THE COURT OF APPEAL

Neutral Citation Number: [2016] IECA 281

[2015 No. 311]

Peart J.
Irvine. J.
Hanna J.

BETWEEN

LINDA FARRELL

PLAINTIFF/APPELLANT

AND

JOHN RYAN

DEFENDANT/RESPONDENT

JUDGMENT of Ms. Justice Irvine delivered on 14th day of October 2016

1. This is the plaintiff's appeal against the judgment of the High Court (Cross J.) delivered on 1st May, 2015, and the consequential Order of the Court dated 19th May, 2015. There is also a cross-appeal by the defendant. In his judgment, the High Court Judge rejected the plaintiff's claim for negligence against the Coombe Hospital. That claim concerned a procedure known as a symphysiotomy which was carried out on the plaintiff on 25th September, 1963, by the then Master of the hospital, Dr. James Stuart, some 12 days prior to the birth of her first child, Vanessa.

2. Core to this appeal is whether the trial judge erred in law or in fact in concluding that the plaintiff had failed to establish that there was "no justification whatever, in any circumstances, for the performance of an antenatal symphysiotomy on the plaintiff at the time it was performed".

3. The reason why the judge formulated his decision in the aforementioned terms was as an indirect result of a plea raised by the defendant at para. 2 of his defence. That plea was to the effect that the plaintiff's claim should be dismissed by reason of her inordinate and inexcusable delay in the manner in which she had pursued her proceedings. In the alternative, the defendant maintained that the passage of time between the events, the subject matter of the proceedings and the trial warranted the dismissal of the claim in circumstances where there was a real and serious risk that the defendant could not be afforded a fair trial. In particular, the defendant relied upon the fact that those responsible for the plaintiff's antenatal assessment and clinical management were, as a result of the passage of time, no longer in a position to give evidence.

4. By letter dated 10th October, 2014, the plaintiff's solicitors, in an effort to stave off the risk that her action might be dismissed by reason of delay and resulting prejudice, wrote to the defendant advising that the case was being re-formulated and would proceed on one issue only, namely:-

> "That there was no justification whatever, in any circumstances, for the performance of an antenatal symphysiotomy on the plaintiff at the time it was performed."

5. The aforementioned wording has its origins in the judgment of the Supreme Court in another symphysiotomy case, *Kearney v. McQuillan* [2010] 3 I.R. 576, that being a case in which a symphysiotomy had been carried on the mother, Mrs. Kearney, by her obstetrician, Dr. Connolly, at our Lady of Lourdes Hospital Drogheda, following the delivery of her baby by Caesarean section. In *Kearney*, the defendants, being the hospital and relevant Health Board, sought an order preventing the plaintiff's claim from proceeding by reason of inordinate and inexcusable delay. They claimed insurmountable prejudice due to the unavailability of certain witnesses. In the High Court, Dunne J. acceded to that application.

6. In the course of the plaintiff's appeal against that decision, Hardiman J. expressed himself satisfied that in the event of the claim being reformulated in a manner similar to that advised by the plaintiff's solicitors in the instant case, Mrs. Kearney's claim could be maintained without undue prejudice to the hospital. He was satisfied to accept Counsel's reformulation of the liability issue in the following terms namely:-

> "That there was no justification whatever, in any circumstances, for the performance of symphysiotomy on the plaintiff at the time it was performed and following delivery by Caesarean section."

7. Hardiman J. considered that the claim so reformulated would avoid the prejudice that would otherwise be suffered by the defendants in defending the action as originally pleaded. As to how it might be defended, at para. 17 of his judgment, he noted as follows:-

> "It should be recorded that, in further discussions with the court, counsel for the plaintiff conceded that the case, reformulated as it was, would be defeated if the first defendant could establish any circumstances in which, in the circumstances prevailing in Ireland in the year 1969, and in the circumstances of this case, a symphysiotomy could have been justified by a consultant gynaecologist. In other words, the first defendant may, if the action is permitted to proceed, defeat the plaintiff's claim on a hypothetical basis and will not be itself defeated simply because its defence, by reason of the absence of Dr. Connolly and his consultant colleagues of the time, can only be hypothetical."

8. He further acknowledged that the hospital would continue to have available to it the defence suggested by the second of the principles advanced by Finlay C.J. in *Dunne (an infant) v. National Maternity Hospital* [1989] I.R. 91 at 109, namely:–

> "If the allegation of negligence against a medical practitioner is based on proof that he deviated from a general and approved practice, that will not establish negligence unless it is also proved that the course he did take was one which no

medical practitioner of like specialisation and skill would have followed had he been taking the ordinary care required for a person of his qualifications."

9. Hardiman J. at para. 19 concluded his observations as to the effect of the reformulation with the following statement:-

> "It appears to the court that, by reason of the reformulation of the case the first defendant is relieved of the necessity to establish specific indications, perceived by Dr. Connolly, and justifying the carrying out of the symphysiotomy. It is enabled to defend the case by establishing in credible evidence some realistic reason for the procedure in the circumstances actually prevailing in relation to the plaintiff in 1969. The most immediately relevant of these circumstances would appear to me that, prior to the symphysiotomy, her baby had been delivered by caesarean section."

10. Thus, when this action proceeded in the High Court on the claim as reformulated, three issues required determination:–

> (i) Whether the plaintiff's claim should be dismissed by reason of delay and prejudice notwithstanding its reformulation in the terms earlier advised.
>
> (ii) Whether the claim was statute barred.
>
> (iii) Liability based upon the claim as reformulated.

11. The plaintiff's appeal is in effect confined to the third of these issues and the defendant's cross appeal to the second. The defendant's cross appeal, as it relates to the determination of the High Court judge that the plaintiff's claim was not statute barred, is the subject matter of a judgment authored by my colleague, Peart, J. Accordingly the facts which are particularly material to the cross appeal will not be dealt with in this judgment.

Background Facts

12. The plaintiff was born on 9th January, 1939. She left school when she was 15 years of age and married her husband, Richard, in May, 1961. She became pregnant for the first time in December, 1962 and had an expected delivery date of 7th September, 1963. On 18th September, 1963, she was admitted to the Coombe Hospital.

13. The plaintiff underwent X-ray pelvimetry, a diagnostic tool, which was reported upon on 23rd September, 1963. This is what the report said:-

> "X-ray report
>
> 23.9.63 Generally contracted.
>
> Anthropoid, sub-pubic arch narrow.
>
> TC. 10.8 T. 10.5
>
> Foetus is small, but there is some disproportion, also outlet is diminished."

14. On 25th September, 1963, the plaintiff was taken to theatre where she underwent a general anaesthetic. The note of what occurred while she was under anaesthesia is recorded in the following manner:-

> "25/9/63 symphysiotomy under G.A. The Master. Dr. McCarney. On EUA the head could not be made to engage in the pelvis. Symphysiotomy performed. Minimal bleeding. No difficulty. Good one inch gap obtained between symphysis."

15. Twelve days later, on 7th October, 1963, at 5:45 a.m, the plaintiff's daughter, Vanessa, was delivered with the assistance of forceps.

16. The plaintiff was discharged from hospital on the 17th October, 1963. Some five years later, on 1st December, 1968, the plaintiff delivered her second baby in the same hospital. Records describe that delivery as an "easy, low forceps after preliminary episiotomy. Infant in good condition".

17. In the High Court, the plaintiff gave evidence that she knew she had been cut across the lower end of her stomach in the course of the procedure that had been carried out on her on the 25th September, 1963, while under general anaesthetic. However, she maintained that she didn't know that she had had a symphysiotomy until 2011. In describing her symptoms post symphysiotomy and prior to birth, she recalled feeling as if she had been "split open" or "split in half" immediately following the procedure. In particular, she remembered feeling unstable when walking.

18. In all of the years that followed her daughter's birth, the plaintiff maintained that she had suffered from back pain, hip pain, some urinary incontinence as well as a number of psychological problems, all of which she, in her own mind, had ascribed to the birth of her daughter rather than to the symphysiotomy.

19. Ultimately, following the sequence of events described in the judgment of my colleague, Peart J., the plaintiff commenced the within proceedings by way of personal injury summons on 6th September, 2012.

Medical terms

20. Before dealing with the judgment of the High Court judge, I believe it may be of assistance to the reader if I briefly engage, in an uncontroversial fashion, with some of the medical terms and procedures which are referred to in the course of his judgment and which will be touched on again later in this judgment.

21. It goes without saying that to be born by the vaginal route, the foetus needs to be propelled from within its mother's abdomen through the pelvis and birth canal before being delivered into the outside world. That passage was described by Professor John Bonnar, Consultant Obstetrician, in the course of his evidence in these proceedings, as the most dangerous voyage that any human will ever make. There are certain conditions and circumstances which may render that passage perilous. A number of these, including a condition known as Cephalopelvic Disproportion *(CPD)*, are to the forefront of these proceedings.

22. As to the meanings to be attached to some of the more relevant medical terms, I will start by borrowing the following helpful

paragraph from p. 3 of the judgment of MacMenamin J. in *Kearney v. McQuillan* [2012] IESC 43:-

> "A *symphysis* is a joint in which the bones are separated by fibro-cartilage which minimises movement and makes the bony structure rigid. A cartilage is a dense connective tissue composed of a matrix of cells, closely interconnected. A *fibro-cartilage* is a type of strong cartilage in which there are dense bundles of fibres in the matrix. The *pubic symphysis* is the joint between the pubic bones of the pelvis. A symphysiotomy, therefore, is the operation of cutting through the front of the pelvis at the *pubic symphysis* in order to enlarge the diameter of the pelvis and to allow delivery of a baby whose head is too large to pass [through] the pelvic opening in the mother."

23. A symphysiotomy carried out in advance of labour may be described with equal validity as a *prophylactic* or an *ante-natal symphysiotomy*. In the course of this judgment I will refer to the procedure as prophylactic symphysiotomy.

