Neutral Citation Number: [2007] IEHC 207

**THE HIGH COURT**

**[2002 No. 15260P]**

**BETWEEN**

**BRIDGET BYRNE**

**PLAINTIFF**

**AND**
**JOHN RYAN**

**DEFENDANT**

**Judgment of Mr. Justice Kelly delivered 20th day of June, 2007**

**Introduction**
1. This is a claim for damages for negligence arising out of a failed sterilisation of the plaintiff. That sterilisation was sought to be achieved by a tubal ligation which was carried out in the Coombe Hospital on 16th December, 1999. Subsequent to it, the plaintiff bore two children.

2. She brings this claim against the defendant, who is the nominee of that hospital.

3. The plaintiff seeks damages under two headings. The first claim is for what her counsel described as the physical consequences of the failure of the operation. The second is for the recoupment of the cost of rearing the two children until such time as they cease to be dependant on their parents. In monetary terms this claim is by far the larger of the two.

4. Apart from the usual difficult questions which a court has to deal with in any medical malpractice suit this case has raised two others, neither of which have been the subject of judicial determination in this jurisdiction. The first is the vicarious liability, if any, of a public hospital for the negligence of a consultant doctor on its staff in treating a public patient. The second is the entitlement to recover damages for the cost of rearing a healthy child born subsequent to a failed sterilisation.

5. Neither of these questions will, of course, have to be answered unless the plaintiff proves that the operation in question was a failure and that its failure was as a result of the negligence of the consultant who carried it out. It is to these questions that I turn in the first instance.

**The Plaintiff**
6. The plaintiff was born on the 6th May, 1962. She married her husband Daniel on 13th October, 1979. She was then seventeen years of age.

7. The first of her seven children, James, was born on 17th December, 1979.

8. The plaintiff had a miscarriage in 1980.

9. On 27th December, 1981 her second son, Derek, was born.

10. On 19th November, 1984 she had twins, Donal and Aisling.

11. Her fifth child, Alan, was born on 19th June, 1988.

12. The plaintiff was dealt with in the Coombe Hospital for each of these confinements and for the miscarriage which took place in 1980.

13. In 1991 she had an ectopic pregnancy despite taking the oral contraceptive pill. Again she was treated in the Coombe Hospital. Following that experience she attended at the Adelaide Hospital for advice on the question of sterilisation. She decided against it. Throughout the 1990's she took the oral contraceptive pill.

14. In 1997 the plaintiff was involved in a motor accident and inter alia suffered depression as a result of it.

15. By late 1998, the plaintiff had decided that she did not want to have any more children. She was quite definite about it.

16. The plaintiff's general practitioner was Dr. Brian Dunne. She consulted him on the question of sterilisation. As a result he wrote a letter of referral to the Coombe hospital in the following terms:

> "19th November, 1998
>
> Gynae Clinic
>
> Coombe Hospital,
>
> Dublin 8
>
> Re – Bridget Byrne, 1567 Lee Drive, Calverstown, Kilcullen, Co. Kildare.
>
> Date of Birth 06/05/1962.
>
> Dear Doctor,
>
> I would be grateful if your (sic) send Bridget an appointment to be assessed for tubal ligation.
>
> She has five children and had a tubal pregnancy in 1991.
>
> Many thanks.

Yours sincerely,

Dr. Brian Dunne".

17. It was as a result of that letter that she ultimately came under the care of Dr. Charles Murray.

**Dr. Charles Murray**
18. Dr. Murray qualified in medicine at University College, Dublin in 1962. He then went to Leeds United Hospital were he worked in the women's and maternity hospital. Whilst there he obtained his membership of the Royal College of Obstetricians and Gynaecologists. Thereafter he went to the United States on a research fellowship. He returned to the Coombe Hospital in 1969 as Assistant Master. He was then made Senior Registrar and in 1975 became a Consultant at that hospital. He remained as a Consultant at the Coombe until his retirement in June, 2001.

19. Dr. Murray has extensive experience of performing tubal ligations. He carried out his first such operation in the middle of the 1960's in England. At that stage the procedure was done by open surgery. It was not done laparoscopically until more recent times.

20. Dr. Murray recounted that in his early years "tubal ligation wasn't tolerated" in the Coombe Hospital. Then the board of the Hospital allowed it in restricted circumstances. Following the decision of the Supreme Court in the *McGee* case (*McGee v. Attorney General* [1974] I.R. 287), all of this changed. To use his own words "the law changed and things changed from there. So I did an awful lot of them."

21. He recalled that he was asked by the then Master to take over the family planning clinic at the Hospital. He described that title as a misnomer because what he called "standard family planning" was conducted elsewhere and the patients referred to this clinic were almost universally sent for consideration for tubal ligation. Thus it was he who was in charge of the conduct of tubal ligations in the Coombe Hospital for many years. By the year 2000 he estimated that he would have carried out that procedure "in the high hundreds and probably in the thousands". He was therefore a consultant of great experience in tubal ligation.

**The operation**
22. The plaintiff was considered suitable for tubal ligation and it was carried out on the 16th December, 1999 by Dr. Murray. Not surprisingly he had no recollection of the operation but the theatre records and operating notes of the procedure had been kept and he was able to refresh his memory by reference to them.

23. The procedure was carried out laparoscopically. Dr. Murray described filling the plaintiff's abdomen with three litres of carbon dioxide gas and then inserting the relevant instruments around the belly button area. He discovered that there were multiple adhesions from the anterior abdominal wall present. That was because the plaintiff had had previous surgery and also had had an ectopic pregnancy. He dealt with those adhesions as part of the procedure. He was able to dissect them off with the instruments which he was using so that he could see what he was supposed to be doing. Then he "just clipped the tubes". He said there was a little difficulty because of the adhesions but he was satisfied that he had clipped the tubes.

24. Dr. Murray went on to say that over the years there were three or four instances where he was not altogether happy that he had achieved a satisfactory tubal ligation. In such circumstances he organised a histo- salpinogram to be carried out some six weeks after the operation. He did not do so in this case.

25. Following the operation Dr. Murray wrote to Dr. Dunne as follows:

> "This is just to let you know that your patient Mrs. Byrne had a laparoscopic sterilisation undertaken here a few weeks ago. The operation was straightforward and she was discharged a few hours later".

26. In evidence Dr. Murray said that the use of the term "straightforward" in that letter meant that there were no complications. He pointed out that the procedure is fraught with a lot of serious things which may go wrong such as damage being caused to the bowel, to the bladder, or to blood vessels. What he meant by the letter was that nothing of that nature occurred.

27. It is quite clear that Dr. Murray believed that he had carried out an effective tubal ligation. He believed that he had been able to deal with the adhesions and had clipped the plaintiff's tubes. Had he had any doubts about, this I am satisfied that he would not have proceeded laparoscopically but would have changed to an open procedure and/or would have had a histo-salpinogram carried out. He was fully satisfied that the operation done by him was a success.

28. Unfortunately Dr. Murray was wrong. It is common case that a second tubal ligation was carried out on the plaintiff in December, 2002. It was done by Dr. Peter Boylan. He made a video recording of the procedure. The video was seen by Dr. Murray and he accepted (and indeed had no doubt) that, rather than clipping one of the plaintiff's fallopian tubes, he in fact attached the clip to tissue just beside it. He was unable to explain how this happened. Counsel then put the following questions to him:

> "Question: Doctor, I have to suggest to you that if you had been using the care which was appropriate to somebody of your experience and eminence that would not have happened?
>
> Answer: I was a very careful surgeon all my life.
>
> Question: I understand that.
>
> Answer: And I operated carefully. I cannot explain why this happened or how it happened but I would reject the idea that I wasn't careful.
>
> Question: But it is not something that can happen if the procedure which you have described is carried out carefully?
> Answer: Well, we were dealing with adhesions here. I freed adhesions to a degree that allowed me, as far as I was concerned, to establish – I was not looking for the full length of the fallopian tube but for an area of tube that I could clip…
>
> Question: So the existence of the adhesions did not prevent you from identifying the fallopian tube?
>
> Answer: I don't think so. I would doubt that.

Question: In fact you have already said to us that if you had been unhappy about your capacity to visualise the fallopian tube because of adhesions, you would have gone to a laparotomy?

Answer: I would have gone to a laparotomy, yes.

Question: So I now return to my question, Doctor, if you had removed or dissected away the adhesions sufficiently to visualise the fallopian tube, how could you apply the clip to something other than the fallopian tube if you had carefully followed the procedure which you have described to us?

Answer: I can't answer that one because I don't know, but I assume that I mistook a roll of tissue which was adjacent to the tube as the tube in this circumstance. That is all I can say. I have no idea…

Question: But what I am putting to you is that that couldn't happen if you carefully followed the procedure which you have described of identifying the fallopian tube, applying the clip to it and then confirming by again identifying the location of the clip that it was on the fallopian tube?

Answer: Yes. Clearly I misidentified the fallopian tube by the sound of things. That is all I can say.

Question: Doctor, I must put it to you that that is not an acceptable result for a tubal ligation carried out by a consultant gynaecologist and obstetrician?

Answer: Well, it is an unfortunate result but I would disclaim the fact I was negligent. I was never negligent in my approach".

29. The question which I must now address is whether this misidentification of a piece of tissue for a fallopian tube, resulting in it rather than the tube being clipped, constitutes negligence.

**Expert Witnesses**
30. Although Professor Colm O'Herlihy was listed as an expert witness to be called on behalf of the defendant, he was not in fact called to give evidence.

