Neutral Citation [2015] IEHC 435

THE HIGH COURT

[2007 No. 7326 P.]

BETWEEN

MARY MCNICHOLAS

PLAINTIFF

AND

ANDREA HERMANN

DEFENDANT

JUDGMENT of Mr. Justice Barr delivered on the 7th day of July 2015

Introduction

1. This case can be very briefly summarised in the following terms. The plaintiff is a married lady. The defendant is a medical doctor who was at the time of the matters complained of a consultant obstetrician and gynaecologist in the Galway Clinic. The plaintiff suffered from prolonged and heavy menstrual bleeding and stress incontinence. She consulted with the defendant in relation to this problem in August 2005. A decision was made that the plaintiff would undergo a total abdominal hysterectomy to be carried out by the defendant in October 2005.

2. After the operation, the plaintiff suffered numbness, pain and loss of power in her left leg. Damage had been done to the femoral nerve in the course of the operation. The plaintiff has two areas of complaint in relation to the care given to her by the defendant. First, she alleges that the pre-operative care given by the defendant was deficient. In particular, the defendant did not advise her to lose weight. If this had been done, the plaintiff alleges that the operation would have been of shorter duration. In such circumstances, the damage to the femoral nerve may not have occurred.

3. The second area of complaint is in relation to the way in which the operation was carried out by the defendant. The plaintiff's case is that the blade of a self-retaining retractor, which was used by the defendant to hold back the abdominal wall and other organs so as to give her a clear vision of the operative field, was caused or allowed to compress the psoas muscle against the pelvic wall, such that injury was caused to the femoral nerve which was compressed between the psoas muscle and the pelvic wall. The plaintiff alleges that the defendant should have released the pressure on the self-retaining retractor a number of times during the operation so as to ensure that the femoral nerve was not being compressed or deprived of blood supply. She alleges that if this had been done, the injury would not have occurred.

4. The defendant denies that her pre-operative care of the plaintiff was deficient. She denies that in not releasing the self-retraining retractor in the course of the operation, she departed from a standard of care which could reasonably be expected of her.

Background

5. The plaintiff had problems caused by extensive menstrual bleeding. The bleeding was large in quantity. It required the plaintiff to wear protective pads between her underclothes. She would bleed for fifteen to twenty days each month. On one occasion, the bleeding was so severe that her mattress was soaked with blood. She also suffered from urinary stress incontinence.

6. In 1996, she was diagnosed as having endometriosis in the area of the uterus. Prof. Bonnar, who gave evidence on behalf of the plaintiff, stated that the plaintiff had ectopic endometrium. It is endometrium which is the lining of the womb having cells grafted onto areas around the ovaries mainly and behind the uterus. It is a benign condition.

7. In March 2004, the plaintiff had a Mirena coil fitted. The coil has a slow release of progesterone in the uterine cavity. This hormone tends to reduce menstrual bleeding. It causes an atrophic partum to develop in the endometrium.

8. An ultrasound carried out at that time showed that the plaintiff had intramural uterine fibroids, measuring 4 x 3cm. Fibroids also cause heavy bleeding. Prof. Bonnar explained that fibroids are properly called fibromyoma. This is a whorling of the uterine muscle fibres with fibrous fibres. They form in the uterus. There is a whorling in that it starts off as a small seedling, which grows to become the size of a hazelnut; it then grows into the size of a walnut and keeps on growing. It is affected by estrogen, which is the growth stimulus for the fibroid.

9. Prof. Bonnar thought that it was the presence of the fibroids which was the reason why the Mirena coil ceased to function for the plaintiff. At this time, the plaintiff had been under the care of Dr. Maebh Ní Bhuinneáin in Mayo General Hospital in Castlebar.

10. She attended again with Dr. Ní Bhuinneáin in April 2005 complaining of pressure in her lower abdomen and frequency of micturiction. By this time, the fibroids had grown further, such that the uterus had become enlarged and was palpable abdominally. At this time, she had a fibroid uterus which was pressing on the bladder, causing some incontinence. A repeat ultrasound showed that the fibroids had grown from 4 x 3 cm to 5.2 x 6.5cm.

11. Dr. Ní Bhuinneáin prescribed Ponstan and Tranexamic Acid. The latter drug is a very effective medication for heavy menstrual bleeding. It also reduces the bleeding from the fibroids. The Ponstan medication also helps reduce bleeding and is used for relieving uterine spasms that cause pain.

12. Dr. Ní Bhuinneáin discussed the various treatment options that were open to the plaintiff to deal with her problem of excessive bleeding. In the course of that consultation, the plaintiff opted to have a total abdominal hysterectomy.

13. In preparation for the operation, Dr. Ní Bhuinneáin advised the plaintiff to lose weight. At that time in May 2007, the plaintiff weighed approximately 107kg. She was advised to reduce her weight to 84kg.

14. Dr. Ní Bhuinneáin also advised that the plaintiff should use the drug Decapeptyl, for eight weeks prior to undergoing the total abdominal hysterectomy. This is an anti-estrogen medication that works at the level of the pituitary gland. It blocks the follicle stimulating hormone, which stimulates the ovary to produce estrogen. It would stop the endometriosis, reduce the size of the fibroids, and reduce the blood supply to the uterus. The drug is used to reduce the vascularity and size of the fibroids. There is an unfortunate side-effect of this medication, which is that it induces a premature menopause. However, this is a temporary phenomenon, which disappears once the plaintiff stops taking the drug.

