should have had face to face meetings with the pathologist."

57. He was later asked, how an endoscopy would have assisted the seventh defendant in addressing what he should or should not do to resolve the problem that he believed existed on the basis of the biopsy that he had.

> "First it would have led to the visual diagnosis of gastritis. This is inflammation of the lining of the stomach. It is very easily recognisable at endoscopy as inflammation of the lining of the stomach.
>
> Secondly, an endoscopist would have taken biopsies and tested them for the presence of helicobacter.
>
> Thirdly, the endoscopist, whether it was Mr. Geoghegan or not, would have been able as I have said to assess the motility of the walls of the stomach and of the pylorus and he would also have been able to enter the duodenum where a duodenal ulcer would have been seen.
>
> Given these benefits, they would have arisen in the mind the incongruity between the alleged existence of an advanced gastric cancer and a benign duodenal ulcer. The two diagnoses are … really mutually exclusive. And it would have led, in my view, to serious questioning of the biopsy report, its origin, its pertinence and its relevance to this young man [the plaintiff] who would have been shown to have inflammation, helicobacter organisms present (which were subsequently confirmed of course by other means) and a benign peptic ulcer. This must surely have given cause for thought, to put it mildly, and at the same time would certainly would have led the average, and I would say currently practising gastric surgeon, to say 'Hold on a minute, there may be an error here'. That would be my opinion. And then further investigations would have taken place."

58. He then went on to deal with his reservations about the referral to Professor Reynolds for a second opinion. He then dealt with the total gastrectomy carried out by the seventh named defendant.

59. Then turning to why the seventh named defendant did not carry out an endoscopy the witness stated:

> "I believe that all patients who are undergoing elective gastrectomy need the benefit of every scrap of information it is possible to obtain to aid the surgeon and guide him in the management of the patient. I strongly believe that to omit a gastroscopy in a putative case of gastric cancer is not the correct way that a general surgeon of experience should proceed."

60. Then he states that a surgeon operating in this field of specialty would have to carry out a gastroscopy as a mandatory provision. In relation to that he says he has no doubt. He has never removed a stomach without the benefit of an endoscopy in an elective operation.

61. The witness then dealt with the fact that in his view the gastrectomy should have been partial and he sets out the reasons and concludes that he found it very difficult to accept that a total gastrectomy was absolutely mandatory.

62. The witness concluded his evidence with the view that:

> "In light of the test for the case of Dunne v. Holles Street (supra) is it your opinion that those omissions amounted to negligence in accordance with the test that you have just described?" To which he answered "Yes" and confirmed that ordinary care would have ensured that these omissions would not have taken place again, to which he answered, "Yes".

63. Cross-examination by Mr. Hanratty dealt with a number of matters. He was asked to comment on his report on the basis that the only reference therein to the mislabelling (or mix-up) is in para. 5.2 on p. 12, where there is a two-line sentence that says:

> "The most salient feature in this case is the regrettable and unfortunate mix-up in the handling of Mr. O'Gorman's biopsy material."

64. He was then asked was that the only reference to the mix-up in that report. His answer was:

> "I think so. I was not asked to go into the pathology laboratory details. I am not a pathologist. I had no remit to examine in detail, nor was I provided with more than what was in the case file in terms presumably of what Mr. Geoghegan was also given and also took over at the time of management."
>
> Q. "But the case in which you were being asked to advise on, whether or not the surgeon in this case had fallen below the requisite standard of care, was a case in which he had been misled by a false diagnosis due to a mistake?"
>
> A. "Yes"
>
> Q. "Did it occur to you that it might have assisted the court in its assessment of whether the surgeon had fallen below the requisite standard of care as to the implications of a false diagnosis of this kind being made in these circumstances?"
>
> A. "Yes"
>
> Q. "And did it occur to you that the frequency of the occurrence of an event such as this would be a relevant factor in the deliberations of the court on whether or not this Dunne v. Holles Street benchmark was met?"
>
> A. "I wasn't aware of the Dunne v. Holles Street benchmark at the time I was making my report in detail. I have stated to the court that I believed it would be a similar set of rules to those under which we operate in the United Kingdom."
>
> Q. "I appreciate that. But whatever the relevant legal benchmark being applied, did it occur to you that it would be of interest or relevance for the court to understand the implications from a surgical point of view, and you are giving expert testimony as a surgical expert. The implications from a surgical point of view of a mix-up of this kind happening in any context?"
>
> A. "Yes, it did occur to me indeed. It formed the basis of much of my analysis which I have already given in testimony."

65. At the end of the morning session counsel put it to the witness that the premise of:

> "Your opinion is that he should have preferred something that was unusual over something that never happened previously?"

66. to which the witness answered:

> "That would seem to be the case, yes."

67. The next matter that was discussed with the witness arose out of an article entitled "Guidelines for the Management of Oesophageal and Gastric Cancer" and specifically in relation to the reference to diagnosis on p. 10. Having stated the view expressed, counsel then said:

> Q. "What that is saying, and correct me if I am wrong, is that to confirm a diagnosis of cancer, it is, in effect, mandatory to have pathological confirmation by samples taken on biopsy?"
>
> A. "By fibreoptic biopsy, that is what it says."
>
> Q. "You see the point in this case is that we already had pathological confirmation on a biopsy sample taken at operation?"
>
> A. "Yes"
>
> Q. "So what was the necessity for doing it again?"
>
> A. "I don't wish to bore your lordship, but to assess the stomach, as I have already said"
>
> Q. "No, no, I am talking now about the histological confirmation of the diagnosis. The problem in this case, as you are aware, is that there was a mix-up in the laboratory which led to a false-positive diagnosis of malignant cancer in this unfortunate man's stomach?"
>
> A. "Yes"

Q. "Everything else flowed from that, is that not right?

A. "Yes"

68. Having discussed the findings of Dr. Egan, Senior Registrar, and her notes of her operation, the witness was then questioned about the second opinion on the histology, referring to that which was said to Dr. Brown in Glasgow.

Q. "You are aware of the fact that the slides were in fact sent over to Glasgow and that they were considered by Professor Brown, that he considered other diagnoses or other possible diagnoses, that he discussed these with Dr. Crotty and subsequently with Dr. Sheahan?"

A. "Yes"

Q. "And ultimately ruled out his alternative thesis and confirmed the diagnosis. You were aware of that as well."

A. "He confirmed the diagnosis, my Lord, on material to which he was asked to comment. He did not confirm the diagnosis of cancer in this particular case. He only looked at the slide, as far as I am aware. And that is a very reasonable thing to do, Mr. Hanratty. He gave an opinion on the material submitted to him."

Q. "Well that is what pathologists do, isn't it?"

A. "Indeed."

Q. "But he didn't raise the spectre of there being a mix-up?"

A. "No, he didn't."

Q. "Was he negligent?"

A. "No, I don't think he is"

Q. "Dr. Sheahan, who saw these slides in the pathology department, he is the consultant against whom incidentally, the case is being dismissed, he didn't raise the spectre of there having been a mix-up. Was he negligent?"

A. "No, I don't believe he was negligent. My comments, my Lord, have related to the clinical management and not to anything else. I am not a pathologist, although I deal regularly with them but I am not a pathologist and I am not about to step into a field that isn't mine."