24. The following terms are also of relevance:-

> • *Cephalopelvic Disproportion* (CPD): This is a condition described as occurring when the foetal head is disproportionately large for the pelvis through which it must pass. That disproportion may be mild, moderate or severe/absolute.
>
> • *X-ray pelvimetry*: This is a radiological procedure which was, according to the defendant's experts, considered a useful tool for the purposes of assessing the patient's risk of *Cephalopelvic Disproportion*. From this examination various measurements were possible, if not always accurate. These included *the True Conjugate*, the *Transverse Diameter* and the size of the *pelvic outlet*.
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> • *Examination under anaesthetic* (EUA): Such an examination was, according to the defendant's experts, another diagnostic tool used for the purpose of trying to assess whether or not the foetus would likely pass through the pelvis in the course of labour and to obtain valuable information as to the possible degree of CPD present in any given case.
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> • *Muller Munro Kerr manoeuvre*: This was a manoeuvre carried out in the course of *EUA* to see if the baby's head could descend into the pelvis.
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> • *True Conjugate ("TC")*: As per Dr. Boylan's evidence, this is "a measurement taken from the top of the pubis over to the sacral promontory." The measurement is achieved by X-ray and 11.5 cm is considered normal.
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> • *Transverse diameter ("T")*: This is the diameter of the pelvic inlet, measured between the terminal lines. The measurement is obtained by X-ray pelvimetry. A measurement of 13.5cm is considered to be normal.
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> • *Sub pubic arch*: The Pubic arch is the notch formed by the inferior rami of the two conjoined pubic bones as they diverge from the midline. This should be round so that a baby's head fits in. Professor Bonnar noted that "normally the subpubic arch would be in excess of 90 degrees because the baby's head has to fit under it when it's being born. If the arch is narrow, the head can't get the space and there is a risk of arrest at the outlet."
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> • *Pelvic outlet*: This is the lower opening of the true pelvis, bounded anteriorly by the pubic arch, laterally by the rami of the ischium and the sacrotuberous ligament on either side, and posteriorly by these ligaments and the tip of the coccyx. Mr. Bowen Simpkins remarked that the outlet is composed of the subpubic arch and the coccyx at the back which can bend out of the way in the course of delivery.
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> • *Anthropoid pelvis*: This is a pelvis in which the transverse diameter is markedly reduced. It is a shape in between the classic female and male shaped pelvis.
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> • *Sub pubic angle*: This is the angle that is formed just below the pubic symphysis by the meeting of the inferior ramus of the pubis on one side with the corresponding part on the other side and that is usually less than 90° in the male and usually more than 90° in the female.
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> • *Contraction*: This is the anatomical description of the shape of the pelvis.
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> • *Outlet Contraction*: According to Mr. Bowen Simpkins this condition exists if the patient has a "very small measurement at the (pelvic) outlet".

25. It is important at this early stage of the judgment to acknowledge that the plaintiff has at all times maintained that while X-ray pelvimetry and examination under anaesthesia were, at the relevant time, considered helpful in terms of assessing whether a patient might be suffering from mild or moderate *Cephalopelvic Disproportion*, they were not capable of actually diagnosing that condition. Such a diagnosis could only be made in the course of labour.

The High Court Hearing

26. The following is a somewhat truncated summary of the case advanced by the plaintiff in the High Court. The plaintiff's arguments are noted commencing at p. 28 of the trial judge's judgment. These were as follows:-

> (i) That there was no clinical justification for the prophylactic symphysiotomy carried out on the plaintiff. There was no evidence from which a clinician of Dr. Stuart's expertise could have concluded that the plaintiff might not have delivered vaginally. Clinicians could only suspect CPD. A diagnosis of CPD was a functional diagnosis that could only be made in the course of labour. Hence, the only reasonable option was to allow Mrs. Farrell a trial of labour. Symphysiotomy was an operation of last resort and its use was limited to an unforeseen crisis of outlet obstruction and then only in the context of a trial of labour. In a case of absolute disproportion, a Caesarean section was always indicated. For suspected cases of mild or moderate CPD, as was suspected in Mrs. Farrell's case, the options were a trial of labour, or Caesarean section.
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> (ii) That, in 1963, the potential risk to women from repeat Caesarean sections could not have provided any valid justification for the plaintiff's symphysiotomy.
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> (iii) That prophylactic symphysiotomy could not be stated to have been a general and approved practice as per the second principle in *Dunne (an infant) v. National Maternity Hospital* [1989] I.R. 91. Such literature as was relied upon by the defendant to support this practice consisted of nothing more than reports written by those clinicians who performed prophylactic symphysiotomy.

(iv) That in the event of the Court concluding that prophylactic symphysiotomy was a general and approved practice, it was one which was inherently defective and as such was indefensible.

27. The trial judge summarised the defendant's case starting at p. 31 of his judgment:-

(i) That, having regard to the prevailing state of medical knowledge and practice in 1963, the findings on X- ray pelvimetry and the examination carried out on the plaintiff under general anaesthetic, it was reasonable for Dr. Stuart to have concluded that the plaintiff could not have delivered her baby vaginally without surgical intervention such that a prophylactic symphysiotomy was a reasonable approach to adopt.

(ii) That at the relevant time it was acceptable to perform a prophylactic symphysiotomy in the presence of clinical findings of a contracted pelvis or disproportion to the extent that an unsuccessful trial of labour could be anticipated. Such circumstances were present in Mrs. Farrell's case in that, *inter alia*, her pelvic measurements were consistent with mild to moderate brim disproportion and moderate outlet contraction.

(iii) That prophylactic symphysiotomy was a general and approved obstetric practice in carefully selected cases in 1963, even if it could be said that in earlier and later years that this was not so. It provided benefits for the mother in terms of her then current and future pregnancies, was neutral as to the outcome for the baby and avoided the risks of repeat Caesarean sections for women who were likely to have a number of pregnancies.

(iv) The fact that many medical experts in Britain and some within Ireland disagreed with the practice of prophylactic symphysiotomy did not mean that the practice should not be considered to be a general and approved practice.

(v) That prophylactic symphysiotomy as practised in 1963, in the presence of certain clinical findings, could not be considered to be inherently defective such as to amount to a breach of the principles outlined in *Dunne*.

Findings of the High Court Judge

28. The first finding made by the High Court judge was that, having regard to the manner in which the plaintiff's claim had been reformulated in her solicitor's letter of 10th October, 2014, the defendant was not prejudiced in his defence to the point that the claim should be dismissed.

29. The second finding of Cross J. was that the plaintiff's state of knowledge, for the purposes of s. 2 of the Statute of Limitations (Amendment) Act 1991, was the date upon which she had received her medical records from the Coombe Hospital, namely August, 2011. That being within the permitted two-year statutory period, her claim was not statute barred.

30. The trial judge's consideration of the issue of liability commences at p. 21 of his judgment where he noted that the first symphysiotomy was carried out in Paris in 1777. Thereafter he traced its use in Dublin's three maternity hospitals from the early 1940s through to the end of the 1960s. He did this by reference to a number of publications and reports wherein the procedure was discussed. He referred to the views of the authors as to the indications and/or circumstances in which symphysiotomy might be deployed. He noted that the procedure became more popular in Ireland during the late 1940s because of the increased numbers of births after the Second World War and the views of treating clinicians at the time that Caesarean section was a procedure which was not devoid of danger. This was especially so in cases where mothers might require repeat Caesarean section because of CPD.

31. The trial judge referred to a number of texts and articles and in particular those authored by Alex Spain (Master of the National Maternity Hospital 1942 to 1948) and A.P. Barry (Master 1949 to 1955) which considered the indications which might justify symphysiotomy. He acknowledged that the procedure as performed on the plaintiff, insofar as it was performed prophylactically, did not fall into the categories proposed by Spain and Barry at the time they authored those articles. However, he went on to note that in the following decade the circumstances in which prophylactic symphysiotomy was considered appropriate were expanded upon and that the procedure became more prevalent in the Dublin hospitals. He recorded the relevant statistics as follows:–

(i) Coombe Hospital: 1959 to 1962. 42 symphysiotomies of which 17 were prophylactic.

(ii) National Maternity Hospital 1960 to 1962. 47 symphysiotomies of which 15 were prophylactic.

32. The trial judge was satisfied that the increased use of prophylactic symphysiotomy was the result of the belief of clinicians that with the assistance of X-ray pelvimetry and EUA they could predict cases in which vaginal delivery would either not be possible or where they were likely to run into complications. In a limited number of these cases, it was believed that prophylactic symphysiotomy would permit the patient to have a vaginal delivery and that this was preferable to Caesarean section.

33. The High Court judge also referred in some detail to the Annual Reports produced by each of the Dublin maternity hospitals concerning their practices in any given year. These described their "Annual Transactions". He noted that these transactions were the subject matter of robust discussion by leading clinicians at meetings of the Royal Academy of Medicine. Visiting experts would debate and test the contents and conclusions reported in the Annual Transactions which, he noted, were published in the Irish Journal of Medical Science. He also referred to the fact that the role of symphysiotomy as deployed in the Dublin hospitals was carefully recorded and was subject to open and transparent review. He noted that the use of the symphysiotomy procedure as practised in what was described as the "Dublin school" was acknowledged in a number of English texts where it was accepted that symphysiotomy had a limited role in childbirth.

34. The trial judge, in the course of his judgment, also drew attention to the comments made by Ian Donald, a leading Scottish obstetrician, in his 1959 publication *Practical Obstetric Problems*, 2nd Ed., (London, 1959) where he stated as follows at p. 432 in relation to symphysiotomy:-

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

35. The High Court judge went on to note that the National Maternity Hospital in 1963, under its new Master, Dr. O'Driscoll, (1963-1969), strongly advocated "active management of labour" with the result that the use of prophylactic symphysiotomy rapidly declined and that this approach was followed in other maternity hospitals. The trial judge accepted that within a year or two of 1963,

prophylactic symphysiotomy could no longer have been categorised as a practice which attracted general approval.

36. The High Court judge concluded that in 1963, in the Dublin maternity hospitals, it was accepted that a trial of labour was not always required for a consultant to conclude that a vaginal delivery would not be possible and that in those cases a prophylactic symphysiotomy was a reasonable though limited option. In this context, it is understood that Cross J. was referring to the potential impossibility of vaginal delivery unaided by medical intervention. Such an approach was justifiable as symphysiotomy was not considered to have adverse effects for the mother, while it had the potential to protect her from the risks considered to be attached to multiple Caesarean sections and was safer for the child.

37. It is clear that the trial judge also concluded that prophylactic symphysiotomy was a practice which was widely accepted at the time by leading consultants, particularly in the Coombe Hospital and the National Maternity Hospital. The practice was one which was defended by the professionals of the time and there was combative peer review of the procedure at annual obstetric meetings which were attended not only by Irish obstetricians but by international experts. Further, there was no evidence of any peer criticism of the practice. Thus, he concluded that the plaintiff had failed to establish that her symphysiotomy was without justification.

38. Finally, the High Court judge expressed himself satisfied that prophylactic symphysiotomy was not a practice which could be considered to have inherent defects which ought to have been obvious to any clinician giving the matter due consideration. This was because obstetricians at the time held real fears concerning the risks to the mother from multiple Caesarean sections. Further, clinicians at the time appeared convinced that symphysiotomy was a relatively benign procedure with little by way of adverse sequelae for the mother and was a practice that was widely accepted by the leading consultants at the time.

39. It was on the aforementioned basis that the High Court judge ultimately concluded that while prophylactic symphysiotomy in 1963 was somewhat controversial, the plaintiff had not satisfied him that the practice could not be justified in accordance with the claim as reformulated on the facts of Mrs. Farrell's case.