15. Following the consultation in May 2005, Dr. Ní Bhuinneáin wrote to the plaintiff's GP informing him of the treatment plan which had been devised for the plaintiff in the following terms:-

> *"Dear Dr. Keane*
>
> *I reviewed Mary in the gynae clinic today. She has heavy and prolonged periods and also has a fibroid uterus. She has a Mirena in situ since March 2004. Pelvic ultrasound on 25th April, 2005, shows fundal fibroid 5.2 x 6.5cms and a small cyst in the right ovary. Her last cervical smear in April 2004 was NAD. Mary was requesting TAH. She said she has lost 4kg in one month.*
>
> *I discussed Mary with Dr. Ní Bhuinneáin. She advised a weight reduction with a goal weight of 84kgs for a BMI of 30. She has also advised Tranexamic Acid for menorrhagia for the meantime. She was given a prescription for Ponstan and Tranexamic Acid. Decapeptyl will be given eight weeks pre-operatively. She was advised to attend the clinic in two months to review her progress. I have also sent a request for dietician review.*
>
> *Yours sincerely*
>
> *Dr. Anitha Padmanabhan Dr. Ní Bhuinneáin*
>
> *SHO Consultant Obstetrician & Gynaecologist"*

16. The plaintiff was not happy with the treatment regime suggested by Dr. Ní Bhuinneáin. In particular, she was worried about taking Decapeptyl as she thought that it gave rise to permanent side-effects; she was only 42 at the time and did not want to go into a premature menopause. She therefore asked her GP to refer her to the defendant for a second opinion.

17. Dr. Keane wrote to the defendant on 25th August, 2005 and asked her to see the plaintiff. He enclosed a copy of the documentation that had been received from Mayo General Hospital, including the letter from Dr. Ní Bhuinneáin of 10th May, 2005. The defendant stated that she received a copy of that letter, but that in the version supplied to her, only the first paragraph was present. This aspect will be dealt with in more detail later in the judgment.

18. The plaintiff attended with the defendant on 30th August, 2005. Having taken down her address, contact numbers and date of birth, the defendant's note of the consultation was in the following terms:-

> *"42 year old lady, 11/04 started with heavy and prolonged periods. Mirena since 03/04 not really helpful, also weight gain.*
>
> *LMP: 30.08.05 15 – 20/28D IMB +, PCB nil*
>
> *CL Smear: 03/04 in NAD*
>
> *Contr: Mirena*
>
> *PGYN. Confirmed fibroid uterus*
>
> *1996 diagnostic laparoscopy endometriosis.*
>
> *Now urinary symptoms as well, urgency, urinary incontinence mainly GIS.*
>
> *POH: P.2 + 0 NVD - the heaviest nine pounds.*
>
> *PMH: Raised BP for about 10 years.*
>
> *PSURG: phaeochromocytoma, cholecystectomy, breast biopsy x 4 benign*
>
> *FH: sister Ca breast deceased aged 43*
>
> *One sister endometriosis*
>
> *SH: married, no dyspareunia, no urinary loss during sex*
>
> *MED: Coversal Plus OD, cyclocaprone useful*
>
> *Smoke: Nil, alcohol socially, allergy nil*
>
> *O/E abdo unremarkable elevated BMI*
>
> *Spec: Period but normal cervix*
>
> *Pv: enlarged uterus, fibroid, no separate adnexal masses*
>
> *Decided for TAH, request PCA."*

19. The defendant translated her note of the history which had been given by the plaintiff. She noted that the plaintiff was a 42 year old lady and that in November 2004 she started to have heavy and prolonged periods. A Mirena had been in place since March 2004

but was not really helpful and led to weight gain. "*LMP*" stood for last menstrual period. That started on the day of the consultation. Then it was noted "15-20/28", meaning that she reported that she would bleed for fifteen to twenty days every month. "*IMB*" followed by a "+" stood for inter-menstrual bleeding, which she had. "*PCB*" stood for post coital bleeding and it was reported as "*nil*". On the next line "*CX Smear*" referred to cervical smear, which was reported as having been done March 2004 with no abnormality detected. "*CONTR*" stood for contraception and at that point it was the Mirena Coil. "*PGYN*" stood for past gynaecological history and it confirmed a fibroid uterus. On the next line it was noted that in 1996, there was a diagnostic laparoscopy which confirmed endometriosis. On the next line it was noted "*now urinary symptoms as well, urgency: urinary incontinence*" and historically taken "*mainly GIS*" standing for genuine stress incontinence. On the next line "*POH*" stood for past obstetric history and it was noted as being a para 2+0. "*NVD*" stood for normal vaginal deliveries and it led to the heaviest baby of 9lbs. The next line read "*PMH*" which stood for past medical history. It was noted as "*raised blood pressure for about ten years*". On the next line "PSURG" meant past surgical history and there was listed pheochromocytoma, cholecystectomy, breast biopsy x 4 and there was an arrow forward to benign findings.