31. Two experts were called by the plaintiff. One was Dr. Peter Boylan who carried out the second sterilisation in December 2002. The other was Dr. Peter McKenna.

**Dr. Peter Boylan**
32. Dr. Boylan qualified in medicine in 1974. He trained in Dublin and London and then worked in the United States. From 1991 to 1998 he was Master of The National Maternity Hospital and is at present a consultant obstetrician/gynaecologist at that hospital.

33. The plaintiff was referred to him by her general practitioner with a request for consideration for tubal ligation. He saw her on 23rd May, 2002 and recorded her earlier medical history. That included the fact that she had the tubal ligation the subject of this action but subsequently bore two children in 2000 and 2001. He carried out the second tubal ligation in December, 2002.

34. In the course of carrying out the procedure he had to dissect away adhesions at the plaintiff's left fallopian tube. Having done so, he was able to see that the clip present was not on the plaintiff's left tube. He took the view that the probability was that the clip had not been placed on the left tube at the first operation. The clip was clearly on the right tube but not on the left. He said as follows:

"Question: In relation to the first procedure then, can you comment on the failure of that operation?

Answer: Well, I think probably the clip was not put on the left tube. It was thought to be on the left tube but I think that it was an error of thought, if you like, or a mistaken impression because it wasn't on the tube and the clip was clearly on the right hand side. The procedure was done by a very experienced and very skilled surgeon who, clearly, formed the impression that the clip had been put in the right place, but I don't think it had.

Question: But is it possible to be sure to check the route of the fallopian tube in order to identify… (interjection)?

Answer: Yes, I mean, there are anatomical reference points which make it clear that you are putting the clip on the tube. When we are teaching juniors, for example, about how to do this procedure, we show them how you identify the tube and differentiate it from another tube which is very close to the fallopian tube, which is the one you are trying to block, which actually looks quite similar and it is one of the common errors that a more junior person would make with a clear view.

Question: But in relation to a person with experience and holding the status of a Consultant, such a person using reasonable care, would you expect them to be able to identify correctly the appropriate tube to clip?

Answer: You would yeah.

Question: Does it follow that a failure to make that identification falls below the reasonable standard of care for such a person?

Answer: Well, I think it is a mistake. Obviously, the clip was put in the wrong place under the impression that it was put in the correct place, but that was incorrect. You know, I don't know whether it is for me to say whether or not it falls below the standard of care, but you would expect the person doing it to take pretty good precautions to ensure it was in the correct place, yes.

Question: Well would such a person have been taught and had explained to them and perhaps even a person of that seniority taught others to take care which would avoid a mistake of this kind?

Answer: Yes, that's a fair comment".

35. In cross-examination Dr. Boylan accepted that there is a recognised failure rate with tubal ligation. The failure rate is higher when an open procedure is used. This is because most of such procedures are done at the time of a caesarean section and the higher

failure rate is attributable to the increased blood supply to the tubes at the time. He identified the commonest reason for failure as the clip being placed other than on the fallopian tube. However he went on to say that a doctor cannot put a clip on something which is not a fallopian tube and claim or believe that he had done a successful tubal ligation. He pointed out that most of the failures occur when the operation is carried out by more junior people because they mistakenly put the clips on the round ligament which looks very like a fallopian tube. He went on to say:

> "In cases like this where there are adhesions and where it is done by a very experienced clinician, then you would expect that extra efforts would be made, because of the adhesions, to make sure that the tube was, in fact, in the right place. But I certainly accept that the clinician may have believed that the clip was in the right place, or else he wouldn't have finished the surgery".

**Dr. Peter McKenna**

36. Dr. McKenna qualified as a doctor in 1974. He is a consultant obstetrician in the Rotunda and Mater Hospitals. Until 2001 he was the Master of the Rotunda. He was never involved in treating the plaintiff. For the purpose of giving evidence he had access to all of the relevant hospital records concerning the plaintiff and the video recording made by Dr. Boylan at the time of the second tubal ligation.

37. Dr. McKenna identified three reasons why a woman can have a baby after a tubal ligation. The first is that she was pregnant at the time of the procedure (a question which I will have to consider later in this judgment). The second is that the clip was not put in the right place, in which case the woman was never sterilised at all. The third is that the clip was in fact put on the right place but through the passage of time it eroded in which case there was a brief period where the egg made contact with the sperm. This third reason is not due to any failure on the part of the operator. It is a failure intrinsic to the technique.

38. He said:

> "My understanding would be that if the patient is pregnant at the time of the procedure, that is her affair. If the technique fails because the clip erodes through, having been put on the right place, well it does happen and nobody is to blame for that. But if the clip is put on the incorrect place and the patient has never been sterilised and the operation was not done correctly that is a different matter".

39. Later he said:

> "One would have expected a Consultant Gynaecologist to put the clips on the correct place. If not, to have recognised that and to have expressed their concern to the patient subsequently".
>
> "Question: Are there anatomical points which enable the correct tube to be located for the purpose of locating the clip in the correct place?
>
> Answer: Yes, there are, it is not that difficult".

40. In cross-examination he accepted that it appeared that Dr. Murray believed that he had in fact placed the clip in the right place and that his procedure was successful. He was then asked (and answered) a question which is really one for the court. It was as follows:

> "Question: But it does not necessarily imply that he (Dr. Murray) was in breach of his duty of care I suggest?
>
> Answer: That is not necessarily for me to say, that is a matter for the legal system. But I would always have approached it that if the woman is pregnant at the time of the surgery, that is her look out. If you put the clip on the right place and it wears through, nobody is to blame. But if you put the clip on the wrong place and there are no extenuating circumstances, the operator has got to face the music for that".

**The Legal Test**

41. The appropriate legal test by which Dr. Murray's conduct of the tubal ligation procedure has to be judged is that prescribed by the Supreme Court in *Dunne v. National Maternity Hospital* [1989] I.R. 91. In that case Finlay C.J. summarised six principles which he distilled from a consideration of a series of earlier cases. The first principle is the relevant one for this case. It reads 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".

42. That principle has to be understood and applied in the context of observations made by the same judge at page 110 of the report where he said:

> "In order fully to understand these principles and their application to any particular set of facts, it is, I believe, helpful to set out certain broad parameters which would appear to underline their establishment. The development of medical science and the supreme importance of that development to humanity makes it particularly undesirable and inconsistent with the common good that doctors should be obliged to carry out their professional duties under frequent threat of unsustainable legal claims. The complete dependence of patients on the skill and care of their medical attendants and the gravity from their point of view of a failure in such care, makes it undesirable and unjustifiable to accept as a matter of law a lax or permissive standard of care for the purpose of assessing what is and is not medical negligence. In developing the legal principles outlined and in applying them to the facts of each individual case, the courts must constantly seek to give equal regard to both of these considerations".

**Conclusions on tubal ligation**

43. I have set out in some detail the evidence given by Drs. Murray, Boylan and McKenna. There is no dispute but that Dr. Murray failed to apply the clip to the plaintiff's left fallopian tube. He was a consultant of very considerable experience when he carried out the operation. The thrust of the evidence from the two experts leads me to the conclusion that that failure on the part of Dr. Murray

was one which no medical practitioner of equal specialist status and skill would have been guilty of if acting with ordinary care. To put it in the words of Dr. McKenna:

> "If you put the clip on the wrong place and there are no extenuating circumstances, the operator has got to face the music for that".

44. The presence of adhesions in the present case did not in my view constitute an extenuating circumstance such as would excuse what occurred. There was a breach of the duty of care owed to the plaintiff.

**The plaintiff's consent**
45. Prior to the operation being carried the plaintiff executed a consent which read as follows:

> "Sterilisation
>
> Consent by Patient
>
> I, Bridget Byrne hereby consent to undergo the operation of sterilisation the nature and purpose of which has been explained to me by Dr./Mr. Murray.
>
> I have been told that the intention of the operation is to render me sterile and incapable of further parenthood. I understand that there is a possibility that I may not become or remain sterile.
>
> I also consent to the administration of a general, local or other anaesthetic.
>
> No assurance has been given to me that the operation will be performed by any particular surgeon".

46. The plaintiff signed that form as did Dr. Murray who confirmed on it that he had explained to the patient the nature and purpose of the operation.

47. All three specialists who gave evidence accepted that tubal ligation is not always successful and has a recognised failure rate. The form of consent executed by the plaintiff recognises that the operation may not be successful. For example, even if the clips are placed correctly they may wear through as described by Dr. McKenna in evidence. In such circumstances no liability could attach to the doctor who performed the ultimately unsuccessful sterilisation.

48. The defendant contends in his written submissions that by executing this document the plaintiff "consented to that risk of failure", thus relieving Dr. Murray of any liability. I cannot accept such a proposition.

49. First, the document in its terms is a consent to the operation being carried out and the administration of an anaesthetic. It is not a consent to the carrying out of a failure; still less is it a consent to the carrying out of the operation in a negligent fashion. It merely records the plaintiff's understanding that there is a possibility of failure. It might be possible to draft a form of consent which would exclude liability on the part of a doctor for negligent treatment but there is no attempt to do so here. In my view the consent executed by the plaintiff cannot be regarded as one which exonerates Dr. Murray in respect of his failure to effectively clip both fallopian tubes.

**Events after the sterilisation**
50. The plaintiff's sterilisation on the 16th December, 1999 was dealt with as a day case. She arrived at 7.30 in the morning, had the procedure carried out and was discharged on the afternoon of that day. She was not asked as to whether she might be pregnant at the time of the operation, nor was she required to have a pregnancy test. Her last menstrual period was recorded in the hospital record as being the 1st December, 1999. She was not asked to return to the hospital after the operation.