69. In relation to his opinion I was surprised that Professor Elder did not place the seventh named defendant's reliance on the pathology report into the context of his own experience in dealing with such pathology reports.

70. I had to wait until the seventh named defendant's evidence was introduced to hear of the relationship between the Consultant Surgeon and the pathologist and the reliance that might be placed on a pathological report by a consultant surgeon.

71. I note that the hospital is a university training hospital and that it had an extremely large and sophisticated pathology department at the time of the error in this case. No member of that department gave evidence to support the hospital's case against the seventh named defendant.

72. Given in evidence before me was a chart setting out the organisation and responsibilities within (the hospitals) Pathology Department, which demonstrates the existence of a highly sophisticated structure. See Annexed 1.

73. I would have expected to hear evidence as to the respective professional duties and responsibilities of surgeons as taught by the hospital in respect of the level of reliance which a surgeon may place on a sophisticated pathology department. No such evidence was tendered.

74. I attach weight to the fact that this witness made only passing reference to the relationship between a surgeon and the pathology department with which he or she works. Given his 30 year experience and the 6,000 (approximately) operations that he carried out he must have relied on pathology reports.

Evidence

75. The evidence in support of the seventh defendant began with Professor John Reynolds. I accept his evidence in full.

164 Q. Having read the letter and having had your discussion with Mr. O'Gorman, what conclusion did you come to and what advice did you give Mr. O'Gorman?

A. My advice to Alan O'Gorman and his father was that surgery was required. At that time it was the primary therapy, in other words the first therapy to be pursued. Radical surgery was required because not only was a stomach cancer diagnosed, but this was a perforated stomach cancer which at least in theory could worsen the outcome of the intervention, surgical and otherwise, compared to if it hadn't ruptured. I would have stressed that relatively early surgery was the most appropriate [thing to do] given the fact that perforation had taken place and/or maybe contamination of that area with cancer cells. I would have painted the possible scenarios, following recovery from surgery, of the requirement for other therapies, in particular chemotherapy and radiation therapy which at that time based on a large trial that was done in the United States, the so-called McDonald or Inter-group study, supported the use of chemotherapy and radiation therapy after appropriate surgery for gastric cancer. And given Mr. O'Gorman's age and given the possibly adverse prognosis because of his young age and because of the perforation, I would have very much been leaning in that direction in terms of making it very likely indeed that that would be recommended following recovery from surgery.

167 Q. Did you yourself suggest that a gastroscopy should be performed in the particular circumstances of this case?

A. No. From my point of view everything was concordant:

The suspicion of a surgeon at the time of surgery of a cancer; the submission to the laboratory of a biopsy from the time of surgery with query gastric cancer on it; and a return of an initial pathology report from a frozen section confirming the type of gastric cancer that occurs in a young person; followed by a latter report on the same page showing the pathology from the appendix removed from Mr. O' Gorman as well as the gastric cancer. On the same page of the same report there was absolutely complete concordance between clinical impression and biopsy proof. And at that stage what a cancer surgeon will do is look to stage the disease by a CAT scan, which was done, and then really get on with treatment. And if surgery is the first treatment, then your impulse is to try and get on with that as soon as it is appropriate. For me doing an endoscopy would not have been an important measure, not at all.

The next witness was Mr. Geogeghan.

49 Q. She then at the top of the next page "Converted to open procedure."

A. She did.

52 Q. Your whole theory about the diagnosis of cancer being inconsistent rests on the interpretation of Dr. Egan's notes being that she found a duodenal ulcer?

A. Mr. Hanratty, I prefer to use my own words. It rests on Dr. Egan's finding of a pre-pyloric ulcer, the significance and diathesis and the pathology of which I have already digressed upon.

54 Q. Yes. The clinical details are there recorded as "gastric ulcer query malignant" as you would expect because that is what was on the card that came to the laboratory, isn't that right?

A. Yes.

55 Q. Then it deals with the macroscopy and the measurements that you query?

A. Yes.

160 Q. Because you yourself were personally involved to the extent that you were the person to whom Mr. O'Gorman was referred for a second opinion in 2002, isn't that right?

A. That is correct.

161 Q. I want to ask you about that. We know from the evidence already, and I might lead to this extent, that Mr. O'Gorman had been diagnosed as having stomach cancer. He had been referred by Prof. Traynor to Mr. Geoghegan. He had a conversation with Mr. Geoghegan at which he and his family were very anxious, in view of this appalling diagnosis, to get a second opinion. Mr. Geoghegan we have been told wrote a letter to you, and we have had the letter. You got this letter, which essentially is a summary of the case, which Mr. O'Gorman brought to you?

A. Yes.

162 Q. Could I ask you to take it from there. Would you relate to the court what happened on the visit of Mr. O'Gorman and members of his family to you in St. James's Hospital?

A. The context of the visit as 1 understood it, following a phone call from Mr. Geoghegan and also then on receipt of the letter, was that this diagnosis had been made, as is in the record of the court in that particular fashion. The overall management of the diagnosed problem, which was a perforated gastric cancer, with respect to the extent of surgery and also any other what we would call adjuvant therapies such as chemotherapy and radiation therapy which may be required – a second opinion was requested in that regard to discuss the full breadth of management, the management spectrum. The discussion which took place in my academic office in the Trinity Centre at St. James Hospital really very much focused on the what to do now. Perforated stomach cancer and what to do and where we should go from there with respect to the extent of surgery and any other treatments.

163 Q. I take it you read the letter that Mr. Geoghegan sent over with Mr. O'Gorman?

A. Yes.

164 Q. Having read the letter and, having had your discussion with Mr. O'Gorman, what conclusion did you come to and what advice did you give Mr. O'Gorman?

A. My advice to Alan O'Gorman and his father was that surgery was required. At that time it was the primary therapy, in other words the first therapy to be pursued. Radical surgery was required because not only was a stomach cancer diagnosed, but this was a perforated stomach cancer which at least in theory could worsen the outcome of the intervention, surgical and otherwise, compared to if it hadn't ruptured. I would have stressed that relatively early surgery was the most appropriate [thing to do] given the fact that perforation had taken place and/or maybe contamination of that area with cancer cells. I would have painted the possible scenarios, following recovery from surgery, of the requirement for other therapies, in particular chemotherapy and radiation therapy which at that time based on a large trial that was done in the United States, the so-called McDonald or Inter-group study, supported the use of chemotherapy and radiation therapy after appropriate surgery for gastric cancer. And given Mr. O'Gorman's age and given the possibly adverse prognosis because of his young age and because of the perforation, I would have very much been leaning in that direction in terms of making it very likely indeed that that would be recommended following recovery from surgery.

165 Q. Surgery being total gastrectomy or possibly less than total?

A. Surgery being adequate gastric clearance with a low threshold for total gastrectomy in a young man because of the possible life-time risk of the remnant stomach becoming cancerous. So very low threshold for total gastrectomy. Adequate removal of all the lymph glands and what is called the omental bursa and then treatment, following at least a month or so after recovery from the operation, with chemotherapy and radiation therapy being likely unless the pathology was shown to be unusually favorable, which was not likely given the scenario of a perforated gastric cancer.