20. On the following page "*FH*" stood for family history. "*Sister CA*" means cancer of the breast (deceased aged 43, one sister endometriosis). The next line "*SH*" standing for social history. "*Married, no dyspareunia*" which meant that she had no pain during intercourse. "*No urinary loss during sex*". The next line was "*MEDS*" standing for medication, and there the defendant listed out Coversyl Plus once a day. "*Cyclocaprone*" arrow forward and then the word "*useful*". The next line deals with smoke – nil; alcohol – socially; allergies – none. "*O/E*" stood for on examination. "*Abdominal*" was marked with a tick, which meant that there were no major masses, tender areas or no major abnormal findings from outside palpation. Then there was an arrow up followed by "*BMI*" meaning increased body mass index. "*Speculum: period*" was noted but "*N*" stands for normal "*cervix*". The next line read "*PV*" with an arrow up meaning "*enlarged uterus, fibroid, no SEP adnexal masses*" meaning no separate adnexal masses. Then there was an arrow down and the words "*decided for TAH*" meaning total abdominal hysterectomy. Another arrow down before the words "*requests PCA*", meaning patient controlled analgesia.

21. Following on the consultation, the plaintiff made an arrangement with the defendant's nurse manager to have the total abdominal hysterectomy operation under the defendant in October 2005. On the same date, the defendant wrote to the plaintiff's GP in the following terms:-

> *"30/8/05*
>
> *Dear Dr. Keane*
>
> *Thank you very much indeed for referring this very pleasant 42 year old lady to my office. She started last year with very heavy and prolonged periods and she had a Mirena coil inserted in March 2004 which does not work for her anymore. Also she complained of quite a lot of weight gain. Her period started today and she would bleed anything between 15 – 20 days every 28 days. Occasionally she has some intermenstrual bleeding and no post coital bleeding. She had a smear test in March 2004 which was normal and she uses the Mirena coil mainly for contraception. Thank you very much indeed for attaching the correspondence from the Castlebar Hospital that confirmed that she has a fibroid uterus. Other than that in 1996 she had a diagnostic laparoscopy and endometriosis was diagnosed. Additionally to that she also has some symptoms of genuine stress incontinence. She is a Para 2 +0 who had normal deliveries, the heaviest child was 9lbs. She suffers from raised blood pressure for the last ten years and had a phoeochromocytoma removed a cholecystectomy and four benign breast biopsies. One of her sisters has breast cancer and she got the disease at the age of 43 and the other sister has severe endometriosis and as I recall I did a TAH and BSO for her fairly recently. Mary is a married lady who has no dyspareunia and no urinary loss during sexual intercourse. She uses coversal plus once a day and Cyclocaprone to lower her menstrual blood flow. The latter seems to have some effect. She is a non-smoker, drinks alcohol socially and has no known allergies.*
>
> *On examination her abdomen was soft and I noticed a slightly raised BMI. At speculum examination I saw period blood but her cervix looked fairly normal and pelvic examination revealed a bulky uterus and no separate adnexal masses.*
>
> *We went through all the possible treatment options including myomectomy, embolisation and TAH. However, Mrs. McNicholas was quite adamant to have a TAH at this stage because the quality of her life is really and truly ruined with things as they are now.*
>
> *Maura, my clinic manager, has booked Mrs. McNicholas in and as soon as we have news for you we will write you another few lines.*
>
> *Best wishes.*
>
> *Andrea Hermann MD, DFFP, MRCOG, MRCPI*
>
> *Consultant Gynaecologist."*

Standard of Pre-Operative Care

22. The plaintiff has made the case that the standard of pre-operative care given by the defendant to the plaintiff was seriously deficient. It was submitted that as the plaintiff was obese when she saw the defendant in August 2005, she should have been advised that she should lose weight before undergoing the total abdominal hysterectomy operation. It was argued on behalf of the plaintiff that had she lost the amount of weight as advised by Dr. Ní Bhuinneáin, the operation would have been considerably more simple and would not have lasted as long as it did. This would have had the result that the compression on the femoral nerve would have been shorter than it actually was in October 2005.

23. When the plaintiff attended the gynaecology clinic in Mayo General Hospital on 11th April, 2005, her weight was recorded at 112 kg. On review in Mayo General Hospital on 9th May, 2005, the plaintiff's weight was 110 kg. It was noted in the medical records on that date that the plaintiff had "*lost 4 kg in one month on her reporting*." On 20th October, 2005, the plaintiff's weight was noted by the anaesthetist to be 107 kg.

24. The plaintiff says that she asked the defendant at the consultation whether her weight would be a problem. She stated that the defendant said no, not at all. The defendant told her that one of the drawbacks of the Mirena coil was that there could be significant weight gain. The plaintiff said that the defendant told her that her weight was not an issue and that she would be a new woman after

the hysterectomy operation.

25. The defendant denied that she said words to the effect that the plaintiff's weight was not a problem for the surgery. Weight was a problem but it was one that could be overcome. She stated that excess weight makes the operation more difficult.

26. The defendant disagreed with the treatment plan devised by Dr. Ní Bhuinneáin in relation to weight reduction. She stated that if a patient had excessive bleeding, it was difficult for them to exercise and therefore it was difficult for them to lose weight. The defendant pointed out that had the plaintiff wanted to lose weight, she could have done so between the time she saw Dr. Ní Bhuinneáin in May 2005 and seeing the defendant in August 2005.