The Appeal

Relevant Legal Principles

40. The role of the appellate court on an appeal such as the present one is not unfettered or unlimited. Its role is perhaps best described in the oft cited decision of McCarthy J. in *Hay v. O'Grady* [1992] I.R. 210. At p. 217 of his judgment, he describes the role of the Court in the following manner:-

> 1. An appellate court does not enjoy the opportunity of seeing and hearing the witnesses as does the trial judge who hears the substance of the evidence but, also, observes the manner in which it is given and the demeanour of those giving it. The arid pages of a transcript seldom reflect the atmosphere of a trial.
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> 2. If the findings of fact made by the trial judge are supported by credible evidence, this Court is bound by those findings, however voluminous and, apparently, weighty the testimony against them. The truth is not the monopoly of any majority.
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> 3. Inferences of fact are drawn in most trials; it is said that an appellate court is in as good a position as the trial judge to draw inferences of fact.... I do not accept that this is always necessarily so. It may be that the demeanour of a witness in giving evidence will, itself, lead to an appropriate inference which an appellate court would not draw. In my judgment, an appellate court should be slow to substitute its own inference of fact where such depends upon oral evidence or recollection of fact and a different inference has been drawn by the trial judge. In the drawing of inferences from circumstantial evidence, an appellate tribunal is in as good a position as the trial judge.
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> 4. A further issue arises as to the conclusion of law to be drawn from the combination of primary fact and proper inference.... If, on the facts found and either on the inferences drawn by the trial judge or on the inferences drawn by the appellate court in accordance with the principles set out above, it is established to the satisfaction of the appellate court that the conclusion of the trial judge as to whether or not there was negligence on the part of the individual charged was erroneous, the order will be varied accordingly.

41. The same issue was dealt with by O'Higgins C.J. in the course of his judgment in *Northern Bank Finance v. Charlton* [1979] I.R. 149. At p. 180, he stated as follows:–

> "A judge's findings of fact can and will be reviewed on appeal. Such findings will be subjected to the normal tests as to whether they are supported by the evidence given at the trial. If such findings are firmly based on the sworn testimony of witnesses seen and heard and accepted by the judge, then the court of appeal, recognising this to be an area of credibility, will not interfere."

42. Regardless of the reformulation of the plaintiff's claim, a subject to which I will later return, it is nonetheless relevant to note the test for medical negligence as described in the decision in *Dunne (an infant) v. National Maternity Hospital* [1989] I.R. 91. At p. 109 of his judgment Finlay C.J. summarised the relevant principles as follows:–

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

5. It is not for a jury (or for a judge) to decide which of two alternative courses of treatment is in their (or his) opinion preferable, but their (or his) function is merely to decide whether the course of treatment followed, on the evidence, complied with the careful conduct of a medical practitioner of like specialisation and skill to that professed by the defendant.

43. To make the general principles applicable to the facts of the *Dunne* case, Finlay C.J. provided the following further guidance commencing on p.109:–

(a) "General and approved practice" need not be universal but must be approved of and adhered to by a substantial number of reputable practitioners holding the relevant specialist or general qualifications.

(b) Though treatment only is referred to in some of the statements of principle, they must apply in identical fashion to questions of diagnosis.

(c) In an action against a hospital, where allegations are made of negligence against the medical administrators on the basis of a claim that practices and procedures laid down by them for the carrying out of treatment or diagnosis by medical or nursing staff were defective, their conduct is to be tested in accordance with the legal principles which would apply if they had personally carried out such treatment or diagnosis in accordance with such practice or procedure.

The Appellant's Submissions

44. Dr. Craven S.C. on behalf of the plaintiff, submits:-

(i) That there was no credible evidence to support the trial judge's conclusions that the plaintiff had clinical features or signs of disproportion such as would have justified a prophylactic symphysiotomy in 1963.

(ii) That even if there were clinical signs to suggest disproportion, there was no credible evidence to support a conclusion that prophylactic symphysiotomy was a general and approved practice to be adopted in such circumstances i.e. in the case of a patient suffering from mild or moderate CPD. In particular, he submits that for the purposes of considering whether such a practice might be considered to be "general and approved" within the meaning of the Dunne principles, that assessment was not to be circumscribed by reference to the practice in Dublin at the time and had to embrace international practice and teaching. There had to be an external analysis of the practice. The fact that there may have been vigorous discussion about prophylactic symphysiotomy in Ireland at the relevant time could not elevate that procedure into what might be considered in legal terms to be a generally approved practice.

(iii) That even if the High Court judge was entitled on the evidence and as a matter of law to conclude that prophylactic symphysiotomy could be considered to have been a general and approved practice within the meaning of the Dunne principles, on the evidence before him he was mandated to conclude that the practice had inherent defects which ought to have been obvious to any person giving the matter due consideration. In particular he maintained that the evidence established that the concerns of clinicians which lead them to favour prophylactic symphysiotomy, such as the risks attached to repeat Caesarean section, had not been borne out. He relied, inter alia, upon Hugo McVey's, "The Treatment of Disproportion by Combined Lower Segment Caesarean Section with Symphysiotomy", (1955), I.J.M.S. 299 and the paper by O'Driscoll and Meagher, "Maternal Mortality in the Dublin Hospitals: 1950-1960", (1962), 69(2) I.J.O.G. 248 which concluded that Caesarean section was a safe operation not associated with serious obstetric handicap in the early 1960s.

The Respondent's Submissions

45. Ms. Egan S.C., on the defendant's behalf submits that:-

(i) There was credible evidence to support the findings of the trial judge that, in the circumstances as they related to Mrs. Farrell, prophylactic symphysiotomy was medically justified. She relied upon the expert evidence as to the findings on X-ray pelvimetry and the findings of Dr. Stuart in the course of the EUA. The pelvis was small, generally contracted, and was veering towards android in shape and the sub pubic arch was narrow. The latter finding was suggestive of less available space for the baby to get out and was considered to be a form of outlet obstruction. The transverse diameter measurement indicated the possibility of a funnel pelvis or outlet obstruction. The words "outlet is diminished" appeared on the X-ray report and there was a statement as to the existence of "disproportion". Further, in the course of his EUA Dr. Stuart had not been able to make the baby's head engage in the pelvis.

(ii) There was credible evidence to support the conclusions of the trial judge that the carrying out of a prophylactic symphysiotomy on Mrs. Farrell in 1963, having regard to the clinical findings, was in accordance with a general and approved practice among clinicians of equivalent experience to Dr. Stuart. The evidence had established that during the 1960's prophylactic symphysiotomy was an approved and appropriate procedure and was a justifiable alternative to a trial of labour where the clinician was satisfied that there was a reasonable risk of mild to moderate disproportion which might be alleviated by that procedure.

(iii) There was more than sufficient evidence to support the trial judge's conclusion that prophylactic symphysiotomy was not a procedure which at that time could have been considered inherently defective. There was significant evidence before the Court as to the risk of mortality pertaining to Caesarean section. There was evidence that in 1963 women in Ireland were prone to having large numbers of children because of the lack of artificial contraception and the fact that sterilisation was a practice not routinely available. There was also evidence that in cases where a woman had a Caesarean section because of CPD that she would likely require a repeat Caesarean section on all subsequent deliveries thus significantly increasing her risks in terms of mortality and other surgical complications which would be avoided in the event of a symphysiotomy being carried out on her first delivery. There was also credible evidence to support the belief of clinicians at the time that symphysiotomy, as a procedure, had little by way of adverse affect for mothers on whom this procedure was carried out.

What was not in Dispute between the Parties

46. It was not seriously disputed that in 1963 symphysiotomy had some role to play in the context of an obstructed labour. A clinician might, with general approval have moved to deliver a baby so obstructed by Caesarean section or perhaps even by symphysiotomy if satisfied that by carrying out such a procedure he could render the pelvic cavity sufficiently favourable to a vaginal delivery. An example of such support referred to in the course of evidence was Cunningham, *A Textbook of Obstetrics*, 4th Ed., (London, 1964) where in chapter 2 at p. 288, it was stated that if the trial of labour wasn't going well but mother and child were in good condition symphysiotomy would often permit rapid progress.

47. It was also not contested that in cases where a clinician, in advance of labour, was satisfied that there was evidence of absolute CPD or other clinical findings which established with certainty that the mother would not be able to deliver her baby vaginally, it was standard practice to perform a Caesarean section.

48. The parties were agreed that the clinical signs and objective findings following Mrs. Farrell's X-ray pelvimetry and EUA were not indicative of absolute CPD but rather suggested the presence of mild to moderate CPD.

49. Finally, the plaintiff did not dispute the evidence of Professor Bonnar, with which Dr. Boylan was in agreement, that it was 90% certain that had Mrs. Farrell been afforded a trial of labour, as was advised was necessary by the plaintiff's experts, she would not have been able to deliver her baby without surgical intervention either by way of symphysiotomy or Caesarean section. A point would have come during her labour, when Dr. Stuart would have to have performed one or other procedure, with all of the attendant consequences of such intervention. Dr. Boylan stated "so it is likely that she would have had a prolonged labour and either a symphysiotomy or an emergency caesarean section after many hours in labour."

Discussion

50. The plaintiff's claim was canvassed in the High Court over some 15 days in the course of which the Court heard the evidence of numerous medical experts who were divided in their opinion as to whether there was any justification for prophylactic symphysiotomy in the circumstances of Mrs. Farrell's case in 1963.

51. On the plaintiff's behalf, the Court had the benefit of evidence from Mr. Peter Bowen Simpkins, consultant obstetrician and gynaecologist, and Mr. Garrett Thomas, a consultant of equivalent expertise. Both experts were committed to a view that there were no diagnostic tools available that would have justified a clinician deciding to proceed with a prophylactic symphysiotomy. They both cast doubt upon the value and validity of X-ray pelvimetry and EUA as tools to assist obstetricians making a diagnosis in such circumstances. However, it is worth noting that both experts were forced to retract these views under cross-examination. The fact that they did so was perhaps not surprising in circumstances where those tools were approved of strongly in Gibberd, *A Short Textbook of Midwifery*¸7th Ed., (London, 1960), upon which the plaintiff strongly relied in respect of the liability issue. This is what he said, at p. 323, concerning X-ray pelvimetry and EUA-:

> "In trying to arrive at a decision as to whether or not a head will pass through a pelvis, all the evidence must be taken into consideration and an opinion will be based chiefly upon the results of bi-manual estimation of disproportion, upon the absolute size of the pelvis as estimated by clinical and X-ray measurement, upon the shape of the pelvis as determined by X-ray, and upon an estimate of the size of the foetus."

52. Notwithstanding the aforementioned concessions by Mr. Bowen Simpkins and Dr. Thomas, both maintained that Mrs. Farrell's clinical signs suggested no more than potential mild or moderate CPD, a condition that could only be definitively diagnosed in the course of labour. That being so, her prophylactic symphysiotomy could not be justified.

53. The plaintiff's experts accepted that in certain cases, such as those of absolute CPD or in the presence of some other condition that would have rendered vaginal delivery impossible, an obstetrician would be justified in abandoning a trial of labour. However, in such circumstances, they advised that prophylactic symphysiotomy was not an option. A Caesarean section was what was mandated. That such was their evidence was hardly surprising given that symphysiotomy was only ever considered a viable option where the clinician considered that a baby might be delivered vaginally if a little more room were to be provided to allow the head to pass through the pelvis. The procedure could never avail the mother suffering from absolute CPD.

54. Leaving aside for a moment cases where the clinician might be satisfied as to the presence of absolute CPD, the plaintiff's experts, when under cross-examination, ultimately accepted that with the benefit of the results of X-ray pelvimetry and EUA, a clinician might reasonably conclude that a vaginal delivery was not likely and might, in such circumstances, proceed to carry out a Caesarean section.