166 Q. Was it apparent to you from the summary contained in Mr. Geoghegan's

A. Yes.

167 Q. Did you yourself suggest that a gastroscopy should be performed in the particular circumstances of this case?

A. No. From my point of view everything was concordant:

The suspicion of a surgeon at the time of surgery of a cancer; the submission to the laboratory of a biopsy from the time of surgery with query gastric cancer on it; and a return of an initial pathology report from a frozen section confirming the type of gastric cancer that occurs in a young person; followed by a latter report on the same page showing the pathology from the appendix removed from Mr. O' Gorman as well as the gastric cancer. On the same page of the same report there was absolutely complete concordance between clinical impression and biopsy proof. And at that stage what a cancer surgeon will do is look to stage the disease by a CAT scan, which was done, and then really get on with treatment. And if surgery is the first treatment, then your impulse is to try and get on with that as soon as it is appropriate. For me doing an endoscopy would not have been an important measure, not at all.

170 Q. We have heard figures bandied about in this court of one in hundreds of thousands, but in St. James it is 1:1000 approximately?

A. That's right.

171 Q. Should it have occurred to you that maybe there was a mix-up in the laboratory?

A. No. If there was something discordant in terms of the surgeon's view of this, if there was something discordant between what the person who did the original operation felt and the pathology or any element of it, then perhaps. But there was nothing, this was all concordant. The surgeon who did the laparoscopy and the laparotomy was concerned about cancer. The biopsy came back as showing cancer and the complete report of subsequent paraffin sections came back as showing cancer. So there was nothing there to question. I would not question it, in answer to your question, based on Mr. O'Gorman's age because we see it. I would not question it based on that.

174 Q. Why didn't you write him a letter putting your views in writing in a case as serious as this where you had been asked for a second opinion?

A. I didn't. I phoned him. The initial approach to me was through a phonecall and there was no sense that Mr. O'Gorman was in any way unhappy with the recommendation that was given to him in St. Vincent's Hospital. I was there to discuss the overall management of gastric cancer with him.

177 Q. When the plaintiff, very understandably, requested Mr. Geoghegan for a second opinion, he wanted a second opinion on the terrible diagnosis that he was at that point in time faced with. Were you not asked for a second opinion on the diagnosis by Mr. Geoghegan?

A. I was asked for a second opinion on the management of the problem through Mr. O' Gorman's father and via Mr. Geoghegan on the management of the problem.

His cross examination began by exploring his relationship with the seventh defendant. I wholly reject the sinister implications put to us that he was so close a friend that his evidence could not be deemed a likely witness. I am satisfied on the balance of probability that he is a colleague and nothing more.

On Wednesday 8th, November 2006, Professor Oscar Traynor gave evidence.

4 Q. Now, can I ask you to direct your mind to February, of 2002 and your particular involvement with the Plaintiff in this case, Mr. Alan O'Gorman. I think you were the consultant under whom Mr. O'Gorman was originally admitted; isn't that right?

A. That is correct.

5 Q. Could I just ask you to account to the court as best you can your own recollection of your involvement with this patient, which spanned a brief period of time up until the time that Mr. Geoghegan, I think, became involved?

A. Yes, Alan O'Gorman was admitted to St. Vincent's University Hospital sometime on the evening of Thursday, 14th February, 2002. He was admitted under my care with acute abdominal pain, a history spanning back approximately three to four days, a pain starting in the epigastric region, i.e. the upper part of the abdomen, and settling in the right iliac fossa. The history was not exactly typical for anything in particular -- it is what we call nonspecific – but over the course of Thursday night and into Friday morning, his history became much more in keeping with acute appendicitis. In other words, his pain settled towards the right iliac fossa. He had an elevated white cell count and he had a marginally elevated temperature, all of which would be fairly classical symptoms and features of acute

appendicitis.

6 Q. Yes?

A. And so on the morning of Friday, 15th February, my specialist registrar, Ms. Bridget Egan, telephoned me to discuss the case with me and to say that she thought that this patient needed to go to theatre for appendicectomy by the laparoscopic route, i.e. keyhole surgery.

7 Q. Yes?

A. Having discussed the case with her in some detail, I agreed that that was the correct course of action and so during the morning of Friday, 15th February, she brought Mr. O'Gorman to theatre and performed a laparoscopy. The appendix was only mildly inflamed. she removed the appendix in standard fashion, but because the appendix was unexpectedly mildly inflamed, she looked around the rest of the abdomen with the laparoscope, i.e. the camera system, and found that there was a lot of what we call turbid fluid in the upper abdomen, which would be in keeping with a perforation of some sort of a viscus or organ in the upper abdomen.

8 Q. Yes?

A. So concerned that this may be a perforated peptic ulcer, she telephoned me a second time and told me what she had found and said that, in her opinion, we needed to open the patient's abdomen and explore as to why he had this turbid fluid in the upper abdomen. Again, I agreed with this course of action and she went ahead and opened the abdomen. On opening the abdomen, she found that he had a perforated gastric ulcer. This ulcer was in the lower part of the stomach, in a region of the stomach which was called the prepyloric region. It was a stomach ulcer which had perforated. There was a lot of induration or hardness around the area of the perforation and she had concerns that this was more than would normally be associated with a straightforward benign ulcer. She had some concerns about the nature of this ulcer and so, because it was a gastric ulcer, which does have the potential to be a cancerous ulcer, she performed a biopsy and sent it for frozen section. She then went ahead and closed the patient's abdomen and then, unexpectedly, when the patient's abdomen had been closed, the report of the frozen section analysis came back saying that this was actually a cancer.

9 Q. Yes?

A. This was quite unexpected but, nevertheless, she phoned me a third time at that point in time and said, look, you know, this turns out to be a cancerous diagnosis that we have got and what should we do. I told her that we should do nothing further at that point in time for two reasons. Firstly, this was simply a frozen section analysis, which is not as reliable as a definitive paraffin section examination and so, obviously, we needed to wait until we had a definitive histological diagnosis.

10 Q. Which you weren't going to have the same day?

A. No, that usually takes several days to come through.

11 Q. Yes?

A. The second reason why obviously we shouldn't do anything further at that time was that we had no consent to do any major surgery. This patient had gone to theatre with acute appendicitis - so he thought -- and obviously we weren't going to undertake major surgery without having informed consent.

12 Q. Yes?

A. So for those two reasons, I suggested to her that we continue what she was doing; that the patient waken up, recover from the surgery and when we got the definitive histological diagnosis, we would then decide what our options were.

13 Q. Have you any doubt in your mind that what she was talking to you about was a gastric ulcer, as opposed to a duodenal ulcer?

A. No, absolutely not. The delineation between stomach and duodenum is fairly clear anatomically and a duodenal ulcer would be far more common than agastric ulcer. A perforated duodenal ulcer would be far more common. So I think for somebody to make a diagnosis of a gastric ulcer would be based on a very clear understanding that this was before the pylorus. It was in the lower part of the stomach, not in the duodenum.