27. The defendant stated that in her notes of the consultation on 30th August, 2005, and in her letter to the plaintiff's GP, she had made reference to the plaintiff's BMI, which showed that weight was a factor which had been taken into account by her pre-operatively.

28. The plaintiff submitted that the reference in the defendant's letter to the GP, where she had referred to a "*slightly raised BMI*" was an understatement of her condition at the time. The defendant stated that the GP knew the plaintiff well and knew of her level of obesity. In these circumstances, it was not necessary to set out in great detail her problem with her weight, as this was already well known to the GP. She stated that if she had been writing to a consultant in London or elsewhere, who did not know the patient, she would have been more explicit on the topic of the plaintiff's weight. She stated that as she was writing to a colleague who knew the plaintiff, she wrote the reference to BMI in a way that was respectful of the plaintiff. She saw no point in rubbing in the fact that the plaintiff was overweight, when Dr. Keane already knew this.

29. The defendant reiterated that she would have given the plaintiff advice in relation to weight loss if she thought that that was achievable. However, where a patient has stated that they have bleeding in an uncontrolled way for between fifteen to twenty days out of every twenty-eight days and, in circumstances where, when the bleeding comes, the patient does not know if their clothes are stained or soiled, it makes the patient feel very insecure and frustrated. It is very difficult for the patient in these circumstances to take meaningful exercise. One's mobility is certainly not increased when one has these types of problems. Since the plaintiff could not engage in exercise, the defendant did not think that a significant weight loss was achievable.

30. Prof. Bonnar, on behalf of the plaintiff, noted that there was no rush to do the operation. The plaintiff had a good haemoglobin level and was not anaemic. He agreed with the treatment plan devised by Dr. Ní Bhuinneáin. He thought that it was appropriate to advise taking Tranexamic Acid and Decapeptyl. In relation to weight loss, he said that excessive weight in a patient was a problem for a pelvic surgeon. Obesity adds to the risks of haemorrhage and pulmonary embolism. He would encourage the patient to lose weight. However, he stated that one can only encourage a patient; one cannot insist that they follow one's advice.

31. In cross examination, Prof. Bonnar stated that he preferred the approach of Dr. Ní Bhuinneáin, which was to advise certain precautions in relation to taking medication and engaging in a weight loss programme and see how things turned out in two months' time; however, he accepted that the plaintiff's symptoms at the time of presenting to the defendant were such that her life was being seriously interfered with and she could not go on like that. He thought that the decision to do a total abdominal hysterectomy was an appropriate one.

32. It was put to Prof. Bonnar that there could be an honest difference of opinion between the two doctors as to the most appropriate pre-operative plan – one being wait and see and take the precautions outlined; and the other being that as this lady was in considerable distress, it was reasonable to go ahead and do the operation. Prof. Bonnar was asked did he agree that it was reasonable for the defendant to go ahead with the hysterectomy at the time that she did. He replied as follows:-

> *"Q. And so that there won't be any lack of clarity about this, Prof. Bonnar, are you agreeing with me that it was reasonable for Dr. Hermann to go ahead with the hysterectomy at the time when she did?*
>
> *A. I agree that that would be a path that the doctor could decide was appropriate, given the symptoms of the patient and given the fact that the doctor had the concerns about obesity that I might have.*
>
> *Q. Yes, ok?*
>
> *A. Yes.*
>
> *Q. So can we then reach a measure of agreement in sort of limiting the level of attack on Dr. Hermann by saying that your real reservations about Dr. Hermann relate to the management in which the…or the management of the actual operation itself?*
>
> *A. Yes, that would be correct. Yes."*

33. Dr. Peter Lenehan gave evidence of behalf of the defendant on this aspect. He stated that both of the approaches adopted, by Dr. Ní Bhuinneáin on the one hand and the defendant on the other hand, were reasonable. Surgeons were often faced with the dilemma that life is not perfect. Sometimes one does not have the ideal circumstances, and where a patient is carrying extra weight that will make the surgery more problematic. He stated that in his experience over many years, it was very difficult for women to lose weight prior to surgery, particularly somebody who has difficult periods, and who has urinary incontinence, thereby making it hard for them to exercise. Sometimes they can be a low ebb psychologically and they can find it very challenging to diet and lose weight.

34. He stated that he had faced the situation many times that if a patient goes to the trouble of getting a second opinion as to whether they can reach the goals in relation to weight loss, which he thought were largely unattainable, he would be very sympathetic towards going ahead with the surgery. He would make exactly the same decision as the defendant had if he was faced with a patient who had major quality of life issues. In relation to the decision to operate on the plaintiff, he thought that it would have bordered on unfeeling not have gone ahead with the definitive treatment – a hysterectomy – at that time.

35. Mr. Lenehan stated that, as was shown by population statistics, the general population is getting more overweight. The weight issue is a common dilemma faced by surgeons. Every surgeon would love to have people who were of a normal body weight, who had never had abdominal surgery before, but that is not the world that we live in.