55. An example of this line of evidence is to be found in an exchange between Dr. Thomas and the High Court judge in the course of which he accepted that in 1963 a clinician might decide, in advance of labour, that either contraction or disproportion was present sufficient to conclude that a trial of labour should not be undertaken and that other management was mandated, that other management being Caesarean section. It is to be noted in this regard that the plaintiff's experts accepted that Mrs. Farrell not only had indications consistent with mild to moderate CPD but that she was also reported as suffering from moderate outlet contraction. Dr Thomas said "you can take the view that suspicion is so high about the reduction of pelvic measurements that you would do an elective Caesarean section, I'm not disputing that."

56. That concession, in reality, put an end to the plaintiff's contention that a trial of labour was mandatory in any case of strongly suspected mild to moderate disproportion. That being so, the principal question to be addressed by the Court was whether, in the presence of clinical findings which strongly suggested that the patient would not be able to deliver vaginally by reason of suspected mild to moderate CPD and/or outlet contraction, the clinician could justify carrying out a prophylactic symphysiotomy as opposed to a Caesarean section. The plaintiff contended that the latter was the only proper and valid approach.

57. The plaintiff's experts also gave forceful evidence that in 1963 symphysiotomy was not a practice that enjoyed general approval. Its use was, they asserted, confined to countries where facilities were poor or non-existent or where Caesarean section was unavailable or unsafe. Symphysiotomy could not be justified in 1963 by reference to the risks attached to Caesarean section given that lower segment Caesarean section had been introduced in Ireland long before 1963, with the result of significantly reduced risks of mortality.

58. It is also important to record that the plaintiff's experts gave their evidence as to whether or not prophylactic symphysiotomy could be justified in the circumstances of the plaintiff's case in 1963, by reference to a wide range of articles, journals and textbooks published in the 1950s and 1960s, some of which were briefly referenced by the trial judge in his judgment.

59. In support of his defence of the proceedings, the defendant relied upon the evidence of Professor John Bonnar and Dr. Peter

Boylan, both of whom are highly regarded consultant obstetricians and gynaecologists, and also the evidence of Professor Mary Daly, a medical historian.

60. Suffice to state that Professor Bonnar and Dr. Boylan expressed themselves satisfied that the prophylactic symphysiotomy carried out on the plaintiff could be justified by reference to the clinical findings made on X-ray pelvimetry and EUA. They advised that in 1963, the procedure was one which was considered to be acceptable if the clinician apprehended that the mother had little prospect of delivering vaginally without surgical intervention in the course of labour, but where they were nonetheless convinced that a little more room would allow the patient deliver vaginally. They told the Court that the practice was approved of at the time because it allowed the babies of mothers with a degree of disproportion, which the clinician considered an impediment to childbirth without Caesarean section, be delivered vaginally. In such cases, prophylactic symphysiotomy would not only facilitate the delivery of the infant in question, but was seen as a practice which would protect the mother from the risks attached to Caesarean section, which was the alternative treatment option. It was also considered a procedure that would have the benefit of making the mother's pelvis more amenable to vaginal delivery on subsequent pregnancies, thus protecting her from the risks to which she would otherwise have been exposed on subsequent pregnancies.

61. Professor Bonnar advised that a mother who required a Caesarean section by reason of CPD would require the same procedure to be carried out on all subsequent deliveries, thus exposing her to all of the risks pertaining to such procedures. The risks to the mother of repeat Caesarean section were emphasised by reliance upon the writings of Chassar Moir in1964, Arthur Barry in 1952 and Hugo McVey who in 1955, in an article entitled "The Treatment of Disproportion by Combined Lower Segment Caesarean Section with Symphysiotomy" advised as follows:

> "Thus a young primigravida delivered by Caesarean section for disproportion faces a lifetime of repeat operations with all the hazards of uterine rupture, adhesions and bladder injury."

The defendant's experts also advised the Court that there was little knowledge at the time that the procedure was one which had significant or long-lasting effects for the mother.

62. As with the plaintiff's experts, Professor Bonnar and Dr. Boylan, each relied upon various articles, commentaries, publications and textbooks to support their view that Dr. Stuart's approach could be justified in the circumstances of Mrs. Farrell's case in 1963.

63. It is to be inferred from para. 11.4 of the judgment of the High Court Judge that he reached the following conclusions:–

> (i) That in deciding to perform a prophylactic symphysiotomy on the plaintiff, Dr. Stuart had relied upon the objective findings in the report on the X-ray pelvimetry and his own clinical findings on EUA.
>
> (ii) That his decision to perform the prophylactic symphysiotomy was driven by his professional judgement that it would not be possible for Mrs. Farrell to deliver her baby vaginally in the course of labour without operative intervention.
>
> (iii) That having concluded that the baby could not be so delivered; Dr. Stuart could reasonably justify proceeding to symphysiotomy without a trial of labour.
>
> (iv) That prophylactic symphysiotomy in such circumstances was a practice which was generally approved of and was one that could not be considered inherently defective.

Decision

64. This Court has had available to it all of the evidence which was presented in the Court below and Counsel have, with great capability, taken the Court through the relevant transcripts and documentary materials said to support their respective positions. In addition, the Court has had the benefit of extremely detailed and helpful written submissions. That said, it is not for this Court to rehearse that evidence, consider the written and oral submissions and then form its own view as to how the liability issue, as reformulated, would best be decided. Its role is not to set up its own scales on which to weigh and assess the evidence on each side of the argument, but rather, as per Hay v. O'Grady, to assess, inter alia, whether the findings of fact made by the trial judge are supported by credible evidence. If they are, then this Court is bound by those findings regardless of how voluminous or weighty the testimony against them. As was stated by McCarthy J., "truth is not the monopoly of any majority".

Clinical Findings and Justification

65. The plaintiff's claim in the High Court was premised on the contention that, at best, clinicians could have suspected mild or moderate CPD but could not have diagnosed the existence of disproportion without a trial of labour. Thus, there could have been no justification for Dr. Stuart performing a prophylactic symphysiotomy.

66. It should be said that following cross-examination, it was difficult for the plaintiff to stand over her original position which was that a trial of labour was mandated. Her experts had accepted that the clinical signs on X-ray pelvimetry and EUA might, in circumstances, guide the judgment of the clinician to a view that vaginal delivery was likely to be impossible, and that in such circumstances a trial of labour was not warranted. Thus, the height of the plaintiff's case was one which asserted that in such circumstances, there was no justification for Dr. Stuart deciding to perform a symphysiotomy as opposed to a Caesarean section.

67. It is to be inferred from the language used in para. 11.4 of his judgment that the trial judge was satisfied that in 1963 a consultant might, without a trial of labour, reasonably conclude that his patient was unlikely to be able to deliver vaginally such that he would be justified in carrying out a prophylactic symphysiotomy as opposed to giving her a trial of labour or performing a Caesarean section. In other words, absolute certainty as to the existence of or an actual diagnosis of CPD was not a necessary prerequisite for performing a prophylactic symphysiotomy. Neither was the clinician mandated in such circumstances to perform a Caesarean section.

68. As to the plaintiff's submission that there was no credible evidence to support the trial judge's conclusions in this regard, it is necessary to recall the backdrop to the expert opinion on that issue.

69. The parties were agreed that the plaintiff had a contracted pelvis with a narrow sub pubic arch. This was described as an anthropoid pelvis which is one that is narrower than usual. Mr. Bowen Simpkins agreed that this condition amounted to a form of outlet obstruction. The results of the pelvimetry demonstrated a reduced transverse diameter and the examination carried out under general anaesthetic established, as a matter of fact, that the baby's head could not be made to engage in the pelvis. Indeed, Professor Bonnar had drawn the Court's attention to the fact that the plaintiff had been contracting for seven hours the night before

the EUA but yet the baby's head had still not engaged. Further, it was his evidence that it was 90% certain that Mrs. Farrell would have had an obstructed labour and could not have delivered her baby without operative intervention. It is also perhaps worth noting that these clinical findings were, to a certain extent, later validated by the fact that on delivery it was noted that there was a "tight fit under the arch".

70. It is clear from the judgment of the trial judge that he considered in significant detail the evidence advanced by the plaintiff's experts in support of their assertion that there could have been no justification for the prophylactic symphysiotomy performed on Mrs. Farrell in 1963; likewise, their evidence that the procedure as performed in her case did not enjoy general approval among clinicians of equivalent expertise to that of Dr. Stuart. Indeed, the trial judge referred to a number of articles authored by prominent clinicians at the time expressing disapproval of the procedure of prophylactic symphysiotomy. One such was the report earlier referred to of Dr. Hugo McVey, a consultant in the Rotunda and Master there before Dr. Browne, entitled "The Treatment of Disproportion by Combined Lower Segment Caesarean Section with Symphysiotomy", (1955) I.J.M.S. 299. In that article, which concerned the proper treatment of disproportion, he referred, at p. 305, to a case in which prophylactic symphysiotomy was performed in the following manner:–

> "...another point merits condemnation: this patient was not allowed a trial of labour prior to symphysiotomy. If the patient did have a vaginal delivery on her next confinement the justifiable question could be asked:" how do you know she couldn't have done it the first time?" A question to which there is no answer because she was not allowed a trial of labour.
>
> This brings us to the question as to whether there is any place for prophylactic symphysiotomy, i.e. symphysiotomy before the onset of labour. It is unanimously agreed that the place of the operation is in minor or medium degree of disproportion. Admitted that this minor degree of disproportion is clinically and radiologically proved can even the most expert obstetrician state that the disproportion will not be overcome by asynclitism and moulding of the foetal head? Only a trial of labour with concurrent assessment of uterine forces, moulding, asynclitism and lateral deviation of the foetal head to the sacral bays will prove if the disproportion is insurmountable.
>
> It is easy to diagnose a minor degree of disproportion at 38 weeks, perform an immediate symphysiotomy and await a vaginal delivery two weeks later. If the patient then has a vaginal delivery, what is being proved? Precisely nothing. The question will still be asked: "How do you know she couldn't have had a vaginal delivery without symphysiotomy? A question to which there is no answer because there has been no trial of labour before symphysiotomy."

However, as was advised by Dr. Boylan when cross-examined concerning this article, he stated that the opinion of Dr. McVey was just one view on the matter. It goes without saying that an honest difference of opinion as between medical practitioners does not mean that a practice cannot be said to be one which enjoys general approval.

71. Another such report referred to by the trial judge was that of Chassar Moir, a professor in the department of obstetrics in Oxford who likewise published a number of articles disapproving of the practice of prophylactic symphysiotomy. What he said was that the practice did not "appeal to him". As Dr. Boylan advised, what he was stating was his opinion that while prophylactic symphysiotomy was a valid thing to do it did not appeal to him in the same way that repeat Caesarean sections did not appeal to the Dublin school of obstetricians. However, even Chassar Moir conceded that there was the odd case where symphysiotomy was justifiable or even ideal.