51. Apart from some discomfort she recovered well from the procedure.

52. In February 2000, she began to suffer from abdominal pains. She consulted Dr. Dunne. He thought she was suffering from adhesions left over from the ectopic pregnancy and that the sterilisation had irritated them.

53. On the 30th March, 2000 she suffered extreme abdominal pain as a result of which she went to the Accident and Emergency Department of Naas Hospital. At the hospital a routine urine sample was taken. A short time later a doctor came and asked the plaintiff how old her baby was. She told the doctor that she was not pregnant and that he must have the wrong chart. However he confirmed that she was three months pregnant. She was detained in hospital for a few days and then allowed home. Following discharge from Naas Hospital she consulted her general practitioner who transferred her to the Coombe for attention.

**June 2000**
54. The plaintiff was seen at an ante natal visit on the 1st June, 2000. Her last menstrual period was recorded in the hospital notes as having taken place on the 2nd January, 2000. A scan was carried out, which suggested that she was twenty three weeks pregnant, rather than the twenty one which was expected by reference to her last menstrual period. This discrepancy between the two dates is an issue which figured during the plaintiff's subsequent hospitalisation and indeed during the trial. Obviously if the length of pregnancy is calculated by reference to the scan, it suggests that the plaintiff was pregnant at the time Dr. Murray carried out the sterilisation. If, on the other hand, it is calculated by reference to the plaintiff's last menstrual period, the pregnancy occurred subsequent to the tubal ligation.

55. The plaintiff alleged that at the time when this scan was done somebody said to her that she might have been pregnant before she had the sterilisation. She alleged that the girl who had carried out the scan said that "the clips were on the tubes and they were secure". It is remarkable that the plaintiff, who had such poor recollection of other events, could remember this. I am not satisfied that this event occurred. All the evidence is to the effect that such an observation could not be made by reference to the scan. I think it likely that there was mention of the possibility of the plaintiff being pregnant at the time of the sterilisation. The plaintiff got the impression from that discussion that she was pregnant at the time of the sterilisation.

56. The plaintiff was not detained in hospital in June and returned home.

57. The plaintiff returned to the hospital complaining of abdominal pain on the 6th July, 2000.

**The July visit**
58. This was the plaintiff's second ante natal visit to the hospital. The plaintiff was complaining of abdominal pain and on this occasion was seen by a consultant, Mr. Tom D'Arcy.

**Mr. D'Arcy**
59. Mr. D'Arcy is a Fellow of the Royal College of Surgeons in Ireland and a member of the Royal College of Obstetricians and Gynaecologists. He qualified in medicine in 1984 and has been a consultant at both the Coombe Hospital and St. James's Hospital in Dublin since 2000.

60. Mr D'Arcy struck me as a very competent and thorough doctor with a great concern for the plaintiff.

61. He explained in great detail the examinations and tests which he carried out on the plaintiff when she came under his care on the 6th July, 2000. His first concern was that, having regard to her complaints and her previous obstetrical history, she might be in pre-term labour. Having carried out these examinations and tests he concluded that she was not. His second concern was to try and establish her dates and to "make sense of the disparity between those that were determined by her last menstrual period or her presumed last menstrual period on the 2nd January, 2000 and those that had been suggested on the basis of her booking scan". It is not necessary for the purpose of this judgment to set out in detail the various tests and calculations which he did and indeed the thinking process behind them. He certainly explored the question meticulously and came to the conclusion that it was more than likely that the plaintiff had conceived after her sterilisation. He was quite unequivocal about this in his evidence and in particular when asked the following question:

> "Q. Going back now to the month of July, 6th July, you are saying on that date you had come to the strong conclusion that the tubal ligation had failed. Inst that what the sum total of your evidence before lunch was?
>
> A. Yes."

62. I am quite satisfied that Mr. D'Arcy thoroughly and comprehensively carried out all necessary tests and examinations on the plaintiff so as to ascertain the true position concerning the length of her pregnancy. He concluded that she had become pregnant after the sterilisation. In my view he was correct in so concluding. The sterilisation had failed.

63. The question arises as to whether the plaintiff was told this. An issue also arises as to whether that information was communicated to other medical or nursing practitioners who would be involved in the subsequent care and management of the plaintiff.

**Was the Plaintiff informed?**
64. The plaintiff had no recollection of ever being informed during the course of her pregnancy with her sixth child Danielle that her tubal litigation had failed. She ought to have been so informed. That is the clear and uncontroverted view of Doctors Boylan and McKenna which I accept. Not only ought she to have been told, but other steps ought to have been taken by way of advice to her and procedures followed which were detailed in the evidence of those two doctors.

65. If the plaintiff had been so informed, I think it likely that she would have behaved in a manner other than she did following the birth of Danielle.

66. None of the doctors called by the defendant had any recollection of a conversation with the plaintiff during the course of her pregnancy in which she was told that her sterilisation had failed. This is understandable given their work load and the lapse of time. However, Dr. Boylan was clear that if an appropriate conversation had taken place with the plaintiff on this topic it would have been noted in her chart. His view in that regard was shared by Dr. Murray himself who said that he would expect a doctor to generally write in the chart that a patient had been informed of a failed ligation and given advice. No such note appears in the plaintiff's medical records.

67. Mr. D'Arcy, quite understandably, had no recollection of having such a conversation with the plaintiff. In his evidence he said that he:

> "certainly would not have given her to understand that her sterilisation had been successful, most certainly not, because there were grounds for considering otherwise having established the difference in her last menstrual period and having established exactly when she was sterilised and having considered also the fact that she had been on the oral contraceptive pill up to one week before she was actually sterilised".

68. Later in his testimony he said that he could not honestly say that he used the exact words that the plaintiff's "tubal ligation had failed". In re-examination he said that if he couldn't say that he used those exact words he believed that he told her that her tubal ligation had failed.

69. As I have already observed nowhere is it noted that such information was given to the plaintiff. In answer to questions which I put to Mr. D'Arcy he said that he does not always write down what he has said directly to a patient. However, he said if there were some very specific facts he would document them. If he felt the need to actually document a very specific meeting with a patient then he would be inclined to dictate a letter as to that meeting which he would then have placed within the notes and a copy sent to the patient's general practitioner or to the patient as well. Whilst he accepted that a failed tubal ligation was a rare occurrence he did not regard it as one of the specific instances where he would note what he might have said to the patient.

70. I am satisfied on the evidence that Mr. D'Arcy did not inform the plaintiff in terms clear to her that her tubal ligation had failed. Whatever may have been said it did not make the position clear to her. Given the comparative rarity of a failed tubal ligation and the consequences of such for the plaintiff I think it probable that if he had told the plaintiff of this he would have either noted the matter in the chart or have prepared a letter for inclusion on the chart with a copy being sent to the plaintiff's general practitioner. Mr. D'Arcy, very reasonably, was more concerned at the time with the plaintiff's pain and the condition with which she was presenting together with her history on previous pregnancies where she had required a cervical suture than with this issue. He did not deal with her again.

71. I also think it likely that, if she had been told, not only would the plaintiff's general practitioner have been informed but as a matter of professional courtesy, Dr. Murray would also have been informed. Neither of these things happened.

72. My findings in this regard are fortified by the actual notations which were made in the plaintiff's chart.

**The Chart**
73. Mr. D'Arcy is the only consultant identified in evidence as having made an entry on the plaintiff's chart during her pregnancy with Danielle.

74. Mr. D'Arcy dealt with the patient on the 6th July, 2000. He noted the discrepancy between her dates by reference to the scan results and her last menstrual period as related by her. Using distinctive green ink he wrote "measurements might suggest that she was pregnant just before TL given variation". He made other notations in green which are not of relevance here. He told me that this entry demonstrated a state in the process of his thinking and that when he ascertained that the tubal ligation had taken place on the 16th December, 1999 and that the plaintiff had been on the oral contraceptive pill until one week before that date he came to the conclusion that the tubal ligation more than likely had failed and that she had conceived after the sterilisation.

75. On the same page in the chart there are notes of what occurred on the plaintiff's first ante-natal visit to the hospital on the 1st June, 2000. Some unidentified doctor had written the words "Lap TL December 99 – failed TL". When Mr. D'Arcy obtained additional information from the plaintiff he inserted into this notation the figure "16" before the word "December" and he wrote under the notation "On OC pill until 1/52 before TL". These notes were made by Mr. D'Arcy in black ink rather than his characteristic green. Although he initialled the green notation he did not initial the notation made in black. It would not have been apparent to anybody reading the chart that the added words in black ink had been written by Mr. D'Arcy.

76. Mr. D'Arcy considered that this notation made it clear to anybody subsequently reading the chart that the plaintiff had a failed tubal ligation. In answer to two questions put by me he said as follows:

> "Question: Mr. D'Arcy am I correct in thinking that the thrust of your evidence is that another medical practitioner in the obstetrics area on looking at this note here would come away with a clear conclusion that a failed tubal ligation was the cause of the problem?
>
> Answer: That is correct.
>
> Question: And does it dispose in your view for once and for all the possibility of her having been pregnant at the time of the tubal ligation?
>
> Answer: Yes it does".

77. Whilst I do not doubt the sincerity of Mr. D'Arcy's views in this regard I cannot accept on the evidence that his notes did in fact achieve this desired result.