14 Q. Well, the reason I ask you is because the evidence has been given to this courton the basis of her description of the ulcer in her operation note, she says "small pinhole perforation distal stomach almost at pylorus (just proximal) significant thickening of surrounding stomach". On the basis of that, it has, in effect, been suggested to this court that what she had here was a duodenal ulcer and that what she thought that she was dealing with and what she meant to say here or to describe was a duodenal ulcer?

A. I was here in this court last Wednesday when that evidence being given and I have to say to you that I find that evidence incomprehensible. This was

15 Q. Well, we also know and, presumably, you heard this evidence as well -- if I could just refer you to page 91 of the admission notes of your admission -- I think you have the book. This, I think, is called the Copy Medical chart Admission 14th February, 2002. Perhaps, for convenience, I will just hand in a copy to you with the page open?

A. Okay.

16 Q. This is the frozen section request form that Dr. Egan sent down to the laboratory. Were you present when the evidence was given as to the implications of the fact that she wrote "gastric ulcer" on this? what she wrote was "gastric ulcer? malignant"; isn't that right?

A. That is correct.

17 Q. Did you hear Prof. Brown ... (INTERJECTION) clearly a gastric ulcer. It was never anything other than a gastric ulcer and I simply cannot understand why it was being referred to by Prof. Elder as a duodenal ulcer. It was never a duodenal ulcer.

Mr. Fitzsimons: Sorry, it hasn't been established that she wrote that.

Mr. Hanratty: No, that she sent it down.

Mr. Fitzsimons: Yes.

Mr. Hanratty: I think it has been established that she didn't write it, as far as I recall, judge -- that somebody else wrote it.

Mr. Fitzsimons: You put it to the witness that she wrote it.

18 Q. Mr. Hanratty: What she caused to be written on the form was "gastric ulcer? malignant" and subject to correction and without doing any injustice to what Prof. Brown Elder said, he raised a question mark over whether that is what she actually meant -- in other words, whether she really meant a gastric ulcer. Are you in any doubt from your own conversations with her as to what was on her mind when she was speaking to you during your telephone conversations?

A. I am not in the slightest doubt about that.

19 Q. And in reference to the "? malignant", was this a gastric ulcer of which she was wary or about which she was a bit concerned?

A. Yes, it clearly was, which is why she sent a biopsy for frozen section. The difference between a gastric ulcer and a duodenal ulcer is important because Prof. Elder rightly pointed out that duodenal ulcers are almost never malignant. It is not true to say that they are never malignant, but they are almost never malignant whereas a gastric ulcer, a stomach ulcer, may be either benign or malignant; it can be either.

20 Q. Yes?

A. Because of the degree of induration or hardness around this ulcer, Ms. Egan was concerned that this actually might be a malignant ulcer, despite the young age of the patient.

21 Q. Yes?

A. So that was the basis of doing a biopsy and asking for a frozen section.

22 Q. So her suspicion of malignancy, even in one of 21 years of age, arose before any diagnosis came back from the laboratory?

A. Yes, there were concerns in her mind about the nature of this ulcer.

23 Q. Well, we know that you have told us she got the frozen section back, she phoned you back, you told her what to do and she did that. Can you then just explain to the court as best you can from your recollection how matters progressed over that weekend?

A. Over the weekend, the patient made a normal type of recovery from his surgery and the next sort of important event took place on the evening of Monday, the 18th, I think it is -- it was the Monday evening anyway.

24 Q. Yes?

A. I do a ward round after my theatre list on a Monday, so somewhere around five o'clock on the Monday evening -- it could have been half four or five, but it was some time around that time I was doing my ward round and Ms. Egan, my specialist registrar, was with me and she told…

35A. No, I left, I was going away on the Tuesday, so I was not still involved in Alan's care on the Wednesday.

36 Q. Right?

A. In fact, I was not involved in any part of the decision about what type of surgery -- by the time the definitive histology report came through, I had already left, so I wasn't aware of the definitive histology report before I left.

37 Q. Can I just ask you to explain, because it is a question that has arisen, is what were the circumstances in which you decided to hand over the case to Mr. Geoghegan?

A. Well, there were two reasons why I handed over the case to Mr. Geoghegan. The first I have already alluded to, and that is that I was going away. Mr. Geoghegan and I work, effectively, as a team. We work together. We have the same ward. We share all the junior staff. The non consultant hospital doctors are the same. We have the same theatre allocations. We have the same outpatient clinics, so we work as a team, you know, as a team of consultant surgeons. And so we would regularly see each other's patients. We would from time to time transfer patients from one to the other, depending on the type of case and the expertise of each individual.

38 Q. Would you discuss your cases with each other?

A. Absolutely, yes.

39 Q. Would you be aware of each other cases and, particularly, unusual cases.

A. Unusual cases, yes. It is probably not true to say that we would be aware of every single case that comes in through the emergency department. I mean, a straightforward appendicitis or something like that, we wouldn't necessarily be involved with. But unusual cases, we would chat between each other about them and discuss the cases, yes.

40 Q. When you handed this case over to Mr. Geoghegan, he obviously agreed to take the case and we know that he had a long conversation with Alan and his family subsequent to that. Did you have any further involvement in the care or management of this patient from that point in time onwards?

A. No, not at all. I was going to say that the second reason why handed Alan O'Gorman's care over to Justin Geoghegan, was that I no longer deal with gastric or oesophageal cancer myself. Since Justin Geoghegan's appointment to St. Vincent's Hospital in 1999, his expertise in this area is greater than mine and so I don't deal with those patients any more. So if we had a gastric or oesophageal cancer, I would normally hand it over to Justin Geoghegan anyway, irrespective of whether I was going away. So that was the end of my involvement with Alan O'Gorman's care.

41 Q. Did you deal with these type of cases in the past, but subsequently come to specialize more with the hepatobiliary (INTERJECTION).

A. Exactly, yes.

I accept the evidence of this witness.

Professor Gerald O'Sullivan then gave evidence.

Mr Justice Lavan: Very well, thank you.

122 Q. Mr Hanratty: You have been asked to come here to assist the court in your capacity as an expert witness and in that context could I ask you to give a brief outline to the court of your qualifications, your experience in your present position and area of interest?

A. I am ... (INTERJECTION)

Mr Justice Lavan: You can lead him on this --it is in front of me.

A. I am a Fellow of the Royal College of Surgeons in Ireland. I am a master in surgery. I am a Fellow of the American College of Surgeons. I am an Honorary Fellow of the Royal College of Surgeons of Glasgow. I am a consultant surgeon at the Mercy University Hospital in Cork. I am a Professor of surgery at the University College Cork. I am the Director in Chief of the Cork Cancer Research Centre.

123 Q. Mr Hanratty: What is your area of practice?

A. My clinical area of expertise would be in surgery of the gastrointestinal tract, with a special interest in the upper gastrointestinal tract. That would be oesophageus, stomach and duodenal surgery.

124 Q. Do you have any position at present in the Royal College of Surgeons in Ireland?

A. At present, I am the President of the Royal College of Surgeons in Ireland.

125 Q. Now, you are aware of the facts of this case and of the particular issues that arise in this with specific reference to the assertion that Mr. Geoghegan fell short of the duty of care that he owed to his patient, and I want to take you through the various issues that have arisen in that context. First of all, to recap, you know that the patient came to him already with a diagnosis, a pathological diagnosis?