36. In relation to the plaintiff's position, she was recorded as having a weight of 107kg; to reduce her weight to 84kg, a weight-loss of 23kg, was in Mr. Lenehan's opinion an unrealistic aspiration. He said that he would discuss weight issues with patients as a general

health issue, but he would not use it as a factor to prevent people having surgery when they obviously needed it. In his experience, it was an unrealistic aspiration to ask someone to lose that amount of weight. Generally, the plaintiff's weight would not have precluded him from going ahead and doing the surgery, if clinically she needed to have it done.

37. Mr. Lenehan stated that he thought that doctors had become somewhat the guardians of morality in society in relation to weight loss. He felt strongly that doctors should not load guilt onto people in relation to their weight.

38. He was asked whether if a person had a BMI of 37, he would discuss that with the patient. Mr. Lenehan stated that he would not make it a major issue, because he thought that there were all sorts of issues surrounding weight in society, including loading guilt onto patients, which he did not believe in. Whether he would raise the issue with the patient depended on the circumstances of the individual patient. He had no set rule about discussing the issue; he certainly did not use the issue of weight to preclude people having surgery when he thought they needed it.

39. He stated that if a person was morbidly obese, such that they may have respiratory problems and were facing into a very complex operation, that was a very different situation than that faced by the plaintiff in this case. There are people who cannot breathe under general anaesthetic and, because of their breathing issues, they have to be ventilated in ICU. Where it becomes a major medical issue like that, it has to be addressed; but where it was a question of a patient being overweight and that increasing the risk of complications, he would not make an issue of that with the patient.

40. Mr. Lenehan stated that if someone asked him would their weight be a problem, he would inform them that it does increase both the complexity of the operation and the risk of complications.

41. Prof. Linda Cardozo also gave evidence on behalf of the defendant. She stated that if a person was bleeding for fifteen to twenty days when she is having her periods, this significantly impairs the person's quality of life. Impaired quality of life leads to overeating and a sedentary lifestyle leads further to the inability to lose weight. If one cannot take exercise and one is overeating, it is going to be very difficult to lose a significant amount of weight. In relation to the goals set by Dr. Ní Bhuinneáin of achieving a weight reduction from approximately 107kg to 84kg, she thought that that was unrealistic. She was of the view that the patient should not be threatened with a refusal to undertake surgery because they were unable to lose weight.

42. Prof. Cardozo stated that excessive weight was always a problem. It would have been wrong for the defendant to say that it was not a problem at all. That would be misrepresenting the facts, because being above a certain weight makes surgery more complicated than it would otherwise necessarily be. However, by the time that a patient who has a serious problem comes to see you, irrespective of her weight, you are going to try to help her. She stated that it was no good upsetting patients by telling them to achieve what is virtually impossible, which is to lose a very large amount of weight in a relatively short time in order to be able to have an operation that would significantly improve their quality of life.

43. The professor stated that a doctor may say many things to patients and they may or may not take heed of them, but to excessively upset a patient in a situation where they need help was counterproductive and would not lead to a good outcome or a good relationship with the patient. Whilst one would not necessarily say that weight would present no problem at all, because obviously it would, one would often try to minimise rather than maximise the possible risks of the procedure. It would not be good practice to ignore the weight issue. On the other hand, it would not be a reason not to undertake the surgery.

44. The witness accepted that the defendant should have warned the plaintiff that surgery is more complicated in the presence of excessive weight. In this case, the plaintiff had gone for a second opinion to a different gynaecologist and she wanted to have a hysterectomy. It was appropriate to give counselling but the plaintiff made the decision to proceed to have a hysterectomy, not the defendant.

45. Prof. Cardozo stated that the decision to proceed to a hysterectomy as taken by the plaintiff at the consultation with the defendant on 30th August, 2005, was entirely appropriate. The operation had, in effect, already been deferred for five months since the initial consultation, where weight reduction was suggested prior to surgery; this had not happened, so it was unlikely to happen in the foreseeable future and the patient's quality of life was impaired to a significant extent by the heavy bleeding. She thought that a hysterectomy at that time was an appropriate intervention.

46. The issue was also raised as to whether the defendant should have prescribed the drug, Decapeptyl to be taken in the weeks leading up to the operation. The defendant stated that she did not prescribe it because it would enhance estrogen levels, which would cause further problems in terms of weight gain.

47. Mr. Lenehan stated that the defendant was wrong in her understanding of Decapeptyl. It is a drug that is designed to suppress the pituitary gland which is the orchestrator of the hormones, including the ovaries. It suppresses the ovaries, reducing estrogen levels to a menopausal state. As a result of that, it reduces the size and vascularity of the fibroids on a temporary basis.

48. However, he was totally against the prescription of Decapeptyl as he thought that it was most unsatisfactory to impose an early menopause on a patient in the weeks leading up to the operation. Whilst some medical practitioners prescribed it in the pre-operative period, he had stopped using the drug twenty years ago. He thought that Decapeptyl was an awful drug to give to patients leading up to a hysterectomy.

Conclusions in relation to pre-operative care

49. In relation to the pre-operative care of the plaintiff, I am satisfied that there were two different approaches taken by Dr. Ní Bhuinneáin and the defendant. The former had, in May 2005, recommended that the plaintiff should try to lose a very significant amount of weight to get down to a BMI of 30 before the operation. She had prescribed Tranexamic Acid and had advised taking Decapeptyl in the weeks leading up to the operation. She had advised that the plaintiff see a dietician and stated that the situation would be reviewed in two months. If the plaintiff had wanted to adopt the "*wait and see*" approach advised by Dr. Ní Bhuinneáin, she would not have gone to the defendant for a second opinion.