78. According to the evidence of Dr. McKenna if there was doubt as to whether the woman was pregnant before or after the tubal ligation a senior clinician ought to have noted in the chart that she needed to have her tubal patency checked at eight weeks. He was unequivocal in his view in that regard. Such a note would infer there was genuine doubt as to the efficacy of the tubal ligation. He could not discern any such entry on the chart. There is none.

79. The evidence of Mr. D'Arcy is that he had come to the clear conclusion that the tubal ligation had failed but there is no unequivocal note to that effect on the chart.

80. That Mr. D'Arcy's entries on the chart did not convey to other medical and nursing staff in the hospital his clear view as to the failure of the sterilisation can be gleaned by reference to notations which appear subsequent to those made by him on the 6th July, 2000.

81. On the same date at 18.50 hours a mid-wife recorded: "Had TL in December 99. Had period type bleed in January, 2000 scan dates today suggests she was pregnant before the TL". Next day, the 7th July, 2000 Dr. Sarma a Senior House Officer in Obstetrics wrote "T/L December 99 pregnant prior". If matters were as clear as Mr. D'Arcy believed it is unlikely that these notes would have made.

82. In my view the criticism made by Dr. McKenna that the plaintiff's chart did not contain an appropriate unequivocal statement as to Mr. D'Arcy's conclusions is well founded.

**Events post Danielle's birth**
83. Danielle was born on the 11th September, 2000.

84. At the time of the plaintiff's discharge from hospital after that event she was seen by Dr. Caoimhe Lynch.

85. Dr. Lynch qualified in medicine in 1999 and was a Senior House Officer in the Coombe having commenced work there in July, 2000. She has since obtained her Membership of the Royal College of Obstetricians and Gynaecologists in London and is also a Member of the Royal College of Physicians in Ireland. At present she is a clinical research fellow and specialist registrar in obstetrics and gynaecology attached to the Coombe Hospital.

86. Dr. Lynch cannot be criticised for the fact that she had no recollection of the conversation which she had with the plaintiff when discharging her from hospital on the 4th September, 2000.

87. Dr. Lynch made good notes in the plaintiff's chart pertaining to the plaintiff's discharge from hospital. It is quite clear that Dr. Lynch was very thorough in satisfying herself that the patient was fit for discharge on the day in question. That can be gleaned not merely from her evidence but also from the notes which she made on that occasion.

88. The note which is relevant for the purpose of this case relates to the plan which Dr. Lynch created for the plaintiff. It read:

> "- To see physiotherapist today prior to discharge
>
> - post natal OPD 6/52
>
> (to discuss fertility – PT pregnant – post TL"

89. Dr. Lynch required the plaintiff to come back to hospital rather than have a normal six week visit with her general practitioner.

This was because as she put it she was

> "Highlighting the fact that she needed to come back to the hospital and the reason – I put it in brackets – was to discuss her fertility because of the fact that she had become pregnant post tubal ligation".

90. Dr. Lynch told me that she did not assume that the plaintiff was pregnant at the time of her sterilisation. When asked what was her view as to when the plaintiff became pregnant she said:

> "Well, I would feel that there was a question that she had become pregnant following a tubal ligation. It was felt looking at the notes and establishing the dates that she was probably pregnant following the tubal ligation but that this had to be confirmed and hence the six week appointment to come back to the hospital".

91. Later in her evidence Dr. Lynch accepted that her note did not indicate that the plaintiff became pregnant following a tubal ligation because she was not in a position to make such a note. That is quite understandable given her juniority. No clear note to such effect was on the chart adding fortification for my finding that the entries made on the chart by Mr. D'Arcy did not clearly record his conclusion that the plaintiff had become pregnant following the tubal ligation.

92. Dr. Lynch was a very junior doctor and was aware of the delicacy of her position and how inappropriate it would have been for her at this juncture to reach a conclusion that the tubal ligation had failed. She quite properly recorded that the plaintiff had become pregnant post tubal ligation.

93. Dr. Lynch was clear that she would not simply have told the plaintiff to come back in six weeks time. Rather she would have explained to her why she wanted her to do so. That was made evident in a number of different places in her evidence. She said:

> "I would have explained why I wanted her to come back…. So one can assume that in the context of saying to the patient that she needed to come back to the clinic in six weeks, that you need to qualify the statement as to why you want her to come back in six weeks. Otherwise, they won't come back at all".

94. Later in her evidence Dr. Lynch told me:

> "But I would say that it was appropriate that she was to come back for her post natal appointment and in highlighting the fact to her that I had questioned whether her tubal ligation was a success".

95. However it is clear from the next answer from Dr. Lynch that she did not make any comment on whether the plaintiff's tubal ligation was successful.

96. The plaintiff was discharged. No contraceptive was prescribed. Dr. Lynch accepts that she did not note informing the plaintiff that she should assume that she was fertile and would become pregnant unless she took contraceptive precautions.

97. Dr. Lynch struck me as a very competent and conscientious doctor who went about her duties in discharging the plaintiff is a thorough manner. I am satisfied that she carried out a full and detailed consideration of the plaintiff's position and her records and had a discussion with her. Dr. Lynch was clearly concerned at the fact that the plaintiff had become pregnant subsequent to a tubal ligation. But there was nothing on the chart by way of a definitive note to say the ligation had failed. It was not up to Dr. Lynch to make such a finding. Indeed she was in a very difficult position because to have expressed the view that the sterilisation was a failure, given her level of juniority, could have created many difficulties given that she would be directly criticising an operation carried out by a very senior consultant in the hospital.

98. I am satisfied that she told the plaintiff to return to the hospital for a check-up six weeks subsequent to the discharge and that she made it clear to the plaintiff that there was uncertainty about her fertility and that it needed to be checked. She was, understandably, unable to say to the plaintiff that the sterilisation had failed.

99. Accordingly the plaintiff was discharged without being told then or at any stage during her stay in the Coombe in clear and unequivocal terms that her tubal ligation had failed.

100. She was undoubtedly told to return for an out-patients appointment six weeks after discharge and she was advised to do so because of uncertainty about her fertility.

101. I should record that Dr. Lynch was not the only member of the hospital personnel to see the plaintiff prior to her discharge. She was also seen by Ms. Elizabeth Byrne. She is a registered nurse and midwife and was employed in the Family Planning Department of the Coombe Hospital as a clinical midwife manager.

102. The hospital records demonstrate that on the 3rd September, 2000 the plaintiff was offered a leaflet that contained advice on all family planning methods that were available. That was given to her by the nursing staff on the ward. In addition however the chart notes that the ward staff requested Ms. Byrne to call on the patient for the purpose of giving family planning advice.

103. Ms. Byrne saw the plaintiff on the 4th September. The purpose of the visit would be to make the plaintiff aware of her fertility and to offer advice on what options were available.

104. Ms. Byrne had no recollection of any discussion with the plaintiff. Whilst she would have had access to the plaintiff's chart it was not her invariable practice to look at it and she was unable to remember whether she did so in the case of the plaintiff. Little assistance can be gleaned from Ms. Byrne's evidence. That is not a criticism of her as it would be quite impossible for her to have a recollection of having dealt with the plaintiff given that she would see about 2000 patients in any year.

**Conclusions on information given to plaintiff**

105. At no stage during her pregnancy or after delivery was the plaintiff clearly informed by any doctor, nurse or other personnel employed by the hospital that her tubal ligation had failed. The fact of the failure was not recorded in the plaintiff's chart in clear terms. I think the criticism made by Dr. McKenna where he said the following is well founded.

> "This is a case of the "emperor's clothes" here. Everybody was not facing up to the obvious that this woman had had a failed tubal ligation and that plan B should come into play and that her tubes should be checked or she should be offered sterilisation again. Everybody was hedging around the main issue that there had been a problem".

106. I am of the view that the plaintiff was aware that questions had been raised as to whether she was pregnant at the time of the sterilisation or not. She was also advised at the time of her discharge to return for an out patient appointment six weeks thereafter. The reason for that visit was explained to her by Dr. Lynch. Dr. Lynch was not in a position to say to her that the tubal ligation had failed but certainly made it clear that there was a question mark over it.

107. Dr. Boylan was of opinion that the failed sterilisation should have been brought to the plaintiffs notice in an unequivocal fashion. She should have been left in no doubt about it. In my view he is correct in that. That obligation was not discharged and there was a breach of the duty of care owed to the plaintiff in that regard.

**Contributory negligence**
108. The plaintiff did not attend the hospital for her six week check-up as advised. Had she done so I think it likely that matters would have been investigated further and a further pregnancy might well have been avoided. To have ignored the advice given to her by Dr. Lynch to attend for such an appointment, given what had occurred, was imprudent and in my view was also negligent. However no case of contributory negligence was pleaded against the plaintiff nor was it urged on me that her failure to take the advice offered to her on her discharge from the hospital amounted to such. Accordingly no further consideration need be given to this question.

**Dr. Dunne**
109. While the plaintiff was pregnant with Danielle she was also attending Dr. Dunne for antenatal care. He told the plaintiff to enquire in the Coombe as to the success or otherwise of her tubal ligation. He was aware of the discrepancy between the scan dates and the date of her last period. He was told that by the plaintiff. The plaintiff also told him that she was pregnant before she had the sterilisation. That information can only have been gleaned by the plaintiff from sources within the hospital. It again underscores the failure to tell her in unequivocal terms that her pregnancy arose subsequent to the sterilisation.

110. Dr. Dunne did not obtain any letter from the Coombe on the topic and accepted the plaintiff's account that she was pregnant prior to the sterilisation being carried out.