A. Correct.

126 Q. Originally, on frozen section; subsequently confirmed by paraffin section; subsequently discussed between the Pathology Department and a Prof. Brown, whose second opinion was sought in Scotland; and subsequently discussed between Mr. Geoghegan himself and Dr. Sheahan in the department?

A. Correct.

127 Q. So, given that background then, would you just give your opinion to the Court firstly on this question of the claim

that Mr. Geoghegan should have done notwithstanding this diagnosis, should have done a gastroscopy?

A. Okay, I think the context is very important and I think the context in which Mr. Geoghegan becomes engaged in the case is the presence of a diagnosis which is plausible based on the operative description and there is no doubt that the specimen that was looked on by the pathologist was a specimen of cancer. There was no other anatomical identifying factor on the specimen, so it was very plausible to assume that that was the actual specimen of a stomach cancer. A signet ring carcinoma would occur in the stomach. There is absolutely no doubt what they were talking about was an ulcer in the distal stomach, a gastric ulcer...(INTERJECTION)

Mr. Justice Lavan: Slowly, professor, for the stenographer.

A Sorry. That is based on the operative description, but it is also based on the final description of the specimen that was processed in the lab after gastrectomy. It was identified there to be within the distal stomach, so there is absolutely no doubt about that.

128 Q. Mr. Hanratty: Well, you are aware of the controversy and, indeed, you heard some of it this morning to the effect that, in fact, this was a duodenal ulcer and, just to explain to you what the evidence was, that because this was a duodenal ulcer, the diagnosis of cancer was inconsistent with the presence of a duodenal ulcer. At least, that is what Mr. Brown Elder has testified to this court?

A. There is anatomically no question about where the ulcer was. It is in the lower end of the stomach.

129 Q. Yes. But what Prof. Brown Elder has said to the court is that on the basis of the operative description of Dr. Egan, "small pinhole perforation distal stomach almost at the pylorus (just proximal)", on the basis of that description, he insisted that this was a duodenal ulcer?

A. Anatomically, no; anatomically, no. I think where the confusion arises is that you can get prepyloric ulcers that can have the came biological basis as a duodenal ulcer, but, anatomically, no. Prepyloric ulcers are actually quite rare in young people. It is more the duodenal type.

130 Q. Yes. But you have seen that having suspected that there was a malignancy in this, Dr. Egan caused frozen section report card to be prepared and can I just very briefly direct your attention to that? Do you have a book of the records?

A. No.

131 Q. I think Prof. Traynor is gone off with -- we have another one, I think. If I can just refer you to page 91 of the book that you have been handed?

A. 91.

132 Q. This, I understand, is the frozen section request form?

A. Yes.

133 Q. On which we have been told Dr. Egan caused to be written the words "gastric ulcer ? malignant"?

A. Yes.

134 Q. It is axiomatic or at least we have been told that gastric is the same as stomach; is that correct?

A. Correct, yes, yes.

135 Q. Ultimately, when the histology was done on the resected stomach -- and I just want to refer you to one page, it is a different book, the ... (INTERJECTION)

A. My memory of reading it, when the histology was done in the resected specimen, the artifact of the suture which closed the ulcer was identifiable histologically and that is something that is not mistaken and that is positioned in the stomach.

Mr. Justice Lavan**:** Just one moment, I missed your reply.

A. When the resected stomach was processed in the lab, the ulcer in question was identified to be within the distal stomach and there is no doubt that the ulcer in question was identifiable by the artifact to the suture material that was used to close that particular ulcer. So the ulcer that was talked about by the surgeon, that was biopsied by the surgeon, that was closed by the surgeon and that is reported in the resected specimen in the laboratory to be from the distal stomach is the same thing.

136 Q. Could I just refer you to page 131 of a different book? I am handing you a book... (INTERJECTION)

A. Thank you.

137 Q. This is, as I understand it, the histology report of the resected stomach and there is a description given under the heading "MICROSCOPY: Total gastrectomy". It says: "Stomach showing extensive chronic active gastritis including numerous mucosal lymphoid aggregates. HLOs are seen. There is focal mucosal ulceration in the proximal duodenum. Foreign body giant cell reaction is seen within the peri-antral serosal tissue consistent with a previous biopsy."

A. Yes.

138 Q. The peri-antral serosal tissue, I take it, is in the antrum?

A. Yes.

139 Q. Is the antrum in the stomach?

A. Yes.

140 Q. Is this the passage to which you are referring to the artifact of the suturing?

A. Yes.

141 Q. Can you just refer the Court to that reference within that paragraph?

A. "Foreign body giant cell reaction is seen within the peri-antral serosal tissue." That is a giant cell reaction to suture material. That is my interpretation.

142 Q. So, in your professional opinion, is there any room for any form of doubt as to whether or not this was a gastric ulcer or a duodenal ulcer?

A. No.

143 Q. You know that when Mr. Geoghegan got this, of course he had the operative description of Dr. Egan and, in fact, he told us he discussed the case with Dr. Egan and he gave evidence then himself of what he saw when he commenced his own operation. He performed a laparotomy and he described his findings at surgery and he said that he saw and palpated the hardening. He said that he visualised the omental fatty patch which Dr. Egan used to repair the site where she took the biopsy from and, of course, the pinhole ulcer itself and he said that it was in the lower stomach?

A. Yes.

144 Q. Is that consistent with all the objective empirical evidence, as it were, as to the location of the ulcer?

A. Yes, there is absolutely nothing inconsistent there.

145 Q. He also said in connection with his decision-making process leading to his decision to proceed to a total gastrectomy that part of that was the appearance of the stomach as he visualised it after he performed his laparotomy and the view that he formed as to how much clear tissue – I think he said 5cm he would require before he would even consider doing a partial gastrectomy. That I take it would be an appropriate thing for him to take into account?

A. The standard of care, once you have a diagnosis of a stomach cancer, is to do a total gastrectomy. Lesser operations would be done for some opt-out reason fitness or otherwise. But the standard of care is now a total gastrectomy and reconstruction. That is the curative operation for cancer of the stomach.

146 Q. Yes. Well as you are aware, I think Mr. Brown Elder was suggesting that he should have done a subtotal gastrectomy or a partial gastrectomy?

A. Okay.

147 Q. Either on the basis of the spread of the cancer or, alternatively, perhaps, as a palliative procedure?

A. Well, let us take the history of the evolution of gastrectomy and let us take and benefit. Now in the 1970's in the UK, there was a vogue for doing subtotal gastrectomy. That was to leave 1cm of stomach below the oesophageus. That was done for safety …..

Mr. Justice Lavan: Slowly, professor, please, for the stenographer. Yes-- except in the following circumstances?

A. Except in the following circumstances where the patient would be unfit or where they would be spread of disease outside the field of resection, and then you would be doing a palliative procedure.

149 Q. Mr. Hanratty: Well, we know that Mr. Geoghegan had this diagnosis. He had it confirmed that there was further confirmation and so on and we know the findings that he had already seen from Dr. Egan, but it was suggested to him that notwithstanding all of that, and notwithstanding that he did have already histological diagnoses, that he should, nonetheless, have done a gastroscopy?