72. Having considered the submissions of the parties and the evidence available to the High Court Judge, I am fully satisfied that there was credible evidence to support his finding that the decision to carry out a prophylactic symphysiotomy in the circumstances of Mrs. Farrell's case was clinically justified by the standards which prevailed in 1963.

73. An example of such supportive evidence was tendered by Professor Bonnar who advised that in Ireland in 1963, prophylactic symphysiotomy had a role to play in cases of suspected mild to moderate disproportion where the clinical signs, such as in Mrs. Farrell's case, suggested that a vaginal delivery would not be possible but where with a little more space in the pelvis the baby might be delivered vaginally thus avoiding the need for Caesarean section.

74. Professor Bonnar told the Court that at the time prophylactic symphysiotomy was being practised, clinicians were particularly anxious to prevent the type of damage that was often caused to the mother and baby as a consequence of an obstructed labour and Mrs. Farrell was at high risk of having an obstructed labour. He advised that obstetricians faced with the type of clinical findings that presented in Mrs. Farrell's case, which suggested that the birth canal was unsafe, had to make a clinical decision as to how to manage the upcoming delivery. The decision was, according to Professor Bonnar, regularly made on the basis of X-ray pelvimetry and EUA in the course of which the Muller Munro Kerr manoeuvre would be used to assess if there was evidence of disproportion and if so the likely degree that might be expected. Depending on those findings, the clinician might decide to carry out a Caesarean section or alternatively decide to make the birth canal less hazardous by carrying out a prophylactic symphysiotomy.

75. Based on the X-ray pelvimetry and EUA, Professor Bonnar expressed himself satisfied that Dr. Stuart would firstly have been concerned about Mrs. Farrell's current pregnancy and how she was best to be delivered. In making his clinical decision as to how best to respond to the clinical findings and in opting for a prophylactic symphysiotomy he would have been trying to give her a vaginal delivery so as to avoid the risks attached to Caesarean section. He further advised that Dr. Stuart, in so deciding, would have been mindful of the fact that in correcting Mrs. Farrell's current and immediate problem he would be assisting her in terms of future deliveries and thus protecting her from the risks pertaining to repeat Caesarean deliveries. He felt that by the standards of the time, the approach taken by Dr. Stuart, having regard to Mrs. Farrell's clinical findings, could not be criticised.

76. It should be noted that the trial judge was referred to a significant body of literature, including an article authored by Donald in 1960, which endorsed the value and use of X-ray pelvimetry as part of good antenatal care and as an aid to diagnosing the possible presence of disproportion. He was also referred to a number of learned articles supporting the value of the performance of the Muller Munro Kerr manoeuvre under general anaesthetic as an aid to discern the favourability of the mother's pelvis to the foetal head. This was important evidence in the context of the challenge to the validity and/or value of these procedures as diagnostic aids by the plaintiff's expert witnesses, albeit that they later fully accepted the value of these diagnostic tools, having regard to the learned articles put to them in the course of cross-examination which supported the use of these tools for the purposes of seeking to assess the extent to which the mother might be suffering from CPD.

77. Professor Bonnar and Dr. Boylan both rebuffed the evidence of Mr. Bowen Simpkins and Dr. Thomas, that without an actual diagnosis of disproportion, which could only be made in labour, you could not justify symphysiotomy. Both stated that in 1963, where the clinical findings were not severe enough to justify an elective Caesarean section but where the clinician was satisfied as a result of X-ray pelvimetry and/or EUA that there was not sufficient room to get the baby through the pelvis without intervention, that symphysiotomy was a reasonable option if that procedure would likely allow the mother deliver vaginally. In such circumstances, a

trial of labour was not mandatory.

78. Dr. Boylan remarked that there were a small number of women who elected to have a symphysiotomy when their labour became obstructed and the baby could not be delivered. He considered prophylactic symphysiotomy carried out in advance of labour in circumstances such as presented in Mrs. Farrell's case, to be an improvement upon such a scenario as the symphysiotomy would be carried out in calmer circumstances and not in an emergency situation potentially in the early hours of the morning. He went on to state his opinion that the X-ray pelvimetry suggested that vaginal delivery would not have been an easy prospect for Mrs. Farrell and probably would not have been possible at all without a symphysiotomy. He also offered his opinion that based on the EUA, Mrs. Farrell was likely to have had a prolonged labour which would have resulted in either a symphysiotomy or emergency Caesarean section.

79. Dr. Boylan referred to the number of prophylactic symphysiotomies carried out in the three Dublin maternity hospitals and noted that:-

> "It is therefore clear that prophylactic symphysiotomy was a well recognised and accepted procedure, supervised and performed by the most senior obstetricians in the three Dublin maternity hospitals at the relevant time"

80. Dr. Boylan further remarked during cross examination that:-

> "Elective symphysiotomy such as what Mrs. Farrell had was considered to have a place in the armamentarium of the practising obstetrician at the time....
>
> We have been over that ground and it is clear that the most senior obstetricians in practice in Dublin, representing the Dublin school, as it was known, and that their decisions to do these symphysiotomies were highly respected by the visitors from the UK and it was considered an appropriate thing to do and, of course, it was highly successful."

81. The Court's attention was also drawn to Dr. Browne's contribution to the transactions of the Royal Academy of Medicine in Ireland, Discussion of the Maternity Reports, I.J.M.S. 6th series, 1962, speaking as the Master of the Rotunda he stated at p. 540 that:-

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

Clearly, the term "elective symphysiotomy" as used in the context of this quotation is what is described elsewhere in this judgment as "prophylactic symphysiotomy".

82. Dr. Barry, who was Master of the National Maternity Hospital, stated in the Annual Clinical Report for the year 1955, Barry, *Symphysiotomy*, (1956) I.J.M.S. at p. 39 that:-

> "Equally we believe that there is a small place for the elective operation in the management of breech presentation associated with contracted pelvis and in the management of contracted pelvis in the young primigravida where the success of a trial of labour seems at the outset a very unlikely proposition."

83. Attention was also drawn to the fact that Dr. Feeney, Master of the Coombe hospital, had altered the opinion which he had held in 1954 which was to the effect that he did not recommend the procedure in that by 1955 his opinion was that he would not ordinarily recommend the procedure. Additionally, Donald, *Practical Obstetric Problems*, 2nd Ed., (London, 1960) at p. 340 noted that there were a number of situations when a trial of labour would not be appropriate and listed among them cases of outlet contraction. In this regard it is relevant to note that Professor Bonnar, in the course of his evidence concerning Mrs. Farrell's presentation, remarked that "the outlet contraction is apparent in both the X-ray pelvimetry and the clinical examination, so it was an integral part of the pelvic contraction in this patient."

84. Without wishing to oversimplify the issue, the difference between the medical experts, before any concessions were made by the plaintiff's experts, was that the plaintiff maintained that because one could not diagnose with certainty the existence of mild to moderate disproportion without a trial of labour, an obstetrician could not justify performing a prophylactic symphysiotomy. The defendant's experts, on the other hand, were satisfied that a clinician might reasonably perform a prophylactic symphysiotomy in the presence of strong clinical indications, such as those available from X-ray pelvimetry and EUA, that the mother would likely have an obstructed labour. Those clinical findings were present in Mrs. Farrell's case. Accordingly, by 1963 standards it was possible to justify her symphysiotomy. Following the concessions made by the plaintiff's experts, and to which I have already referred, and in particular that of Dr. Thomas who accepted that labour was not the only test for disproportion and that a decision to intervene in advance of labour might be made based on the obstetricians clinical judgment as to the significance of findings on X-ray pelvimetry and EUA, the real contest was whether, in such circumstances, there could ever have been justification for opting to conduct a symphysiotomy rather than the Caesarean section which the plaintiff's experts urged was mandatory.

85. Hopefully it is clear from the evidence, to which I have referred, that there was ample evidence to support the trial judge's decision to reject the plaintiff's assertion that a symphysiotomy could never be justified without trial of labour. There was clearly evidence to support the alternative proposition and that the trial judge preferred, as he was entitled to do, the evidence of the defendant's experts. For similar reasons he was entitled to reject the plaintiff's claim that if a clinician had reasonably formed the view that the patient would not be able to deliver vaginally because of evidence of suspected moderate or mild disproportion, a Caesarean section alone was the only justifiable procedure

86. In these circumstances, I am quite satisfied that the plaintiff has not established any basis upon which this Court might reasonably interfere with the conclusions of the trial judge that the plaintiff had failed to establish that there "was no justification whatsoever in any circumstances for the performance of a symphysiotomy on the plaintiff at the time it was performed." For my part, I am entirely satisfied that there was credible evidence to support his conclusion that, based on the clinical findings on X-ray pelvimetry and EUA it could not be said that Mrs. Farrell's symphysiotomy could not in any circumstances have been justified.

Deviation from a General and Approved Practice

87. It is to be inferred from the judgment of Cross J. that he rejected the plaintiff's claim that prophylactic symphysiotomy, in circumstances such as existed in Mrs. Farrell's case in 1963, did not enjoy the status of a "general and approved" practice.

88. As was advised by Walsh J. in *O'Donovan v. Cork County Council* 1967 I.R. 173, whether a particular practice is a "general and

approved" one is an issue of fact to be determined in the same way as any other issue of fact. At p. 194, of his judgment this is what he said:–

> "If some witnesses say that a particular practice is a general and approved one and other medical witnesses deny that, then it is an issue of fact to be determined as any other issue of fact. This particular issue cannot be withdrawn from a jury merely because the practice finds support among some medical witnesses if there be others who deny the fact that it is a general and approved practice."

Accordingly, the High Court judge, having decided this issue in favour of the defendant, the question for this Court is whether there was credible evidence to support that finding.

89. Advice as to what may be considered to be a general approved practice is to be found in a number of the authorities referred to by the parties in their written and oral submissions. Accordingly, I will briefly refer to what I consider to be some of the more helpful guidance on the issue.

90. Finlay C.J., in *Dunne* advised at p. 109, that for a practice to be "general and approved", it need not be universal but must be approved of and adhered to by a substantial number of reputable practitioners holding the relevant specialist or general qualifications".

91. In *Purdy v. Lenihan & Ors.* [2003] IESC 7, Keane C.J., referred to the requirement that doctors act "in accordance with a recognised practice" and that they adopt a practice "which a substantial body of medical opinion would have favoured at the time".

92. In *Bolam v. Friern Hospital Management Committee* [1957] 1. W.L.R. 582 at p. 587, the issue of general and approved practice is discussed by McNair J. He stated as follows:-

> "I myself would prefer to put it this way, that he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. I do not think there is much difference in sense. It is just a different way of expressing the same thought. Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view."

93. The decision in *Bolitho v. City and Hackney Health Authority* [1998] A.C. 232 is also of significance. Browne-Wilkinson L.J, at p. 241, advised as follows:-

> "My Lords, I agree with these submissions to the extent that, in my view, the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. In the Bolam case itself, McNair J. [1957] 1 W.L.R. 583, 587 stated that the defendant had to have acted in accordance with the practice accepted as proper by a 'responsible body of medical men'.
>
> Later, at p. 588, he referred to 'a standard of practice recognised as proper by a competent reasonable body of opinion.' Again, in the passage which I have cited from Maynard's case [1984] 1 W.L.R. 634, 639, Lord Scarman refers to a "respectable" body of professional opinion. The use of these adjectives – responsible, reasonable and respectable – all show that the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter."