111. Following her birth, Danielle had some health problems which involved her being brought back to hospital on occasion. Dr. Dunne was involved in at least one of those episodes which occurred when she was a few weeks old. That brought him into contact with the plaintiff. On the basis of what he was told by the plaintiff and the lack of any communication from the Coombe he was satisfied that she was infertile due to the sterilisation. Consequently he offered her no advice on any form of contraception.

112. The plaintiff came to him in March, 2001 and asked him to conduct a pregnancy test upon her. He did so. It was positive and her estimated date of delivery was the 5th October, 2001. In fact her seventh child Damien was born prematurely on the 13th August, 2001.

113. Dr. Dunne was now quite certain that the tubal ligation had failed and following the birth of Damien he advised the plaintiff to have a coil inserted. This was done in December, 2001 and the second tubal ligation was performed by Dr. Boylan on the 5th December, 2002.

114. Had Dr. Dunne been told of the correct position by the hospital I believe he would have advised the plaintiff on appropriate contraceptive measures. In fact no form of family planning was practiced by the plaintiff following the birth of Danielle and within a short time her pregnancy with Damien occurred.

**Vicarious liability**
115. There was a breach of the duty of care owed to the plaintiff by Dr. Murray in carrying out the tubal ligation. A second breach occurred by the hospital personnel failing to clearly tell the plaintiff of the failure of the sterilisation and to offer appropriate treatment to rectify that position.

116. Is the defendant hospital vicariously liable for any damages which arise as a result of the first breach? The hospital contends that it is not.

**Dr. Murray's contract**
117. The defendant referred to many aspects of Dr. Murray's contract in arguing against vicarious liability. In the result they are not all that relevant on the topic since the defendant contends that ultimately the test to be applied is one of control. For completeness sake I deal hereunder with the terms of the contract.

118. Dr. Murray entered into a contract for appointment as a consultant at the Coombe Hospital on the 30th March, 1998. The contract is in the form generally referred to as the "consultant's common contract".

119. Under the contract Dr. Murray, as a category one consultant, undertook to work an aggregate of what are described as 33 'notional hours' at the hospital per week. Under clause 6 of the contract he was responsible for producing an agreed schedule specifying how he intended to discharge his full contractual commitment over a period from Monday to Friday. He was obliged to furnish to the hospital such information on the discharge of his scheduled sessions as was necessary and reasonable to establish that he was fulfilling his contractual agreement.

120. Clause 8.3 of the contract permitted Dr. Murray to conduct private practice in accordance with the terms of a memorandum of agreement appended to the contract.

121. Clause 5 of the contract dealt with the nature of consultant appointments. It read as follows:

> "5.1. For the purpose of this contract, a consultant is defined in the following general terms:
>
> > A consultant is a registered medical practitioner in hospital practice who, by reason of his training, skill and experience in a designated speciality, is consulted by other registered medical practitioners and undertakes full clinical responsibility for patients in his care, or that aspect of care on which he has been consulted, without supervision in professional matters by any other person. He will be a person of considerable professional capacity and personal integrity.
>
> 5.2. Being a consultant involves continuing responsibility for investigation and for the treatment of patients without supervision in professional matters by any other person. This continuing responsibility for investigation and for treatment

of patients is a personal matter between each consultant and each patient in his care and it extends for as long as the patient remains in the consultant's care. The consultant may discharge this responsibility directly in a personal relationship with his patient, or, in the exercise of his clinical judgment, he may delegate aspects of the patient's care to other appropriate staff, or he may exercise responsibility concurrently with another doctor or doctors. Notwithstanding this however, the unique position of the consultant in the hospital requires that he carries the continuing responsibility for his patients so long as they remain in his care.

5.3. *The employing authority and the consultant acknowledge that the provision of services to patients is a joint task which sets obligations on both parties."* (My emphasis)

122. The contract is a curious document in many ways and has all the hallmarks of having been drafted by a committee. For example under clause 2 of the agreement it is provided that it is subject to the terms and conditions specified in the contract, its appendices and in the memorandum of agreement appended to it. In that memorandum of agreement one finds reproduced verbatim in clause 2 the definition of consultant contained at clauses 5.1 and 5.2 of the contract itself. There is however an addition in clause 2 of the memorandum in the following terms:

"The agreed objective of the parties to this memorandum is the maintenance of the highest standards in the public hospital system. To this end, the remuneration, general conditions of employment and facilities are intended to attract and retain the major part of the practices of consultants of the highest calibre on the sites of public hospitals."

123. Going back to the contract itself, clause 6.1 reads as follows:

"The Coombe Lying-in Hospital recognises your right to the exercise of your independent judgment in clinical and ethical matters (subject to the provisions of clause 8.11). Consultants in the Coombe Lying-in Hospital carry full clinical responsibility for patients under their care within the medical policy as determined from time to time by the Master and approved by the Board of the hospital."

124. Clause 9.4 of the contract required Dr. Murray to keep himself indemnified against claims arising from malpractice and negligence in relation to his appointment. The hospital agreed to reimburse him to the extent of 90% in respect of the cost of such indemnity. Clause 2.10 of the memorandum of agreement contains a similar obligation.

125. The memorandum of agreement also repetitiously stipulates the role of the consultant in terms similar to those contained in clause 5 of the agreement. There are however some additional provisions most particularly contained at paras. 6.4.2. and 6.4.3. of the memorandum of agreement. They read as follows:

"6.4.2. Insofar as the work of the consultant is created by the demand placed on the hospital for the provision of specialist hospital services the consultant can be *seen as providing a service to patients on behalf of the hospital* (my emphasis). The work arising from him from the hospitals accident and emergency service is an example of the service provided by a consultant to patients on behalf of the hospitals. *The work arising for him from general practitioner referrals or from secondary or tertiary referrals to the hospital where the hospital has a defined responsibility for providing such a service, are other examples of services the consultant is asked to provide.* (My emphasis). It should be noted that regardless of the mode of referral, once a patient and doctor come into contact, then the relationship is a personal one between the patient and the doctor.

6.4.3. It can be seen from the description of the unique characteristics of consultant work that *not alone does he provide some overall service to patients on behalf of the hospital to a population, he may also diagnose and treat patients directly referred to him personally* (My emphasis). He may also wish, or be required, to undertake research and developmental work; to participate, as of right, in the selection process for Non Consultant Hospital Doctors; engage in teaching and education; conduct private practice and engage in systematic evaluation or audit of medical work with colleagues."

**The Defendants Submissions and Conclusions on Vicarious Liability.**

126. The defendant submits that the hospital is not vicariously liable for Dr. Murray's breach of duty by reference to four propositions which are contained in his written submissions. They are

"1. The correct legal criterion by reference to which a determination is made as to whether the hospital is vicariously liable for the consultant is the extent of the control exercised by the hospital over the actions of the consultant.

2. This is so whether or not the consultant was an employee of the hospital under a contract of service or an independent contractor under a contract for services.

3. In any event, the consultant was not in fact an "employee" of the hospital in that he was engaged by the hospital as a consultant obstetrician under the consultants common contract which, as a matter of construction, is a contract for services.

4. The hospital was not "in control" of the actions of the consultant in carrying out the plaintiff's tubal ligation procedure".

127. The defendant asserts that the issue of whether a person is liable in law for the wrongdoing of another is determined by reference to the element of control that is exercised regardless of the nature of the contract which governs those persons.

128. The defendant refers to the decision of the Supreme Court in *Moynihan v. Moynihan* [1975] 1 I.R. 192 and the High Court in *Holohan v. Minister for Defence and Others* (Unreported, Kinlen J. 30th July, 1998). In that case that judge stated that "the basis in modern jurisprudence for vicarious liability is control" and cited with approval an observation contained in the 3rd Edition of McMahon and Binchy on the Law of Torts which said of *Moynihan's* case that "the decision is important because it clearly indicates that the control concept is used, not as a justification for vicarious liability, but rather as a test to determine the person for whose actions liability will be imposed on the defendant". In the written submissions the defendant refers to the current edition of McMahon and Binchy and quotes the following section (paragraph 43.18) where this statement appears "since the Supreme Court decision in *Moynihan v. Moynihan* however the degree of control which the principal exercises seems to be emerging as the single most

important, if not the crucial factor in establishing liability, in Ireland at least".

129. The defendants did not quote the following passage which occurs on the next page of that issue of McMahon and Binchy. There the authors say of the control test as follows. "The control test, however, while useful in many cases does not seem to be determinative in all circumstances, for example, in what has become known as "the hospital cases". Is the health authority or the hospital authority vicariousably liable for the negligence of resident surgeons, anaesthetists, nurses, etc? In these cases there is no question of the employer controlling the way in which the surgeon operates, and if the control test is doggedly adhered to the plaintiff may be denied access to "the deep-pocket". After much uncertainty the rule seems to be well accepted that medical staff in the fulltime service of hospitals are employees for the purposes of vicarious liability. That this has been accepted in Ireland can be seen from such cases as *O'Donovan v. Cork County Council.* Here in an action against the defendant council for the alleged negligence of a surgeon and an anaesthetist the defendant council, while denying negligence, did not even contest the proposition that it would be vicariously liable if negligence were proved on the part of the surgeon or the anaesthetist. The remnants of the ancien regime have not disappeared completely, however, since Irish health services still retain distinctions between public and private patients, which impact on the issue of vicarious liability. In *Bolton v. Blackrock Clinic Limited*, the plaintiff unsuccessfully sued a cardiothoracic surgeon and a consultant thoracic physician for negligence in her treatment. She also sued the hospital where these specialists worked, on the basis of direct and vicarious liability. Having dismissed the plaintiff's claim against the specialists, Geogehgan J. observed "that being so, there cannot be any question of vicarious liability of the hospital for medical negligence. Indeed at any rate the plaintiff was a private patient of the doctors in a private hospital, the question of vicarious liability may not arise".