A. I don't think a gastroscopy would have contributed anything, quite frankly.

The highest level of evidence is a full thickness biopsy of the stomach. Gastroscopy, and we often face the situation, will often be benign in the presence of an infiltrative cancer of the stomach because they spread submucosally. It is not infrequent for us to know that the patient in our heart has a carcinoma like a linitis plastic because we can see spreading of the folds and thickening and oedema of the stomach, but the biopsies come back benign and often are repeated and repeated. It is quite a difficult situation to get a positive biopsy. A negative biopsy does not exclude the disease. Once you have a full thickness biopsy, you have a higher level of evidence that you can get by the endoscope.

150 Q. Well, Mr. Brown Elder was suggesting that you can get more than a superficial piece of tissue on your gastroscopy.

It was put to him specifically that a full thickness biopsy taken at an operation is a superior basis for a diagnosis than a biopsy taken at gastroscopy and his response to that was, no, that in a gastroscopy you can get, I think Mr. Fitzsimons put yesterday, if I am not mistaken, a full thickness biopsy on a gastroscopy?

A. Well, first of all, I would be surprised that this would be controversial because it is well known that the biopsy forceps we use in the stomach or use in the distal oesophageus are mucosal biopsies. They do not go through the submucosa unless you are lucky at times, but they are generally mucosal biopsies. The second thing is they do not take full thickness biopsies. If they were taking full thickness biopsies, the upper GI endoscopy would be fraught with difficulties from perforation. Because if you are taking a full thickness biopsy, you are, effectively, perforating the stomach. You would have to close it, so they just don't do that.

151 Q. Yes?

A. This is an area always of controversy within gastroenterology as to how we can improve the biopsy forceps because, by their very nature, they are tiny and full thickness and they are fraught with false negative results.

152 Q. Well, Mr. Geoghegan said that the reason that he didn't do it and the reason that he gave to the family for not doing it was that it didn't have the potential to change his management plan because he already had a positive diagnosis?

A. Yes, I think that is very reasonable, yes.

153 Q. And his evidence was that if he took biopsies and got more negatives, it still wouldn't change his situation?

A. Absolutely, they weren't going to make any difference to him at this particular stage, yes. He had the diagnosis with the highest level of evidence that you can get.

154 Q. Mr. Brown Elder said but he could have also mapped the stomach, I think was the phrase that he used, with a view, perhaps, to determining whether a partial or total gastrectomy could be done?

A. The context of mapping does not arise in this particular circumstance because, here, you are talking about a cancer which involved a full thickness or an infiltrative cancer of the stomach. where the context of mapping arises is where you see small and superficial cancers of the stomach and you may map the outline of them either to do a superficial resection, a very limitedresection. They are rare and they are circumstances in which the tumour does not infiltrate into the submucosa and you could do something more limited or restrictive, like a mucosal resection.

155 Q. Yes?

A. So it just doesn't arise here.

156 Q. Well, one of the reasons that Mr. Brown Elder says that Mr. Geoghegan should have done a gastroscopy was because he should, in effect, have not believed or not accepted the diagnosis that came back from the laboratory; he should have queried it?

A. My own interpretation was that there was a reasonable or fair amount of querying because two different pathologists in two different institutions read the biopsies and didn't question it, and there were three consultant surgeons looked at the case and never questioned that there was a mistake. So I would think in the circumstance there was a fair amount of consideration of Mr. O'Gorman's welfare, but nobody under any circumstances tripped to the idea that some place that there had been a mislabelling of the specimen.

157 Q. That is the point. Mr. Geoghegan himself told the court yesterday that it would be not an uncommon thing to query a diagnosis and to discuss it with the pathologist, but what Mr. Brown Elder was actually suggesting was that he shouldn't have queried the diagnosis because nobody was suggesting that the diagnosis was incorrect, albeit on the wrong specimen. What Mr. Brown Elder was saying was that Mr. Geoghegan should have raised the possibility that there had been a mix-up of the tissue in the laboratory?

A. I don't believe that. I have never in my entire professional career seen this circumstance and I have never raised that with any of my pathology colleagues, to my memory. I don't think it is something that you would expect the surgeon to think of. They don't work in the pathology department and the background where they engage with pathologists is in a professional conversation over the diagnosis, and I would think in my reading of the notes that such discussions did take place.

158 Q. Mr. Geoghegan was also criticised in that he did not himself decide originally to do a CT scan, but that he did it almost at the insistence of the family and that it was suggested he fell below his duty of care to his client in failing himself of his own initiative to do a CT scan as part of his work-up to proceeding to a gastrectomy?

A. Again, the findings of a CT scan are a lower level of evidence than the findings at laparoscopy and at laparotomy and I will take you back to a trial which we did back in the mid 90's where we compared imaging of CT with the findings of laparoscopy and laparotomy in gastric cancer and 20% of the situations, the CT scan would have misdiagnosed. The CT scan is of value when it demonstrates pathology in this particular context. It is not of value otherwise.

159 Q. Yes. well, Mr. Geoghegan said that I think what you said that he already had the information from the open….

Mr. Fitzsimons: If I could suggest that Prof. Elder said it should have given pause for thought or sounded alarm bells and started a chain of enquiry.

Mr. Hanratty: He did, but he ... (INTERJECTION)

Mr. Justice Lavan: You can clear that matter up yourself, Mr. Fitzsimons.

Mr. Fitzsimons: May it please your Lordship.

167 Q. Mr. Hanratty: He did say that it would give pause for thought despite the combination of factors that you describe here, but he ultimately came down and said he should have suspected that there had been a mix-up in the laboratory.

A. Well, I think there was pause for thought. I think the specimen went to Glasgow and was reviewed in Glasgow by expert pathologists, who agreed with the diagnosis. I think an outside consultant's opinion was sought on the appropriateness of surgery in this particular circumstance. So I do think that there was pause for thought but nobody suspected that a mislabelling had occurred. I wouldn't have suspected that. It is not in our nature as surgeons who work in the surgical department and who normally have a tight relationship with the professional side of the pathology department to go questioning at that particular level. You know, if we do that, then we would question every single biopsy of the 17,000 or 30,000 or whatever is done in the year. You would be questioning the labelling of them.

168 Q. It was put to Prof. Brown Elder that Dr. Egan didn't suspect it, Prof. Traynor didn't suspect it, Prof. Reynolds didn't suspect it, Dr. Sheahan didn't suspect it and Prof. Brown didn't suspect it. But his point was that Mr. Geoghegan should have suspected it because he was the surgeon?

A. I would disagree. I mean, I think if all the others didn't suspect it, particularly if the two pathologists who work in pathology departments and who intimately know the working of pathology departments, if they didn't suspect it and they would know that this was an unusual occurrence in a young person. And when an outside opinion was sought, it was sought questioning that this was an unusual occurrence in a young person. If they hadn't thought that there was a mislabelling error, I don't think you can hold Mr. Geoghegan up to having a higher standard than the people whose specialty it is.