50. The plaintiff went to the defendant for a second opinion in August 2005. The defendant took a detailed history from the plaintiff at that consultation. She was still experiencing prolonged bleeding and stress incontinence, which was having a serious adverse effect on her quality of life. In these circumstances, it was reasonable for the defendant to conclude that due to her ongoing symptoms, the plaintiff was unlikely to be able to lose much weight. While excess weight increased the risk of surgical complications, it was the view of Prof. Cardozo and Mr. Lenehan that, in the plaintiff's case, it was not a reason which would prevent the operation going ahead.

51. I am satisfied that the approaches of both doctors were reasonable in the circumstances. There was an honest difference of opinion between the two doctors as to how best to treat the plaintiff. Accordingly, I find that the defendant did not depart from an appropriate standard of care when she advised the plaintiff, in August 2005, that she could undergo a total abdominal hysterectomy when it suited her later in the year.

The Operation
52. The plaintiff was admitted to the Galway Clinic on 19th October, 2005. On the following day, she underwent a total abdominal hysterectomy by the defendant, who wrote a note of operation in the following terms:-

> *"Operating notes.*
>
> *20.10.2005*
>
> *TAH*
>
> *- cleaned, draped, catheterised*
>
> *- lower transverse incision*
>
> *- fibroid uterus, extensive endometriosis especially on the right side*
>
> *- blunt dissection and proceed initially to S-TAH*
>
> *- separate removal of the cervix*
>
> *- 1Vicryl and 2-0 Vicryl for pedicles*
>
> *- continuous interlocking 2 – 0 Vicryl to the vault ¼ inch drain to POD*
>
> *- 1 Vicryl to Sheath, 2-0 to Fat, clips to skin*
>
> *- Foley: clear urine*
>
> *- EBL 1.5l: swabs, needles and instruments correct*
>
> *- in summary very difficult surgery*
>
> *- signed"*

53. Records at the Galway Clinic showed that the anaesthetic was given to the plaintiff at 10.15hrs and the operation commenced at 10.17hrs. It ended at 12.35hrs.

54. The defendant stated that this was a difficult operation due to four factors: the presence of endometriosis; the presence of fibroids; the plaintiff's obesity; and the fact that she had had previous surgery to her abdomen. The defendant said that there had been extensive bleeding during the operation. In the defendant's operation note, blood loss had been estimated at 1.5 litres. In the nursing record, it was noted to be "*2650ml approx*". In the notes supplied by Nurse Flynn, blood loss was recorded as 2950mls. This was the information that had been handed over to her by the recovery team. Prof. Bonnar stated that from a comparison of the plaintiff's haemoglobin levels before and after the operation, he would estimate the blood loss at about 2 litres. By any reckoning this was a significant amount of blood loss. In an average hysterectomy, which did not have the complicating factors that the plaintiff had, blood loss would normally come in at between 220-600mls.

55. The defendant gave the following account of how a transverse abdominal hysterectomy would generally be carried out by a surgeon. The surgeon would consider the operation and try to anticipate any problems that might arise. When the plaintiff had been brought to theatre, the surgeon would clean and dry the skin of the abdomen. The surgeon would then make a transverse incision, going through the layers of the abdominal wall and then entering the peritoneal cavity, meaning the inside of the abdomen. Once that had been done, it was the defendant's practice to check the pelvic organs, to see what the uterus looked like and whether it was mobile. The defendant would then view the ovaries, and have a brief look over the bowel and the omentum, which is the fat net that covers all the internal organs. She would also check the liver. An examination of the surface of the liver would be carried out because sometimes there can be undiagnosed cancer in the abdomen. The next step would be to ask the anaesthetist to tilt the table slightly in a way that the patient comes head down. She would pack then the bowels away, so that they would not obscure her vision of the operating field. They would be packed away with cotton packs, which are bigger than swabs; they are around the size of an A4 page. Once she had packed the bowel away, the defendant would use a self-retaining retractor by putting one blade above the bladder and two lateral blades guiding the retractor so that the incision would be transformed into something of a square; she would then look into the square to carry out the operation. The defendant stated that she used a Balfour self-retaining retractor when carrying out the operation. The defendant stated that it was common practice to use a self-retaining retractor. She had been trained by about thirty-five consultants throughout her training and none of them worked without a self-retaining retractor.

56. When the bowel had been packed away, the defendant would put in the self-retaining retractor; she would then proceed by putting two long straight clamps to the lateral aspects of the uterus and then on both sides she would cut through the round ligament, and open up the peritoneum front to back. The next step would be to go from behind through the peritoneum; she would then make a decision as to whether to preserve the ovaries or not. The defendant would either go more medial or more lateral, whatever was appropriate. The next big pedicle would then be the uterine artery. The defendant would clamp those, stitch those with 2 – 0 Vicryl or 1 Vicryl, depending on the size of the patient and the size of the pedicle. Then the defendant would basically work step by step down until reaching the cervix. Again it would be a clamp, cut, stitch until she made ground down there alongside the cervix and then she would remove the cervix that is basically dipping into the vagina. The defendant would apply some pull, open up the upper part of the vagina and ease the cervix out. She would hand specimens over to the scrub nurse. The defendant stated that the upper vagina would bleed so she would have to suture this.