94. In *Kearney* in the Supreme Court MacMenamin J. stated as follows concerning the issue of "general and approved" practice in that case:-

> "It further follows that, in performing this symphysiotomy in the absence of sufficient indications, Dr. Connolly engaged in a practice which no other competent medical practitioner in his area of specialisation and skill would have followed, if taking ordinary care. The evidence did not establish that the practice of symphysiotomy was sufficiently general by 1969, or generally approved by colleagues of a similar specialisation and skill to warrant this operation. The position was, rather, that there were adherents of a school of thought which considered it justifiable in certain circumstances. But none of those circumstances were present here. There was no indication of pelvic deformity. There was no indication of absolute disproportion. Thus, the procedure carried out by Dr. Connolly in this case was deeply and fundamentally flawed in a way which should have been obvious to any doctor of similar skill or specialisation. The second aspect of the defence also fails."

95. Based on *Kearney* it is clear that what the Court is concerned with in this case is whether, in 1963, having regard to the clinical findings in Mrs. Farrell's case, there was credible evidence to support the trial judge's finding that Dr. Stuart, in performing a prophylactic symphysiotomy, had followed what at the time was considered to be a general and approved practice. It goes without saying that critical to the decision in Kearney was the fact that the symphysiotomy was carried out after the baby had actually been delivered and in circumstances where the Court had found as a fact that there was no evidence whatsoever of any clinical findings, whether of CPD or otherwise, such as might in any circumstances have justified that procedure. It therefore could not be said, as was advised necessary in Bolitho, that there was any logical basis for the procedure and further it had to be accepted that no benefit accrued to the mother or baby as a result of the procedure.

96. So, was there evidence to support the conclusion that, in 1963, there was a body of opinion that was responsible, reasonable and respectable, to justify prophylactic symphysiotomy in any circumstances whatsoever in Mrs. Farrell's case? Had the procedure a logical basis, and in approving of the practice, did those who supported it take into account the perceived risks and benefits of the procedure at the time?

97. Professor Bonnar, whose evidence the High Court judge clearly considered credible, advised that in his opinion, the use of prophylactic symphysiotomy in a case such as that of Mrs. Farrell would have met with general approval amongst clinicians of equal status to Dr. Stuart in Dublin's maternity hospitals in 1963. He supported his own actual knowledge of this state of affairs by relying upon the fact that the procedure was heavily discussed in the medical literature in the fifteen or so years preceding 1963, over which period the use of prophylactic symphysiotomy increased. He also relied upon the fact that the practice was reported upon in Journals

such as the 'British Journal on Obstetrics and Gynaecology' and in various textbooks including those published in the UK without criticism. He told the Court that Douglas Baird, who was probably the world's leading specialist concerning the complication of a contracted pelvis, had written, not unfavourably, about the use of symphysiotomy in Dublin at the time.

98. Professor Bonnar's evidence was supported by a number of publications including the annual reports of Dublin's three maternity hospitals where the procedures were recorded and summarised. I accept that the references to prophylactic symphysiotomy in these reports are sparse, but this is understandable as Professor Bonnar and Dr. Boylan made clear that the practice was one which was only suited to rare and select cases such as that of Mrs. Farrell. Nonetheless, those reports serve to illustrate that the practice of prophylactic symphysiotomy was being performed openly and was the subject matter of ongoing evaluation and review and that the practice was subjected to external audit.

99. It is true to say that the evidence before the High Court established that the practice of prophylactic symphysiotomy was not universally approved of and that its popularity waxed and waned in the decade preceding 1963. However, even Donald, who did not advocate in favour of the procedure, in his textbook, Donald, *Practical Obstetric Problems*, 2nd Ed., (London, 1959), advised of the benefits of the practice, particularly where women might have large numbers of children. I have referred to the following quote earlier in this judgment but I will nonetheless repeat it here for ease of reference. This is what he said in chapter 20 at p.432:-

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

100. Of some relevance to the issue as to whether prophylactic symphysiotomy enjoyed general approval amongst a reasonable and respectable body of clinicians in 1963 is the fact that the practice was approved of at the very highest levels of obstetric practice in Dublin's maternity hospitals at that time. After all, these were hospitals which were internationally renowned for their expertise. Concerning this issue Dr. Boylan said:-

> "It is therefore clear that prophylactic symphysiotomy was a well recognised and accepted procedure, supervised and performed by the most senior obstetricians in the three Dublin maternity hospitals of the relevant time."

The same opinion was shared by Professor Bonnar who advised that at the time the three Dublin hospitals would have been considered to be leaders in obstetric care. It might reasonably be said that a responsible, respectable and reputable body of opinion was to be found in these major hospitals and their practices at the time.

101. However, the fact that there was evidence that the practice of prophylactic symphysiotomy was approved of in cases such as that of Mrs. Farrell by obstetricians who were considered both respectable and responsible and who held prestigious positions such as that of Master in one of Dublin's Maternity Hospitals is not the end of the matter. Neither is the fact that Dublin, in 1963, was seen to be a centre of some excellence in the practice of obstetrics. The Court was, nonetheless, obliged to be satisfied that there was a logical basis for the procedure and the failure of the defendant to provide such evidence was the principal reason why the defence in Kearney failed.

102. In the present case, as already discussed, the logic of performing a prophylactic symphysiotomy on Mrs. Farrell, having regard to the state of knowledge at the time, was explained by Professor Bonnar and Dr. Boylan. The objective findings suggested a high probability that she was suffering from mild to moderate CPD with the consequence of an equally high probability of an obstructed labour. Thus, absent a prophylactic symphysiotomy, she had, they believed, a 90% chance of requiring emergency intervention be that by way of Caesarean section or symphysiotomy to deliver her baby. Thus, for this and the other medical reasons already advised, there was clearly a logical basis for the procedure.

103. However, before the judge could finally conclude that there was a reasonable and responsible body of opinion that approved of the practice, he also had to be satisfied that the exponents of that body of opinion had directed their minds to the comparative risks and benefits of the procedure as they were known at the time.

104. Having reviewed the evidence in this case, I am satisfied that there was an abundance of evidence to demonstrate that those who supported prophylactic symphysiotomy were mindful of the comparative risks and benefits of the procedure. There was no evidence to suggest that the clinicians who were carrying out the symphysiotomy procedure were doing so oblivious to any concerns that it might have adverse consequences for the patient. In fact the evidence was to the contrary. For example, Dr. Feeney in the Coombe Hospital, as noted in the Coombe Clinical Report for the year 1954, carried out a significant review of patients who had had the procedure performed precisely for the purpose of ascertaining its consequences for the patient. Having done so he concluded that it appeared to have few such consequences. I will refer to this study later.

105. As to the benefits of prophylactic symphysiotomy, the Court was advised of the risks to a baby of a lengthy obstructed labour in a compromised birth canal. It also heard evidence concerning the risks to the mother from a difficult instrumental delivery as might occur in an obstructed labour. Further, the Court was told of the benefit to the mother, who had clinical signs suggestive of mild to moderate disproportion, of prophylactic symphysiotomy. Not only would she avoid the risks attached to Caesarean section on her then current pregnancy, but she would benefit from the procedure in all future deliveries, given that the pelvis would then be more accommodating. I have already, at para. 91 above referred to the statement in, Donald*, Practical Obstetric Problems*, 2nd Ed., (London, 1959), in chapter 20 p. 432, concerning the advantages of symphysiotomy.

106. I have also earlier referred to the writings of Dr. Browne, Master of the Rotunda in 1962, in the Transactions of the Royal Academy of Medicine in Ireland, in the I.J.M.S. 6th Series, (1962) where he opined that the longer he had held the position of Master the more worried he had become about the risks to the mother of Caesarean section and of the need to find ways of avoiding them, one such being symphysiotomy in advance rather symphysiotomy than done during labour.

107. Regardless of fact that the evidence established that there was only one maternal death in the Coombe Hospital due to Caesarean section between 1957 and 1963, the Court heard evidence that Caesarean section carried with it a not insignificant risk of mortality. Johnstone, *A Textbook for Midwifery Students*, (London, 1952) in relation to Caesarean section, states that in good surgical conditions, the maternal mortality should be less than 1%. Reliance was also placed on work published by Gibberd, *A Short Textbook of Midwifery*, 7th Ed., (London, 1960) which referred to the procedure carrying a mortality risk of 0.5%, or one in two hundred. Further, the defendant's evidence was that where a woman had a Caesarean section for disproportion, all subsequent deliveries would likely be by Caesarean section, thus exposing her to very significant risks including that of mortality. Chassar Moir, in his edition of *Munro Kerr's Operative Obstetrics*, 7th Ed., (London, 1964), advised that Caesarean section damages the uterus and creates the possibility of rupture in future pregnancies. For a woman who was able to deliver vaginally following symphysiotomy, she would avoid

those mortality and other Caesarean section risks which were far from insignificant. These risks were, the Court was advised, very significant in 1963 due to the fact that 30% of all mothers in the Republic had five or more births.

108. Professor Mary Daly gave evidence as to the circumstances in which Irish obstetricians were practising compared to their UK counterparts. She referred to the fact that Irish women had particularly high parity due to the unavailability of artificial contraception and the lack of sterilisation. It is against this backdrop that the Court was required to decide whether the practice of prophylactic symphysiotomy in 1963, in a case such as that of Mrs. Farrell, had a logical basis and could be considered to meet with approval, having regard to the benefits and risks pertaining thereto.

109. As to the risk to the mother from repeat Caesarean section, the plaintiff led statistical evidence to suggest that 85% of women who had a Caesarean section on their first birth went on to deliver vaginally on their second birth. Thus, Counsel for the plaintiff argued in the course of the appeal that the inferences that the trial judge drew from the evidence as to the mortality risk to women from repeat Caesarean section were wrong. They would not face repeat Caesarean section, as was advised by the defendant's witnesses.

110. However, that evidence was robustly challenged by the defendant's experts, and in particular, Dr. Boylan who contested the significance of the plaintiff's statistics on the grounds that they did not apply to that cohort of women to whom Mrs. Farrell belonged, namely, women who had their first child by Caesarean section because of disproportion. Not only did the Court have the benefit of the defendant's expert evidence as to actual practice of women having repeat Caesarean sections where they had their first Caesarean section for disproportion, but the preponderance of the literature referred to in the course of the hearing seemed to accept that this was normal practice. I will select but two references in this regard. The first is Donald, *Practical Obstetric Problem*, 2nd Ed., (London, 1959), which at p. 432 states "In a city like Dublin, where high degrees of parity are common, this is a factor of some importance, as it helps to eliminate the need for repetitive Caesarean section with all its penalties" and the second quote is from McVey, 'The Treatment of Disproportion by Combined Lower Segment Caesarean Section with Symphysiotomy', (1955), I.J.M.S. 299 at p. 299, to which I have already referred but which I will repeat here again for ease of reference which states:-

> "Thus a young primigravida delivered by Caesarean section for disproportion faces a lifetime of repeat operations with all the hazards of uterine ruptures, adhesions and bladder injury. In gross disproportion Caesarean section is unquestionably correct, but in minor or medium degrees of disproportion if symphysiotomy allows of vaginal delivery on this and all other subsequent pregnancies it is surely the operation of choice".