169 Q. Do you think that that is a reasonable criticism of Mr. Geoghegan in these circumstances?

A. That it was reasonable to?

170 Q. That it is reasonable to criticize him or to single him out for criticism for not having suspected it?

A. I think it is unreasonable. I think it is unreasonable because I think a surgeon has an extremely tight relationship with his pathology department colleagues in terms of the diagnosis and management of patients and they do discuss. If this doesn't come up in discussion or isn't raised or isn't thought about between them, well then I think it is very difficult to ask one person in isolation, who is preoccupied with the care and the safety of the particular patient, to be held to a higher standard than that. I mean, I can't see how I would have the competence or he would have the competence to challenge a professional colleague in charge of laboratory about what is going on, or two or three layers beneath them. I don't think one could do that.

Mr Justice Lavan: I would like you to continue the exploration of that point, Mr. Hanratty, starting off at medical students. What is one trained to understand in relation to the relationship between pathology and the surgeon operating? Do you understand what I am asking you?

A. Yes. We would have a very good training of what old Berkeley [inaudible] used to describe as the "living pathology". We would identify pathology in the living and we would have a good understanding of the structure and the behaviour of the cancer. The nuances of the diagnosis histologically would be the provenance of specialist histopathologists. And they would have a department and staff working and answerable to them of junior doctors, technologists, technicians and the like who would prepare the specimens, cut them, mount them, paraffin them and so on. We would have no contact at that particular level at all.

171 Q. Mr Hanratty: Could I direct your mind specifically to the evidence given in this case by a risk management expert who was commissioned by St. Vincent's Hospital to investigate this event and specifically to try and identify what happened and to make recommendations to prevent such a thing from happening again. The opinion that he gave, which was essentially consonant with an opinion of another risk management expert, was to the effect that the error which had been made by the hospital staff in this case was of an absolutely basic nature. They had two different samples from two different patients on the bench at the same time. That is what happened, although they couldn't identify who specifically was responsible for it. I think the question, if I am inferring correctly, that the judge was interested in is this: what is the level of trust that surgeons have or are conditioned or trained to have from the very start of their training right through their clinical practice; the level of trust they would have in a histological diagnosis?

A. The level of trust is almost absolute.

172 Q. Mr. Geoghegan's evidence ... (INTERJECTION)

A. There is a level of professional contact and trust and relationship that builds between your consultant colleague in the pathology department and the …

182 Q. Should he not have set about negating or refuting the diagnosis in some way?

A. A consultant surgeon in his own hospital working with his own colleagues whom he trusts looking at the evidence presented to him, taking the evidence of two outside consultants, I can't see how he could turn it around and do something different. I would put the other point to you. If he had dilly-dallied and waited around for three months and then we had metastatic disease, where would the culpability lie?

183 Q. And then turning to paragraph 5 of your report you consider the question was the diagnosis and management plan reviewed. Could I ask you to give your views to the court on that particular question?

A. My interpretation of what I read was that I thought the diagnosis and management plan was reviewed because there was a conversation between the surgeon and the pathologist and the specimen was taken to Glasgow and was looked at by one or I think maybe two pathologists in Glasgow. Also there were special stains done in Glasgow to exclude gastro-intestinal stromal tumour. They looked for neural elements in it. They didn't see it and they said this is an infiltrative cancer of the stomach. There was also a question raised, insofar as I can remember, on the frozen section of maybe this is a lymphoma. Wait for a paraffin section and we look at the paraffin section. So the diagnosis was questioned, one because of its initial validity and, secondly, the differential diagnosis to which type of tumour it most likely was. And all came down on the fact that this was a signet ring carcinoma, which would be the infiltrative type seen more likely in this particular age group should it occur. I think after the fact everybody did question the diagnosis. Nobody questioned the mislabelling.

184 Q. On that very subject could I ask you to turn to paragraph 6 of your report where you address an issue which has certainty, in terms of time spent in this case, and received relatively little attention and where you say:

"The mistake was, the mislabelling of the specimen, a specimen which was adequate for diagnosis of cancer. This resulted in the patient ultimately having a gastrectomy which, if the specimen had not been mislabelled, would not have been performed"

A. Correct

185 Q. Do you make the point there that everything that happened in this case is referable back to that fundamental error?

A. Absolutely.

186 Q. Not only was Mr. Geoghegan mislead by the diagnosis based on that error, but even Dr. Sheahan the consultant histopathologist himself?

A. Every single consultant of the five people who were associated with this were mislead by that particular event. I would have to say it is an extremely rare event in my experience in a pathology department, and I have personally never come across it in my clinical practice. It is so rare that it wouldn't really enter our consciousness that there has been a mislabelling somewhere.

187 Q. In paragraph 7 you record your conclusion:

"I think in the circumstances Mr. Geoghegan cannot be faulted in any way for his management of this patient"

A. Yes.

188 Q. Do you stand over that conclusion?

A. I would, yes.

End of direct examination of Professor O'Sullivan by Mr. Hanratty. Professor O'Sullivan was then cross examined as follows by Mr. Fitzsimons:

189 Q. Mr. Fitzsimons: Professor, I want to start by asking you about a proposition that I have written down here and I want to ask you is it true or false what I am going to read as of 2002:

"There are numerous reports of carcinoma of the stomach occurring in this age-group"

That being 21-year-olds. Is that true or false?

A. Yes, there would be reports.

I find Professor O'Sullivans evidence compelling and I accept it fully. He has dealt with the issue in dispute between the hospital (representing also the second, third, fourth and fifth defendant) and the seventh defendant.

I accept on the balance of probabilities that an endoscopy was not warranted in the unusual circumstances of the case, when an open operation had been performed.

Likewise, I accept that this witness clearly dealt with the level of trust that surgeons have or are conditional or trained to have from the very start of their career.

The last witness called in support of the seventh defendants case was Mr. Patrick Broe.

Mr. Fitzsimons: If it is of assistance to my Friend to the speed of things, I am quite happy that Mr. Broe's reports be treated as his direct evidence and I will cross-examine him. If that helps my Friend?

Mr. Hanratty: I am grateful but there are a couple of issues that came up in a slightly different context.

Mr. Justice Lawn: That is a sensible suggestion.

414 Q. Mr. Hanratty: I think that is very helpful and it will certainly greatly shorten my examination-in-chief of the witness. Mr. Broe, if I may bring you directly to the specific issues that have arisen in this case by reference to each of the criticisms that have been made. The main and original criticism that has been made by Prof. Brown Elder of the management of this case by Mr. Geoghegan is that in advance of proceeding to gastrectomy, he should have done a gastroscopy and that in some way the gastroscopy could have informed his judgment or his decision making as to the management plan that was appropriate for this patient. I will ask you to give your opinion to the court on that point.

A. Well, of course there is a lot of emphasis on gastroscopy in relation to the diagnosis. But in fact the diagnosis in this case, as we have already heard numerous times, was well established by a laparotomy, which is a rather unusual in the diagnostic process was clearly not of any use. Prof. Elder's point was that you could map areas of the other stomach if you could look at the motility of the stomach. And those points were true. But equally, the surgeon at the initial laparotomy would have seen that the stomach was not in any way thickened above the antrum are where this process was going on. So the addition of endoscopy would in my view have possibly confused the equation because you would have had, as has been pointed out, 20 biopsies or more showing no abnormality except maybe a severe gastritis which subsequently was shown on the resected specimen. But you would be still left with a confirmed full thickness gastric biopsy at the site of the ulcer with a diagnosis of gastric carcinoma. So therefore, what was the surgeon to do except proceed on that basis. In addition, there was evidence from the operation of a thickened stomach, thickened antrum etc and in some instances a lump described.