57. The defendant stated that she used continuous interlocking Vicryl for the vaginal vault at the front and the back and if the vagina happened to be very wide, she may have put a stitch in the middle, but she always left a little bit of space to the right and

the left so as to drain the area. Once she had done that, she would check again that there was no bleeding, that the urethras were intact, and that she had not caused any injury. Then she would decide whether to put a drain in. The defendant stated that she usually packed the operating field with a white swab. Then she would ask the anaesthetist to reduce the anaesthesia slightly, where the blood pressure of the patient rises, just in case there are tiny little bleeders, which she could then see and secure.

58. Once that had been done, the defendant would again appraise as to whether she would be better off with the drain to drain any wound secretion, or proceed to close up the operative site. Then she would close the rectal sheet with No. 1 Vicryl, the fat layer with interrupted stitches, again according to the size of the patient. She would then decide whether fat stitches were required. After that she would close the skin. Her habit was to close the skin with clips. After she had done that she would apply the dressing, write the notes and before closing the abdominal cavity she would speak to a scrub nurse and make sure that the swabs, needles and instruments were correct, so that nothing was left behind.

59. In the plaintiff's case, the defendant had found a fibroid uterus which had led to enlargement of the uterus. The uterus was heavier than normal. Also fibroids bleed more and there may be extensive bleeding when they are present. In this case, the defendant described the size of the uterus in a letter to the GP as "*a massive fibroid uterus*".

60. The significance of the endometriosis was that not only was she dealing with a bigger organ, but there was an enlarged organ gluing itself onto the inner lining of the peritoneum. So not only was it heavy and stiff, but it was also glued to structures around it. Endometriosis makes organs stick together. The defendant stated that when the endometriosis was extensive, the only way to deal with it was to loosen the uterus from the lining of the peritoneum, always being aware of the uterer and the bowel and checking to see if it was bleeding. If it was, she would get it dry and move along. It was a very slow process. She had to take her time with it. This is what was meant by blunt dissection.

61. The defendant stated that one will encounter diffuse bleeding in this procedure of loosening the uterus from the peritoneal lining. One has to deal with the bleeding there and then. So if one makes progress of 2mm, if it bleeds one has to secure the bleeding either by stitch, by tie or by diathermy. This makes the operation take longer, but it is necessary to be careful at this stage of the operation.

62. Next the defendant stated that she dealt with the upper pedicles first, meaning around the ligament; she cut, tied and then step by step loosened up the body of the uterus. Then she clamped and stitched the uterine artery so that she did not have any problems with major blood loss. Once she had loosened the uterus, she decided to cut over the cervix and remove the uterus. She had made the decision to proceed by a sub-total abdominal hysterectomy first, and then would go on to remove the cervix.

63. She made that decision due to the increased BMI of the patient, which made operating on the patient difficult. Once she had the uterus out of the way, she had a clear vision of the cervix. When she removed the uterus, the bleeding had been dealt with. When she was able to take the uterus out of the abdomen, she had completed the difficult part of the operation. That left the cervix to attend to, which she stated was a very easy, routine thing to do. This took about a further fifteen minutes to include suturing the vaginal end. She then proceeded to put in a catheter and a drain, and closed up the abdomen.

64. Prof. Bonnar accepted that where there was a fibroid uterus and extensive endometriosis, there would be considerable bleeding. In such circumstances, it was appropriate for the defendant to take extra care and time to remove the uterus, and then achieve haemostasis before proceeding to remove the cervix. It was critically important to achieve haemostasis. He accepted that it was appropriate for the defendant to get the bleeding under control before attempting removal of the cervix.

65. Prof. Bonnar stated that if the bleeding had been stopped and the defendant had good vision of the cervix, it was appropriate to proceed to remove the cervix. He would have done the same thing in those circumstances.

66. On the day of the operation, the defendant wrote the following note to the plaintiff's GP:-

> *"Dear Dr. Keane*
>
> *I performed today a TAH. Things have been very difficult due to Mary's weight but also due to the fact that she had a massive fibroid uterus and extensive endometriosis on the right hand side.*
>
> *Hence she had some more blood loss than usual but I sincerely hope that she is recovering nicely. Very best wishes.*
>
> *Andrea Hermann - Consultant Gynaecologist."*

67. The defendant had a note of seeing the plaintiff after the operation. She noted that she had seen the plaintiff at 2.45pm on 20th October, 2005. The note read:-

> *"Well. Surgery explained. Urine clear. Dressing dry. No PV loss."*

68. The plaintiff stated in her evidence that after the operation, in the afternoon, the defendant had said to her that she had lost almost three litres of blood. The defendant stated that she was unable to make any comment on the plaintiff's recollection of the conversation.

69. On 21st October, 2005, the defendant noted as follows:-

> *"11.40am all well. Wound dry. Urine clear. Very little in Redivac."*

70. On 22nd October, 2005, the defendant's notes stated as follows:-

> *"2.00pm. All well. Wound NAD. Drain foleys (with an arrow up, meaning that the drain was taken out)."*

71. On 23rd October, 2005, the defendant noted as follows:-

> *"11.00am. Well apart from left leg. Loss of power as well as pins and needles. (Arrow forward) for neurological review."*

72. It is appropriate at this stage in the narrative to go back and look at the use of the self-retaining retractor by the defendant in the course of this operation.