130. In my view the authors of McMahon and Binchy are correct in identifying that the control test is not of universal application and that hospital cases are to a considerable *extent sui generis.*

131. This view is not peculiar to Ireland. Later in the defendant's written submissions there is a quotation from the 19th Edition of Clerk and Lindsell on Torts in the chapter dealing with vicarious liability. The defendant quotes the following: "Visiting consultants and surgeons, on the other hand, have been said not to be the employees of the hospital authorities, but, however this may be, the development of a different approach to the liability of hospital authorities for negligence occurring in the course of the treatment of their patients has probably deprived the point of practical significance. In many of the cases the tendency has been to treat the question of the hospital authorities liability as raising issues of primary, as well as vicarious responsibility. The hospital itself, it is said, is under a duty to its patients which it does not discharge simply by delegating its performance to someone else, no matter whether the delegation be to an employee or an independent contractor. On this basis it makes no difference whether or not a visiting consultant is a servant. There is some support for this view in *Wilshire v. Essex Area Health Authority* where Brown Wilkinson VC stated (obiter):-

> "A health authority which so conducts its hospital that it fails to provide doctors of sufficient skill and experience to give the treatment offered at the hospital may be directly liable in negligence to the patient".

132. This quotation is cited as being illustrative of cases where a hospital may be found to have been in breach of its own primary duty of care to its patients. It is suggested that on the evidence in the present case no issue arises as to any alleged breach by the hospital of its primary responsibility to its patient and the only possible basis for a finding of liability against it is on the basis of vicarious liability in respect of the performance of the sterilisation. This is not correct. There was in my view a breach of the hospital's primary duty to inform the plaintiff of the failure of the sterilisation so the question of vicarious liability does not arise on that issue. On the question of the failed sterilisation there was also in my view a breach of primary duty given the fact that the plaintiff was a public patient referred to the hospital and not to an individual consultant. Fortification for this view can also be had by reference to those parts of Dr. Murray's contract which I have emphasised and in particular clause 5.3, 6.4.2 and 6.4.3 of the memorandum of agreement. Lest however I am wrong in this view I will deal with the question of vicarious responsibility for the failed operation.

133. In citing the above quotation from Clerk and Lindsell the defendant failed to refer to the preceding paragraph from the same work in which the following is to be found "it was formerly thought that hospital authorities could not be liable vicariously for the negligence of a member of their medical staff, whether professionally qualified or not, if the negligence occurred in the course of an operation or treatment calling for the exercise of medical skill and knowledge. As the element of control over the method of working was lacking, according to the traditional view it followed that they could not be regarded as the employees of the hospital authority. In modern case law however, a different view has prevailed and such professionally qualified persons as radiographers, house surgeons, full time assistant medical officers and staff anaesthetists have been held to be employees of the hospital authority for the purposes of vicarious liability. Indeed it is submitted that any member of the full time staff of the hospital should be regarded as an employee of the hospital authority".

134. These passages from both Irish and English textbooks appear to me to be fully justified by reference to the case law cited in them and are correct. I do not propose to add to an already lengthy judgment by citing from all of the cases cited. However a number of quotations from two of the cases in my view accurately describe the position.

135. In *Cassidy v. Ministry of Health* (1951) 2 KB 343 the Court of Appeal, in allowing the appeal, held that a hospital authority is liable for the negligence of doctors and surgeons employed by the authority under a contract of service arising in the course of the performance of their professional duties. The decision to allow the appeal was a unanimous one. However Denning LJ (as he then was) went further than the other two Lords Justices where he said (at p. 362):-

> "It has been said, however, by no less an authority than Goddard LJ in *Golds* case (1942 2 KB 293) that the liability for doctors on the permanent staff depends, on "whether there is a contract of service and that must depend on the facts of any particular case". I venture to take a different view. I think it depends on this: Who employs the doctor or surgeon – is it the patient or the hospital authorities? If the patient himself selects and employs the doctor or surgeon, as in Hillyer's case, the hospital authorities are of course not liable for his negligence, because he is not employed by them. But where the doctor or surgeon, be he a consultant or not, is employed and paid, not by the patient, but by the hospital authorities, I am of opinion that the hospital authorities are liable for his negligence in treating the patient. It does not depend on whether the contract under which he was employed was a contract of service or a contract for services. That is a fine distinction which is sometimes of importance; but not in cases such as the present, where the hospital authorities are themselves under a duty to use care in treating the patient.
>
> I take it to be clear law, as well as good sense, that, where a person is himself under a duty to use care, he cannot get rid of his responsibility by delegating the performance of it to someone else, no matter whether the delegation be to a servant under a contract of service or to an independent contractor under a contract for services".

136. At the conclusion of his judgment Denning LJ said

> "turning now to the facts in this case, this is the position: the hospital authorities accepted the plaintiff as a patient for treatment, and it was their duty to treat him with reasonable care. They selected, employed, and paid all the surgeons and nurses who looked after him. He had no say in their selection at all. If those surgeons and nurses did not treat him with proper care and skill, then the hospital authorities must answer for it, for it means that they themselves did not perform their duty to him. I decline to enter into the question whether any of the surgeons were employed only under a contract for services, as distinct from a contract of service. The evidence is meagre enough in all conscience on that point. But the liability of the hospital authorities should not, and does not, depend on nice considerations of that sort. The plaintiff knew nothing of the terms on which they employed their staff; all he knew was that he was treated in the hospital by people whom the hospital authorities appointed; and the hospital authorities must be answerable for the way in which he was treated".

137. Denning LJ may have been somewhat ahead of his time in expressing these views. Neither of his colleagues on the Court of Appeal went so far since they decided that the hospital authority was liable in respect of doctors who were employed under a contract of service. However the views of Denning LJ in my view are correct and are applicable in the instant case.

138. In *Roe v. Minister of Health* (1954) 2 QB 66 the Court of Appeal again had to consider the question of vicarious liability. All three judges delivered separate judgments to the same effect in that they dismissed the appeal. In his judgment Somervell LJ regarded the question of vicarious liability as being settled by reference to whether or not the doctor was part of the permanent staff of the hospital. More to the point, however, for this case is the judgment delivered by Morris LJ.

139. He said (at p. 90)

> "If a patient in 1947 entered a voluntary hospital for an operation it might be that if the operation was to be performed by a visiting surgeon the hospital would not undertake, so far as concerned the actual surgery itself, to do more than to make the necessary arrangements to secure the services of a skilled and competent surgeon. The facts and features of each particular case would require investigation. But a hospital might in any event have undertaken to provide all the necessary facilities and equipment for the operation and the obligation of nursing and also the obligation of anaesthetizing a patient for his operation. The question in the present case is whether the hospital undertook these obligations. In my judgment they did. There can be no doubt but that they undertook to nurse the plaintiffs and to provide the necessary facilities and equipment for the operations. I think they further undertook to anaesthetise the plaintiff. The arrangements made between the hospital and Dr. Pooler and Dr. Graham, together with the arrangements by which a resident anaesthetist was employed, had the result that the hospital provided a constantly available anaesthetic service to cover all types of cases.
>
> It is true that Dr. Pooler and Dr. Graham could arrange between themselves as to when they would respectively be on duty at the hospital: and each was free to do private work. But these facts do not negative the view, to which all the circumstances point, that the hospital was assuming the obligation of anaesthetising the plaintiffs for their operations. I consider that the anaesthetists were members of the "organisation" of the hospital: they were members of the staff engaged by the hospital to do what the hospital itself was undertaking to do. The work which Dr. Graham was employed by the hospital to do was work of a highly skilled and specialised nature, but this fact does not avoid the application of the rule of respondeat superior."

140. The views of the members of the Court of Appeal in these two cases, expressed as they were over 50 years ago, appear to be correct to this day and of application in the instant case.

141. The plaintiff was referred not to a particular surgeon but to the Coombe Hospital. She had no say in the choice of who would carry out her sterilisation. It was done by Dr. Murray. He was part of the "organisation" or permanent staff of the hospital. The performance of the operation was part of a service provided by the hospital to the plaintiff. Dr. Murray was the person in the hospital's organisation via whom that service was provided.

142. In these circumstances it matters not whether Dr. Murray was employed under a contract of service or a contract for services. In my view having regard to the principles enunciated in both *Cassidy* and *Roe's* case the hospital here is liable for any want of care on the part of Dr. Murray.

**Damages for pregnancy, birth and second sterilisation**

143. The defendant concedes that in the event of a finding of negligence the plaintiff is entitled to damages for the pain suffering and inconvenience of pregnancy and childbirth and of course for having to have the sterilisation repeated. Special damages for extra medical expenses are also conceded. These concessions are made by reference to the views expressed by the majority of the members of the House of Lords in *McFarlane v. Tayside Health Board* (2000) 2 A.C. 59.

144. In the light of these concessions I am not called upon to consider whether as a matter of principle it is open to the plaintiff to recover damages arising from her pregnancy and the births of Danielle and Damien.