415 Q. If he had done a gastroscopy and he visualised this severe gastritis that was subsequently shown on the histology when the stomach was taken out, would that have confirmed or negated the diagnosis of cancer that he already had?

A. It would certainly not have negated it, absolutely not. But he made a point in his evidence that the presence of Helicobacter, which is unusual in young patients with gastric cancer, which would have been identified in these biopsies, would have started the bells clicking. But in fact in a review from Brennan and Slone Kettering, which would have the largest database and most experience of gastric cancer, 23% of young patients with gastric cancer were in fact Helicobacter positive. So I don't think it would have necessarily ruled it out or raised suspicion of it not being a cancer.

416 Q. The suggestion really is that because of the age of this patient and the rarity of gastric cancer in persons of that age, Mr. Geoghegan should have paused for consideration of the possibility and raised the possibility that in fact there must be some other explanation, including and in particular that there has been some mix-up in the laboratory of specimens?

A. Well, as has been stated, this was never described in the laboratories at St. Vincent's Hospital. Indeed it is a very rare event in histopathology laboratories throughout the world thankfully because we depend greatly on the integrity of the pathology report. Three pathologists had looked at this. The diagnosis was confirmed. It was never questioned. So I think doing an endoscopy to either help in planning of the operation or to review the diagnostic process would have still left you with what to do about a positive diagnosis of gastric cancer in a young man, admittedly a very young man to have that diagnosis. But as we have seen in the literature, it is present, it occurs in young patients, albeit rarely.

417 Q. On that point, have you come across it in your own practice?

A. I have. I would have an experience over 20 years of about 600 oesophageal gastrectomies.

Mr. Justice Lavan: 600?

A. Cancers of the oesophagus and/or stomach. In those 600 I have dealt with three patients, one of whom was 19, one of whom was 29 and one of whom was 30.

418 Q. Mr. Hanratty: The suggestion really is that such a thing is so rare that you almost shouldn't believe it in your practice if you come across it and you should start looking more or less immediately for another explanation?

A. Well certainly if it is presented in a particular manner, maybe yes. But in this case the specimen went to the laboratory. The laboratory reported it as gastric cancer. No-one had any reason to believe the events that subsequently transpired. Therefore, the die was cast to some extent. And you would not on a day-to-day basis start querying have you mixed it up down in the laboratory.

419 Q. The evidence in this case was that initially it was a frozen section specimen that was sent to the laboratory for frozen section analysis while the original operation was being done.

A. Correct.

A. my view absolutely appropriately. He did the appropriate operation. He cleared out the lymph glands, as you would in somebody that age, with an aggressive operation for a gastric carcinoma.

431 Q. Could I finally refer you to the last page of your report in front of you?

A. I do.

432 Q. This is at Tab 1 of our book, Judge. Where you address your mind to what was the real cause of the problem in this case, you say:

"Alan O'Gorman unfortunately had his stomach removed because of a mis-diagnosis of gastric carcinoma. This was due to a laboratory error where patient's specimens got mixed up. Mr. Geoghegan was invited to deal with the

definitive surgery after the diagnosis had been confirmed. The die was cast in relation to Mr. Geoghegan's subsequent dealings with the case. In my view he acted entirely appropriately on the basis of the clinical and pathological diagnosis applied. Specifically Mr. Geoghegan was not negligent in his dealing with case".

What is being put in essence to Mr. Geoghegan is as follows: The hospital made a serious error, as a result of which a mix-up in specimens occurred, as a result of which a correct diagnosis was made but unfortunately on a sample from the wrong patient. But Mr. Geoghegan is still responsible in whole or in part for the fact that this unfortunate patient lost his stomach. What is your view on that proposition?

A. I think given the relationship between surgery and pathology, as Prof. O'Sullivan has pointed out, it is core to the clinical care of patients. Mr. Geoghegan was given the diagnosis from the pathology laboratory of a gastric cancer, verified by two or three pathologists. He had the support of a second opinion. He looked after this young man in the appropriate manner given the diagnosis that was given.

End of direct examination of Mr. Broe by Mr. Hanratty. Mr. Broe then cross-examined as follows by Mr. Fitzsimons:

433 Q. Mr. Fitzsimons: I gather, Mr. Broe, from your comments there that once Mr. Geoghegan was presented with the diagnosis basically he had no other function in the matter other than to get on with the management of the case?

A. Surgeons object to being called technicians, but surgeons are trained to do surgery. They are involved in the diagnostic process but that doesn't mean they have to go and re-invent the wheel every time a case is presented to them and re-do every single diagnostic investigation. So I would have thought that for Mr. Geoghegan, given the sort of information he was getting from several pathologists and from his colleague Prof. Traynor, there was really no reason to question on his part could there be something very odd going on here, since we know that gastric cancer can I accept the evidence of Mr. Broe.

Tendered in evidence by the seventh named defendant was a diagram showing the organisation and responsibilities within the Pathology Department of the Hospital. It was confirmed that this represented the organisation of that department at the time the serious error was made.

It is not in issue that prior to that time this department was organising itself for an important certification as to its excellence. Likewise, it is not in issue that any error had ever occurred in that department from its foundation prior to the date the seventh named defendant received this erroneous report.

At pages 95 and 96 of Professor Elder's cross-examination by Mr. Hanratty the witness expressly declined to allege negligence against Mr. Brown, the Glasgow pathologist, and Mr. Sheahan, the Hospital pathologist. Nonetheless, he confirmed his view that the seventh named defendant, as a clinician, had a greater duty than that of the two pathologists.

Conclusion

76. I am satisfied in the exceptional circumstances of this case that an endoscopy was not necessary having regard to the prior investigations carried out by Dr. Egan and I conclude with the clear view that a surgeon is not expected to be a pathologist, given the sophisticated pathology department which was provided for him by the first defendant (the hospital) which was relied upon by consultant surgeons since the creation of the pathology department.

77. As to the dispute as to the location of the problem in the stomach I prefer the evidence adduced by the seventh named defendant and his witnesses.

78. Taking the evidence of Professor Elder and keeping in mind his view of the mislabelling of the plaintiff's sample as being a salient event in this case, before going on to assess the seventh named defendant's conduct as negligent and having regard to the other matters already referred to, then comparing same to the witnesses adduced by the seventh named defendant, I conclude that Professor Elder's opinion on the need for an endoscopy is a counsel of perfection based on hindsight. He was not aware of Irish law and the test laid down for assessing medical negligence when he wrote his opinion on 31st October, 2004.

79. I therefore accept the evidence of the seventh named defendant and his witnesses and conclude, in the unusual circumstances of this case, that it would be unfair to make a finding of negligence against him. The hospital has ignored the specialisation of its pathology department. In failing to call evidence from that department of its specialists, its protocols and the history of its surgeons relying on its pathology reports, it has placed the seventh named defendant in a most invidious position with regard to his vindicating his professional reputation.

80. This Judgment is approved on the 5th December, 2006.