Accordingly, I reject the plaintiff's submission that the judge drew incorrect inferences from the evidence on this issue.

111. While it was urged upon the Court that in considering what might be considered a general and approved practice, it should carry out its assessment by reference to international standards rather than those which pertained in Ireland in 1963, that is a submission that I do not accept. The fact of the matter was that in 1963 artificial contraception was not lawfully available in Ireland and sterilisation was not routinely available. As a result, women in Ireland were, according to the evidence, having large numbers of babies and this exposed them to risks quite different to those faced by their UK counterparts. Clinicians had to make clinical decisions in that medical setting. As has often been stated, medical advancements are made in response to medical needs and the practices of clinicians and the treatment options available to them are invariably influenced by prevailing circumstances.

112. Considering the different circumstances faced by women of childbearing age in Ireland as opposed to their UK counterparts in 1963, it is hardly surprising that there was also some difference in obstetric practice and the treatment options considered appropriate. It would, I believe, be erroneous to be guided by what was considered to be the approved practice in the UK at a time when the attendant conditions were not present in this jurisdiction. It is relevant to note in this regard that obstetricians in Dublin were not operating in ignorance of what was general practice in the UK. Prophylactic symphysiotomy was considered appropriate and acceptable practice in this country only in rare and selective cases of the type earlier discussed where for that particular patient it would allow the baby be delivered vaginally and thus avoid the risks attached to one but also potentially many more Caesarean sections. This approach also seems to accord with the premise that for a practice to be general and approved it must have a logical basis.

113. Insofar as the judge was required to be assured that the clinicians who favoured the procedure had factored into their judgment the risks and benefits of the procedure, there was no evidence that the clinicians concerned appreciated that the practice they were pursuing might have any serious or long-lasting consequences for the mother. Dr. Boylan and Professor Bonnar both stated that this was the commonly understood situation at the time. Further, Donald (1959) reported at p. 432-:

> "Fibrous union always occurs and the pelvic girdle nearly always regains its former stability, so that locomotion is not interfered with."

114. Other evidence was tendered to the High Court in support of the claim that symphysiotomy was considered to be a benign procedure back in 1963, and indeed for a long period thereafter. As noted in the Coombe Clinical Report for 1954, starting at p. 54, Dr. Feeney reported that in May, 1955 he had been able to get in touch with 50 patients, on whom he had performed a symphysiotomy between January, 1950 and December, 1953 for the purposes of carrying out a follow up interview. Hence the patients who were followed up had undergone their operations between five and a half and one and a half years before the review. Dr. Feeney described the follow up as "preliminary" given that the time interval was quite short and there were no full clinical and radiological examinations carried out. Whilst advising of the need for a more detailed study, he reported that he considered the majority of his patients' complaints to have been of a minor nature.

115. Dr Feeney's study considered a number of different complaints made by his patients, including difficulty with walking or lifting heavy articles, back pain, and incontinence. It is not necessary, however, to set out his conclusions in any great detail. I consider it sufficient to note his findings that 44 patients reported no difficulty walking, 39 had no difficulty with heavy lifting, 35 experienced no back pain, 38 reported normal bladder control and that while others reported some symptoms, the vast majority of patients in the selected categories did not present with serious complaints.

116. The Court was also referred to Björklund's, *Minimally Invasive Surgery for Obstructed Labour: A Review of Symphysiotomy During the Twentieth Century* (Including 5000 Cases), (2002) 109 B.J.O.G. pp. 236-248, a literature review of studies dealing with symphysiotomy from 1900 to 1999. While this survey significantly post dates the period of time with which the Court was concerned in the instant proceedings, it was nonetheless evidence of significant value to the defendant insofar as it demonstrated that the long term sequelae of symphysiotomy was not recognised at any time proximate to the 1960s. The author arrives at several conclusions. First, that the results indicated that symphysiotomy was safe for the mother and compared favourably, from a risk to the mother's health perspective, with Caesarean section. Secondly, that it was a potentially life saving operation for the child. Thirdly, that it

resulted in a permanent enlargement of the pelvis, which facilitated future vaginal deliveries. Finally, that severe complications in the long term were rare when the operation was carried out by experienced surgeons despite pain and discomfort in the post-operative period.

117. There does not appear to have been much literature to support the existence of any significant known *sequelae* for women who underwent symphysiotomy. However, it should possibly be noted that the plaintiff's experts debated the value of the Björklund study. Mr. Bowen Simpkins was quite critical of it and the trials that featured in it, noting that the author's conclusions about morbidity were wrong and that the patients were in parts of the world where follow up was impossible. Dr. Boylan however was of the opinion that the detailed follow up was long enough for conclusions on morbidity to be considered valid and that very long term follow up runs into difficulty because of the presence of confounding variables.

118. So, while it is undoubtedly true to say, as was argued by Dr. Craven on the appeal, that the evidence established that the practice of prophylactic symphysiotomy was one which was very rarely deployed, the fact that there were only small numbers carried out does not mean that the trial judge was not entitled, on the evidence before him, to conclude that prophylactic symphysiotomy was a general and approved practice in those relatively rare cases where clinical findings were made in advance of labour which strongly suggested that the mother could not deliver vaginally without operative intervention, but was likely to deliver vaginally following symphysiotomy. In 1963, two-thirds of all obstetricians practiced in Dublin and prophylactic symphysiotomy was carried out in two of the three Dublin maternity hospitals. It should however be stated that in the Rotunda, in 1963, symphysiotomy was only carried out after the mother had laboured and failed.

119. While Dr. Craven criticised and relied heavily upon the lack of peer-reviewed literature supporting prophylactic symphysiotomy, what the *Dunne* principles require is an examination as to whether or not the doctor followed a practice which was general and which was approved of by his colleagues of similar specialisation and skills. It is not a literature assessed test. Obviously, literature may be of assistance insofar as it may establish beyond doubt that a particular practice was one which enjoyed general approval.

120. As to what was reported concerning symphysiotomy in the medical literature of the time, the only Irish medical journal in 1963 was the 'Irish Journal of Medical Science' where the annual transactions of the hospitals were reported. Those transactions were discussed at meetings which were described by Professor Bonnar as being robust and combative. Meetings of that nature, to which international obstetricians were invited and which were attended by nearly every obstetrician in the country, are, I believe relevant for the purpose of considering whether the practice of prophylactic symphysiotomy was one which was truly subjected to peer review.

121. The writings of Dr. Feeney, Dr. Arthur Barry and Dr. Alex Spain on prophylactic symphysiotomy were cited in the leading British textbooks of the time. The writings were not cited with disapproval. The Transactions demonstrate that the Masters of all three Dublin hospitals *i.e.* Brown, Barry and Feeney, all practised prophylactic symphysiotomy. Further, while in the Transactions of the Royal Academy of Medicine in Ireland, in the I.J.M.S. 6th Series, (1950) at p. 866 Barry remarks that "all cases of minor or medium disproportion should have trial labour" this position, according to the evidence in the High Court had changed by 1963.

122. Having regard to the expert testimony of Professor Bonnar and Dr. Boylan and from the literature introduced in evidence in the course of the High Court hearing I am quite satisfied that there was ample evidence upon which the trial judge was entitled to conclude that in 1963 prophylactic symphysiotomy was a general and approved practice amongst clinicians of like expertise to Dr. Stuart. The practice was supported by many learned articles and publications, and while not universally favoured, no out-and-out condemnation of the practice appeared, even in the UK texts where the procedure was discussed.

123. I am also satisfied that there was evidence upon which the Court was entitled to conclude that there was a logical basis for the procedure once it was confined to the relatively rare type of case where the clinicians had available to them clinical findings and indications such as those which were present in the instant case. Further, there was strong evidence to suggest that those who supported the practice were influenced in their professional judgment by what they perceived to be the immediate benefit of prophylactic symphysiotomy to the mother in terms of her current delivery and its significant potential long-term benefits to her in respect of her future pregnancies, insofar as she would avoid of all of the risks attendant upon repeat Caesarean section, of which there might be many.

Inherent Defect

124. In the High Court, the trial judge was urged to conclude that even if he came to the conclusion that prophylactic symphysiotomy was a practice which enjoyed general approval amongst a reasonable and responsible body of clinicians of equal status to Dr. Stuart, he should nonetheless find that he was negligent as the practice was one which was inherently defective within the meaning of the *Dunne* principles.

125. Before considering the conclusions of the trial judge on this issue, it is perhaps relevant to reflect briefly on what Walsh J. stated at p. 193 in O'Donovan concerning the issue of "inherent defect":-

> "A medical practitioner cannot be held negligent if he follows a general and approved practice in the situation with which he is faced... That proposition is not, however, without qualification. If there is a common practice which has inherent defects which ought to be obvious to any person giving the matter due consideration, the fact that it is shown to have been widely and generally adopted over a period of time does not make the practice any less negligent. Neglect of duty does not cease by repetition to be neglect of duty".

126. This passage would suggest that the onus is on the plaintiff to demonstrate that the practice employed by the defendant in this case was so obviously defective that any person giving it due consideration would have come to that conclusion. That is a heavy onus and a burden which I am quite satisfied was not discharged by the plaintiff in the present case.

127. While there was evidence as to the differences between the practices deployed in Ireland and the UK in cases of suspected disproportion as noted in the literature, there was no outright condemnation of the practice of prophylactic symphysiotomy as practised in Ireland in 1963, notwithstanding the fact that the practice is referred to in textbooks, medical articles and journals and also in the annual reports of the hospitals where it was carried out. If the defect was so obvious that it could or should not have been missed by any clinician giving the matter due consideration, why did the various learned authors not discuss and expose the alleged flaws in the procedure? As it happens, the literature at best establishes the existence of two schools of thought on the matter, with the English authors preferring their own practice, but nonetheless acknowledging a different practice in Ireland.

128. The trial judge, in his judgment, gave three reasons for dismissing the plaintiff's claim that the practice of prophylactic symphysiotomy, in the circumstances that presented in Mrs. Farrell's case, was inherently defective. He relied upon the following

findings:-

(i) Obstetricians at the time held real fears concerning the risks to the mother from multiple Caesarean sections.

(ii) Obstetricians at the time appeared convinced that symphysiotomy was a relatively benign procedure with little by way of adverse *sequelae* for the mother.

(iii) Prophylactic symphysiotomy was a practice that was widely accepted by the leading consultants at the time.

129. I have to say, I have misgivings as to the approach adopted by the trial judge on this issue. That being so, I will deal with each of his conclusions in turn.