145. In *McFarlane's* case Lord Gill, the Lord Ordinary (as he then was) considered that pregnancy could not be equiparated with a physical injury. Even if it could, he held that it was not an injury for which damages are recoverable. The existence of a child and the mother's happiness derived from it could not be ignored and they outweighed the pain and discomfort.

146. He held that damages were not recoverable as a matter of principle. That was not a view shared by the Inner House of the Court of Session or the majority in the House of Lords. Whether Lord Gill's view is to be preferred to that of the other judges is a matter which I am not called upon to decide in the light of the concession which the defendants make as to the entitlement of the plaintiff to damages. I will assess these damages later.

147. The largest part of the plaintiff's claim in these proceedings is in respect of the cost of rearing the two children born subsequent to her first sterilisation. That sum has been agreed at €27,000 to date and €354,678.00 for the future. The question to which I must now turn my attention is as to whether the plaintiff is entitled to recover such damages.

**Damages for rearing Danielle and Damien**

148. In *McFarlane's* case Lord Gill disallowed the claim for damages for the costs of rearing the child that was born following the failed vasectomy of the father. He said:

> "I am of the opinion that this case should be decided on the principle that the privilege of being a parent is immeasurable in money terms; that the benefits of parenthood transcend any patrimonial loss, if it may be so regarded, that the parents may incur in consequence of their child's existence; and that therefore the pursuers in a case such as this cannot be said to be in an overall position of loss".

149. In the present case the plaintiff has been at pains throughout her case to make it clear that both Danielle and Damien were welcomed into her family by both parents and their siblings. The parents have since separated but Danielle and Damien continue to be "loved, cherished and supported by both of them. Their children are a source of joy and satisfaction to them. They, no more than any other parents, do not assess their relationship with Danielle and Damien in terms of profit and loss. They do not seek compensation from the courts in respect of any of the intangible burdens in the upbringing of their children. They accept those burdens as do any parents gladly". Given this acknowledgement of the joy and satisfaction that these two children have brought to her there is a certain incongruity in the plaintiff seeking to recover the costs of rearing them from the defendant. I think there is much to be said for the observations of Lord Gill in this regard.

150. Lord Gill's decision was appealed to the Inner House. The appeal was allowed. The case then went to the House of Lords which restored the conclusion of Lord Gill. Their Lordship's House held unanimously that a negligent doctor is not required to meet the cost of bringing up a healthy child born in circumstances such as obtain in the instant case. In reaching that conclusion the legal reasoning and the language used by the five Law Lords differed. But in essence the conclusion which was reached was that fairness and reasonableness do not require the damages payable by a negligent doctor should extend so far as to require him to pay for the cost of rearing an unintended healthy child.

151. That view expressed by the House of Lords is one which has found favour in the majority of the common law countries where this issue has arisen.

152. The speeches of their Lordships in *McFarlane's* case contain a detailed analysis of all of the previous decisions in England, Wales, Scotland, the Commonwealth countries, other common law jurisdiction and a number of civil jurisdictions.

153. In his speech Lord Steyn traces the history of such claims in England beginning with *Udale v. Bloomsbury Area Health Authority* [1983] I.W.L.R. where Jupp J. rejected a claim for the cost of bringing up an unwanted child. That Judge observed that the birth of a child is "a blessing and an occasion for rejoicing". In 1986 Peter Pain J. in *Thake v. Maurice* [1986] Q. B. 644 declined to follow *Udale's* case and allowed such a claim. He observed that social policy which permitted sterilisation implied that it was generally recognised that the birth of a healthy child was not always a blessing. These divergent approaches were considered by the Court of Appeal in *Emeh v. Kensington and Chelsea and Westminister Area Health Authority* [1985] 1 Q.B. 1012. The unwanted child in *Emeh's* case had been born with congenital disabilities. The defendants argued that damages should be limited to the extra costs of upbringing attributable to the disabilities. Full costs were allowed but in what was described as a 'modest sum of £6,000'.

154. It is clear that the decision in *Emeh's* case was one which created unease amongst judges. As is recorded by Lord Steyn that was memorably articulated in *Jones v. Berkshire Area Health Authority* (Unreported, 2nd July, 1986) another unwanted pregnancy case where Ognall J. said:

> "I pause only to observe that, speaking purely personally, it remains a matter of surprise to me that the law acknowledges an entitlement in a mother to claim damages for the blessing of a healthy child. Certain it is that those who are afflicted with a handicapped child or have longed desperately to have a child at all and are denied that good fortune, would regard an award for this sort of contingency with a measure of astonishment. But there it is: that is the law".

155. Since the decision of the House of Lords in *McFarlane's* case it is no longer the law in England and Wales. Furthermore the decision in McFarlane was subsequently considered by a differently constituted judicial committee of the House of Lords in *Rees v. Darlington Memorial Hospital NHS Trust* [2004] 1 A.C. 309 and was not disturbed.

156. That the view of the House of Lords in *McFarlane* is not out of kilter with other jurisdictions can be ascertained by reference to the following passage from the speech of Lord Steyn:

> "In the United States the overwhelming majority of state courts do not allow recovery of the costs of bringing up a healthy child: see the review in *Johnson v. University Hospital of Cleveland*, 540 N.E. 2d 1370. In Canada the trend is against such claims: see *Kealey v. Berezowski* [1996] 136 D.L.R. (4th) 708 which contains a review. By a majority the New South Wales Court of Appeal in *CES v. Superclinics (Australia) Pty. Ltd*. 38 N.S.W.L.R 47 held that the plaintiff had, through the negligence of the defendants lost the opportunity to have an abortion which would not necessarily have been unlawful. The court ordered a retrial on the issue as to whether an abortion would have been unlawful. Kirby P. considered that damages could be awarded for the cost of bringing up the child. Priestly J.A. was prepared to allow a limited recovery for "wrongful birth" but not for child rearing expenses and Meagher J. A. agreed with Priestly J. A. on this point, though in a dissenting opinion he concluded that public policy was an absolute bar to the award of damages in "wrongful birth" cases. In New Zealand there is a no fault compensation scheme. It is, however, instructive to note that the Accident and Compensation Authority held that there was no causal connection between the medical error and the cost of raising the child. In Germany the Constitutional Court has ruled that such a claim is unconstitutional in as much as it is subversive of the dignity of the child. But the Bundesgerichtshof has rejected this view and permits recovery of the costs of bringing up the child. The Federal Court observed that compensation not only has no detrimental effect on this child, but can be beneficial to it. In France The Cour de Cassation has ruled that:
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> > "Whereas the existence of the child she has conceived cannot in itself constitute for the mother a loss legally justifying compensation, even if the birth occurred after an unsuccessful intervention intended to terminate the pregnancy".
>
> Such claims are not allowed. From this comparative survey I deduce that claims by parents for full compensation for the financial consequences of the birth of a healthy child have sometimes been allowed. It may be that the major theme in such cases is that one is simply dealing with an ordinary tort case in which there are no factors negativing liability in delict. Considerations of corrective justice as between the negligent surgeon and the parents were dominant in such decisions. In an overview one would have to say that more often such claims are not allowed. The grounds for decision are diverse. Sometimes it is said that there was no personal injury, a lack of forseeability of the costs of bringing up the child, no causative link between the breach of duty and the birth of a healthy child, or no loss since the joys of having a healthy child always outweigh the financial losses. Sometimes the idea that the couple could have avoided the financial costs of bringing up the unwanted child by abortion or adoption has influenced decisions. Policy considerations

undoubtedly played a role in decisions denying a remedy for the cost of bringing up an unwanted child. My Lords, the discipline of comparative law does not aim at a poll of the solutions adopted in different countries. It has the different and inestimable value of sharpening our focus on the weight of competing considerations. And it reminds us that the law is part of the world of competing ideas markedly influenced by cultural differences. Thus Fleming has demonstrated that it may be of relevance, depending on the context, to know whether the particular state has an effective social security safety net".

157. Whilst the five Law Lords in McFarlane came to the same conclusion they did so for different reasons. I think there is little to be gleaned by quoting large extracts from their individual speeches. Rather I should attempt to summarise the rationale for the decision. In the case of Lords Slynn, Steyn and Hope they took the view that a claim such as the present one was neither fair or just or reasonable. In the case of Lord Clyde considerations of distributive justice appeared to weigh heavily in leading him to his conclusion. Lord Millett's view was rather similar to that expressed at first instance by Lord Gill to the effect that the advantages and disadvantages of parenthood are so bound up together that the benefits should be regarded as outweighing any loss. All of these appear to me to boil down to the view which I have already expressed in this judgment to the effect that their Lordships took the view that such a claim was neither fair or just or reasonable.

158. Indeed I am fortified in this expression of opinion by reference to the later case of *Rees v. Darlington Memorial Hospital NHS Trust* [2004] 1 A.C. 309.

159. That was a case which resulted in seven Law Lords being assembled since they were asked to reconsider *McFarlane's* case. A number of their Lordships were common to both cases. By a majority the decision in *McFarlane* was applied. In not disturbing *McFarlane* the Court considered developments which had taken place in the meantime in other countries and in particular the Australian case of *Cattanach v. Melchior* [2003] H.C.A. 38.