130. I accept without reservation the finding of the trial judge that obstetricians in 1963 had real reason to be concerned about the risks to mothers posed by repeat Caesarean section. There was an abundance of evidence to support the validity of such concerns, some of which has been referred to earlier in this judgment. However, the existence of such risks could never justify a clinician carrying out a procedure which, if subjected to any reasonable analysis, would be shown to be inherently defective. In this case, the clinicians appear to have been convinced that prophylactic symphysiotomy was without defect and that it offered the further benefit of protecting the mother not only from the risks attached to the initial Caesarean section, but from repeat Caesarean sections. Hence, in coming to his conclusion that prophylactic symphysiotomy was not an inherently defective procedure, I am satisfied that the trial judge's reliance upon the clinicians concerns regarding the existence of such risks was misplaced.

131. As to the trial judge's reliance upon his finding that clinicians were of the view that symphysiotomy was a relatively benign procedure with little by way of adverse *sequelae* for the mother, the evidence strongly supports that conclusion. As already stated, there was no contemporary local or UK based literature at the time suggesting that the effects of symphysiotomy were other than relatively benign when compared to the risks pertaining to Caesarean section. However, that said, I am not satisfied that such a finding impacts upon the issue as to whether or not the practice of prophylactic symphysiotomy was one which ought to have been considered to be inherently defective in 1963.

132. As to the trial judge's reliance upon his finding that the practice of prophylactic symphysiotomy was widely accepted by Ireland's most senior obstetricians at the time, regrettably, I find myself once again coming to the conclusion that this finding was also immaterial to the issue at hand. Indeed, the whole purpose of the "inherent defect" principle is to ensure that clinicians recognise that they cannot blithely follow the practices of their contemporaries without applying their own skill and judgment concerning the validity of the professional decisions they make on a day-to-day basis. Just because a practice is followed time and time again does not mean it may not be inherently defective. It would be wholly unjust if a clinician could defend conduct, which if properly scrutinised would be seen to be manifestly defective, on the grounds that they might reasonably say "well, every one else was doing it."

133. Notwithstanding these reservations, I am quite satisfied, having regard to what has earlier been recorded in the course of this judgment, that the plaintiff did not discharge the heavy onus that rests on a party who wishes to rely upon "inherent defect" to displace a defence built on proof that the defendant had followed a general and approved practice, in reliance upon a claim

134. While Counsel for the plaintiff asserted that the trial judge erred in law in his approach to the issue of inherent defect, and I agree with him for the reasons I have just outlined, it is not clear to me what evidence he can legitimately seek to rely upon to justify his submission that this Court should displace his conclusion on the issue. While Dr. Craven denied that his case in respect of inherent defect was rooted in the evidence of Dr. Bowen Simpkins and Dr. Thomas which was in synchrony with the writing of Dr. Hugo McVey in 1955 to which I have earlier referred at para.70 of this judgment, I can find no other evidential basis upon which he might argue that the High Court judge erred in failing to conclude that the procedure of prophylactic symphysiotomy was inherently defective.

135. It will be remembered that core to the plaintiff's expert evidence and the aforementioned article was the claim that mild to moderate CPD could only be diagnosed as a matter of certainty in the course of labour. Thus, if symphysiotomy was carried out in advance of labour, there was no way of knowing that the mother might not have delivered without that intervention. Accordingly, a practice which excluded a trial of labour was inherently defective.

136. However, the defendant never contended that the diagnosis of mild to moderate disproportion could actually be made in advance of labour or that it was so made in the case of Mrs. Farrell. He asserted that by the standards of the time, it was not necessary to have made that diagnosis in advance of carrying out a prophylactic symphysiotomy. According to the defendant, and this was accepted by the trial judge, the procedure could be justified even without a diagnosis in the presence of clinical indications suggesting likely mild to moderate CPD or other clinical findings which rendered it highly unlikely that the mother would, without surgical intervention, be able to deliver her baby. The High Court judge accepted that there were a small number of cases, such as that of Mrs. Farrell, where there were strong clinical indications to suggest that the mother would probably have an obstructed labour which might be avoided if a symphysiotomy were carried out.

137. The High Court judge clearly preferred the evidence of Dr. Boylan and Professor Bonnar on this issue and was satisfied that a diagnosis was not required in a case with clinical findings of the nature disclosed in Mrs. Farrell's case. That being so, the inherent defect argument which was similarly based on the premise that the clinician could not justify carrying out a prophylactic symphysiotomy because he could never later prove that the mother might not have laboured without such intervention is, in my view, unstateable.

138. For my part, having regard to the other findings of fact made by the trial judge, all of which I am satisfied were based on credible evidence, I am not satisfied that the plaintiff has demonstrated that he erred in his conclusion that the practice of prophylactic symphysiotomy, in circumstances such as those present in Mrs. Farrell's case, was an inherently defective practice. The uncontroverted evidence was that she had very significant clinical findings which suggested a 90% chance of an obstructed labour which would result in an emergency Caesarean section or an emergency symphysiotomy. Judging the procedure by the standards and knowledge of the day, particularly having regard to the evidence of Professor Bonnar and Dr. Boylan, it cannot be said that the trial judge erred in concluding that the practice was not inherently defective.

The Decision in Kearney

139. I feel it would be remiss of me if I were to conclude this judgment without reiterating what is well understood by lawyers, but not always fully understood by members of the public, and that is that every medical negligence case falls to be decided on its own unique facts.

140. The fact that the plaintiff in this action failed in her claim relating to a symphysiotomy performed on her 1963, does not necessarily mean that a court considering the circumstances in which another symphysiotomy procedure was performed on a different patient might not come to a different conclusion. I apprehend that there are many women who underwent this procedure, and who have endured much by way of pain and suffering, who will not understand how this could be so and will find it difficult to comprehend how it could come to pass that Mrs. Farrell should fail in her claim having regard to the fact that Mrs. Kearney succeeded in hers. Accordingly, I will take the opportunity to write a few short paragraphs in the hope that I can make the situation more comprehensible.

141. While the liability issue in both cases was the same, namely, whether any justification for the symphysiotomy procedure could be found having regard to the circumstances as pertained at the time, the facts of the two cases were remarkably different.

142. In *Kearney*, the baby had been delivered before the symphysiotomy was carried out. Accordingly, the procedure was not performed to protect the mother and baby from the risks involved in an obstructed labour. In Mrs. Farrell's case, where the procedure was carried out prior to the onset of labour, all of the clinical indications suggested she was likely to have an obstructed labour. Dr. Boylan and Professor Bonnar said it was 90% likely that she could not have delivered without a Caesarean section or a symphysiotomy.

143. In *Kearney*, the High Court judge found no evidence of any obstruction or pelvic deformity likely to cause the patient difficulty in the course of any future delivery. Thus, there could never have been any justification for carrying out a procedure which had the consequential benefit of making the pelvis a little more accommodating on future deliveries. Not only were there no medical notes or records to demonstrate any abnormality of the pelvis or any risk of CPD, an X-ray examination carried out 11 days after the delivery of her baby showed that Mrs. Kearney's pelvis was absolutely normal. In Mrs. Farrell's case the position was entirely different. X-ray pelvimetry and examination under general anaesthetic provided objective evidence which strongly suggested that Mrs. Farrell was suffering from mild to moderate CPD. Further, her pelvis was not normal. It was anthropoid in presentation and she also had signs of outlet contraction.

144. The evidence clearly established that Mrs. Farrell's symphysiotomy was performed to avoid an obstructed labour and to allow her deliver vaginally thus facilitating her avoidance of all of the risks that she might otherwise be exposed to in the course of one and probably several more Caesarean sections in the course of her lifetime. No such considerations arose in Mrs. Kearney's case.

145. Thus, unlike in *Kearney* where the procedure was carried out in the absence of any clinical indications that might justify its performance, in Mrs. Farrell's case the symphysiotomy was performed for a range of clinical reasons which at the time were generally approved of by those at the very top of the obstetric profession in this country.

Conclusion

146. This is indeed, as was advised by the learned High Court judge in his judgment, an extremely sensitive and difficult case. The plaintiff, Mrs. Farrell, has, for the greater part of her adult life, laboured under a range of physical and psychological disabilities which the trial judge accepted were caused or contributed to by a symphysiotomy procedure carried out on her by Dr. Stuart, the Master of the Coombe Hospital, 12 days prior to the delivery of her daughter, Vanessa, in 1963.

147. The practice of prophylactic symphysiotomy has long since, and for good reason, been abandoned. Assessed by present day obstetric standards and in a country where women can now better control their own fertility, the practice of prophylactic symphysiotomy would likely be considered an inherently defective one. However, the mechanics of labour were not as well understood in 1963 as they are now and the circumstances faced by women of childbearing age have changed substantially over the years. Even by the late 1960s, there was a much greater understanding as to the mother's ability to deliver a baby which appeared to be disproportionately large for her pelvis.

148. However, by the standards of 1963, and in the very particular circumstances of Mrs. Farrell's case, it simply cannot be said that there was not credible evidence to support the conclusion of the trial judge that she had failed to establish that the prophylactic symphysiotomy to which she was subjected could never, in any circumstances, have been justified. I am quite satisfied that the trial judge was entitled to conclude that a reasonable and respectable body of clinicians of like expertise to that enjoyed by Dr. Stuart would have approved of the use of prophylactic symphysiotomy in the circumstances of her case in 1963, and that that practice was not one which, judged by the then prevailing standards, could be considered to have been inherently defective within the meaning of the Dunne principles.

149. There was credible evidence from Dr. Boylan and Professor Bonnar, which was supported by various learned medical articles, reports and materials, that in 1963, there were circumstances in which clinicians considered it possible, in advance of labour and with the then perceived benefits of X-ray pelvimetry and EUA, to predict or suspect likely CPD such that they could be reasonably certain that the mother would not be able to deliver vaginally without surgical intervention by way of Caesarean section or symphysiotomy. In the rare case, and I accept that the evidence established that there were very few cases which fell into this category, where it was considered that the provision of a little more room within the pelvis, something that would be achieved by symphysiotomy, would allow the baby to be delivered vaginally, that procedure would have met with general approval.

150. In 1963, symphysiotomy or in this case prophylactic symphysiotomy, was considered to offer significant benefits to the mother. It protected the mother and baby from the dangers of an obstructed labour. It rendered the mother capable of a vaginal delivery thus protecting her from the mortality and other risks which attached to Caesarean section, which would have been the likely alternative necessary intervention. Further, it would enable the mother, who, whether because of the unavailability of artificial contraception or sterilisation or otherwise, was considered likely to have a high number of deliveries, avoid the risks including those of mortality already discussed attendant upon repeat Caesarean section. These were not insignificant given that there was credible evidence to support the conclusion that once a mother had a first Caesarean section for disproportion, she would likely have all subsequent deliveries by Caesarean section.

151. Finally, the understanding of clinicians at the relevant time was that symphysiotomy was a relatively benign procedure without significant adverse consequences for the mother and such studies as existed concerning the practice supported that view. Clearly with the passage of time, advances in medical knowledge and the greater scrutiny and follow up of patients who were subjected to this procedure, those views and findings have long since been abandoned if not discredited.

152. For all of the aforementioned reasons, I would dismiss the appeal.