160. Perhaps the most useful speech from those in the majority in the *Rees* case is that of Lord Bingham of Cornhill. In reviewing the decision in *McFarlane* he said:

> "The five members of the House who gave judgment in *McFarlane* adopted different approaches and gave different reasons for adopting the third solution listed in paragraph (3) above (i.e. that no damages may be recovered where the child is born healthy and without disability or impairment). But it seems to me clear that all of them were moved to adopt it for reasons of policy (legal, not public, policy). This is not a criticism. As Lord Denning M. R. said in *Dutton v. Bognor Regis Urban District Council* [1972] 1 Q.B. 373, 397:
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> > "This case is entirely novel. Never before has a claim been made against a council or its surveyor for negligence in passing a house. The case itself can be brought within the words of Lord Atkin in *Donoghue v. Stevenson*: but it is a question whether we should apply them here. In *Dorset Yacht Co. Limited v. Home Office* [1970] A.C.1004, Lord Reid said, at p. 1023, that the words of Lord Atkin expressed a principle which ought to apply in general "unless there is some justification or valid explanation for its exclusion". So did Lord Pearson at p. 1054. But Lord Diplock spoke differently. He said it was a guide but not a principle of universal application (p. 1060). It seems to me that it is a question of policy which we, as judges, have to decide. The time has come when, in cases of new import, we should decide them in accordance with the reason of the thing.
> >
> > In previous times, when faced with a new problem, the judges have not openly asked themselves the question: what is the best policy for the law to adopt? But the question has been there in the background. It has been concealed behind such questions as "was the defendant under any duty to the plaintiff? Was the relationship between them sufficiently proximate? Was the injury direct or indirect? Was it foreseeable, or not? Was it too remote? and so forth.
> >
> > Nowadays we direct ourselves to considerations of policy. In *Rondel v. Worsley* [1969] 1 A.C. 191, we thought that if advocates were liable to be sued for negligence they would be hampered in carrying out their duties. In *Dorset Yacht Co. Limited v. Home Office* [1970] A.C. 1004, we thought that the Home Office ought to pay for damage done by escaping Borstal boys, if the staff was negligent, but we confined it to damage done in the immediate vicinity. In *S.C.M. (United Kingdom) Limited v. W.J. Whittall and Son Limited* [1971] 1 Q.B. 337, some of us thought that economic loss ought not to be put on one pair of shoulders, but spread among all the sufferers. In *Launchbury v. Morgans* [1971] 2 Q.B. 245, we thought that as the owner of the family car was insured she should bear the loss. In short, we look at the relationship of the parties: and then say, as a matter of policy, on whom the loss should fall".
>
> The policy considerations underpinning the judgments of the House were, as I read them, an unwillingness to regard a child, (even if unwanted) as a financial liability and nothing else, a recognition that the rewards of parenthood (even if involuntary) may or may not bring cannot be quantified and a sense that to award potentially very large sums of damages to the parents of a normal and healthy child against a national health service always in need of funds to meet pressing demands would rightly offend the community sense of how public resources should be allocated".

161. While this latter observation may have little application here nonetheless it seems to me that the question which I have to ask is one of principle or, if one prefers, policy.

**Principle/Policy in Irish Law**

162. The decision in the Supreme Court in *Fletcher v. The Commissioners for Public Works* [2003] 1 I.R. 465 makes it plain that it is proper to exclude an award of damages in certain circumstances on the grounds of policy. That case raised a question which had not been considered in this jurisdiction before. It was whether, and if so, to what extent and subject to what limitations, an action might lie in negligence where the sole injury for which damages were sought to be recovered was a psychiatric condition resulting from fear of contracting an illness in the future as a consequence of alleged negligent acts and omissions. In this court O'Neill J. awarded damages to the plaintiff. His decision was reversed by a unanimous Supreme Court with two written judgments being delivered. The first was that of Keane C. J. and the second was by Geoghegan J.

163. Both judgments recognised that a question of policy fell to be decided by the court. Indeed in his judgment Geoghegan J. mirrored to some extent the observations of Lord Denning M. R. in *Dutton's* case, the relevant extract from which is contained in the quotation from the speech of Lord Bingham in the Rees case which I have already reproduced.

164. Geoghegan J. said:

> "It is against this background of the case law, which I have reviewed, that this court must decide, as a matter of policy and of reasonableness, whether claims for damages for psychiatric injury only and resulting from fear of asbestos related diseases of a degree which is objectively irrational are recoverable. Traditionally, courts do not always use the actual word "policy". They may attempt to draw artificial limits to what can be regarded as being reasonably foreseeable or they may, in considering proximity or other questions in relation to the existence of a duty of care, invoke the concept of reasonableness so that a duty of care will not in fact be imposed if the court considers it unreasonable to do so. The third control mechanism which the court may impose is in relation to particular heads of damage or finally, they may expressly deny a claim on grounds of public policy".

165. Keane C. J. and Geoghegan J. both cite with approval observations from two different members of the House of Lords in the case of *White v. Chief Constable of South Yorkshire Police* [1999] 2 A.C. 455. Keane C. J. cites the views of Lord Steyn whilst Geoghegan J. those of Lord Hoffmann.

166. Having quoted from Lord Hoffmann's speech Geoghegan J. said that he agreed

> "that pragmatic control mechanisms must be applied in actions for pure psychiatric damage and, in many instances, even in the interests of distributive justice".

167. These observations of the Supreme Court appear to entitle me to decide on the recoverability of damages as a matter of principle or legal policy since the question has never heretofore been considered by courts in this jurisdiction. In making that decision the court is entitled to have regard to concepts of reasonableness and distributive justice.

**Decision on costs of upbringing**
168. I conclude that it is not open to the plaintiff to recover damages for the cost of upbringing the two healthy children which she bore subsequent to her failed sterilisation. I do not believe that the law in this jurisdiction should be extended so as to allow the recovery of such damages.

169. I am persuaded that the conclusions reached by the House of Lords in both in the *McFarlane* and *Rees* cases are correct. They are to be preferred to the majority view expressed in the Australian case of *Cattanach v. Melchior.* I have not cited particular passages from the judgments in that case since I share the view of Lord Millett (as expressed in *Rees*) that "despite the diversity of opinion, the judgments cover familiar ground and contribute no new insight".

170. I am of opinion that it would not be fair or reasonable to visit a doctor who negligently performs a sterilisation procedure with the cost of rearing a healthy child that is conceived and born subsequent to the failure of such procedure. Even if one disagrees with this approach the refusal to award damages in circumstances such as this can be equally justified by considerations of distributive justice as particularly exemplified in the speech of Lord Clyde. Alternatively the view can be justified by reference to the views of Lord Gill at first instance and Lord Millett in the House of Lords to the effect that the benefits of a healthy child outweigh any loss incurred in rearing the child. Whilst the parties here have agreed the quantum of damages a decision in favour of the claim made would open the door to a limitless range of claims related to every aspect of family life.

171. I obtain some comfort that in arriving at this decision, the court is in harmony with the majority of decisions in the common law world. The vast majority of state courts in the United States, the courts of England and Wales, Scotland and a number of civil law courts are of like mind.

172. I am also of opinion that the conclusion which I have arrived at blends more harmoniously with the constitutional order which obtains in this jurisdiction then would a decision to the contrary. The value which the Constitution places upon the family, the dignity and protection which it affords to human life are matters which are, in my view, better served by a decision to deny rather than allow damages of the type claimed.

173. Accordingly I refuse to award damages in respect of the costs of rearing Danielle and Damien.

**Assessment of Damages**
174. There is no doubt but that the plaintiff is entitled to recover damages for having to undergo a second tubal ligation. That was carried out on the 5th December, 2002. The plaintiff has no recollection of it. It was carried out by Dr. Boylan and was quite straightforward. It did not involve overnight hospitalisation and the plaintiff had no complaints thereafter. She must also have had the usual anxiety that accompanies any surgical procedure and is entitled to be compensated for that. It was however a minor procedure carried out speedily and uneventfully. I award the sum of €10,000 damages to compensate for having to undergo this second operation.

175. As I have already pointed out, the defendant has conceded that in the event of a finding of negligence the plaintiff is entitled to damages for the pain, suffering and inconvenience of pregnancy and childbirth together with any special damages for extra medical expenses involved. The question of principle as to whether there is in law an entitlement to such damages will have to await another case where a concession such as the one made in this case is not forthcoming. It is sufficient to record that there is no unanimity of judicial opinion throughout the common law world on the topic.

176. Pregnancy is not an illness or a disease. It does cause pain, sickness and distress. It is an entirely natural process. In the present case it resulted in the births of two unique human beings, Danielle and Damien, who are both healthy. Danielle was born one month prior to term. She did have some breathing difficulties and some infections thereafter but they had all resolved within a year and she is a healthy child. Damien was born seven and a half weeks prior to term. He is also healthy.

177. I accept the plaintiff's evidence that both pregnancies had attendant difficulties over and above what might be regarded as the norm. In the case of Danielle the plaintiff had to wear a support strap which was found to be ineffective and so for six to eight weeks prior to and subsequent to her confinement was on crutches. In the case of her pregnancy with Damien she had similar difficulties and was on crutches for three weeks prior to his birth. She had to remain on crutches for six to eight weeks subsequent thereto. Danielle's pregnancy was the longer of the two and the more difficult from the plaintiff's point of view.

178. In assessing damages I also take account of the shock and emotional distress caused to the plaintiff when she discovered that she was pregnant with these two children. She did not want either pregnancy and would not have had them but for the defendants breaches of duty.

179. I assess damages in respect of the pregnancy and birth of Danielle at €45,000. In respect of the pregnancy and birth of Damien I award €35,000.

**Result**
180. I award the plaintiff a total of €90,000 damages in respect of the second tubal ligation and the pregnancy and birth of Danielle and Damien. I dismiss the claim for agreed damages in the total sum of €381,678 for the upbringing of the two children.