Use of the Self-Retaining Retractor
73. In the operation, the defendant used a self-retaining retractor to hold back the abdomen and other tissues so that she could have a better view of the operative field. She used a Balfour model of self-retaining retractor. The retractor can be pulled apart laterally so as to separate the abdomen to enable the surgeon to have a clear view of the operative field. The blades of the retractor are held in place by a nut which is on a ratchet system.

74. The defendant accepted that it was the surgeon's responsibility to insert the self-retaining retractor. She stated that she took great care in so doing. She did this because at the point of placing the retractor in the skin, she saw the operating field was visibly a challenge. She stated that she took enormous care to place the retractor accurately and also in a sustainable way. She made sure that she did not impinge on bladder tissues or the small bowel or anything coming into contact with the retractor.

75. The defendant stated that she did not release the retractor in the course of the operation. She was not aware of any practice among doctors which suggested that self-retaining retractors should be released during an operation. She stated that she trained with or under thirty-five consultants, none of whom had the practice of releasing the self-retaining retractors during an operation. In relation to the suggestion that she should have released the retractor, she stated that with this particular operation she was dealing with extensive bleeding. There was considerably more than the usual amount of blood loss during the operation. One had to make a decision whether it was wise to release the retractor which would cause the operating field to collapse, the bowel would come forward, she would have had to take the packs out, and put fresh packs in and then put the retractor in again. This would take about 10 minutes. During this time, the bleeding would be continuing. The other alternative was to stay at the surgical site and continue with the hysterectomy. This is what she did.

76. Prof. Bonnar on behalf of the plaintiff stated that great care had to be taken when inserting the self-retaining retractor initially. The first thing that a surgeon must do was to put his finger down and check that the lower end of the retractor had not caught the psoas muscle. He did not criticise the use of a self-retaining retractor in this operation, but stated that it was necessary to take great care how the retractor was put in and that the surgeon should make sure that there was no constant pressure over a protracted period of time. It was necessary to release the pressure on the self-retaining retractor so as to allow the blood supply back in and prevent ischemia. Then the pressure can be put back on.

77. Prof. Bonnar stated that the surgeon should not just check the retractor when it was inserted, but it should be checked during the operation as well. A surgeon should release the ratchet and let the retractor come in certainly two or three times if the operation is over two hours.

78. Prof. Bonnar stated that even if the retractors were in the correct position, they could still cause damage to the nerve. It was, therefore, necessary to release the retractors when operating for a prolonged period. The incidence of femoral neuropathy in benign hysterectomies was approximately 0.2%.

79. Prof. Bonnar referred to a number of academic works which he said showed that releasing the pressure on the retractors was advised where the operation was in excess of two hours. In particular, he referred to an article written by Daniel L. Clarke–Pearson M.D. and Elizabeth J. Geller M.D. in the American Journal of Obstetrics and Gynaecology, published in March 2013. Although the article post-dated the carrying out of the surgery by the defendant, the particular sections of the article to which he referred were footnoted as having come from studies carried out in 2004, 2002 and 1996. Prof. Bonnar referred in particular to the following portions of the article:-

> *"Neuropathy after hysterectomy is a rare but significant event. A review of the literature reveals a rate of 0.2–2% after major pelvic surgery. For benign hysterectomy, the rate is likely to be nearer the lower end of this range because more nerve injuries are associated with radical pelvic cancer surgery…the most common neuropathy associated with pelvic surgery involves the femoral nerve…the most common sites of femoral nerve injury are the anterior surface of the psoas muscle and the inguinal canal. Femoral nerve injury along the psoas muscle usually is attributable to direct compression of the femoral nerve from the blades of a self-retaining retractor. This risk is increased with a thin body habitus, long retractor blades and prolonged operative time. Prolonged compression of the nerve by retractors results in ischemic injury as well as 'stretch' injury…prevention of a femoral nerve injury is accomplished by good surgical technique. Care should be taken with the placement of any self-retaining retractor. Examination of placement of the retractor blade should be performed and periodically checked during the case to ensure that they are not directly lying on the psoas muscle. For some retractors, such as an O'Connor–O'Sullivan retractor, the lateral blades may be elevated off the psoas muscle by placing towels between the retractor and the abdominal wall. For other retractors, elevation of the retaining ring off the abdominal wall and selection of appropriately sized retractor blades (such as a Bookwalter retractor) is the surgeon's responsibility."*

80. Prof. Bonnar also referred to a chapter from an American textbook called "*Clinical Problems, Injuries and Complications of Gynaecologic and Obstetric Surgery*" edited by Daniel M. Nichols M.D. and John O.L. Delancey M.D. In particular, he referred to the following portions contained in the chapter dealing with *Injury to the Femoral Nerve During Laparotomy*:-

> *"Mechanism of Injury*
>
> *Since the femoral nerve is not in the true pelvis, direct operative injury is unlikely. Stretching also is not a likely cause because it would require an extraordinary force to create such a damage injury. Studies involving retractors placed in cadavers have shown that the site of the injuries is 4cm above the inguinal ligament and that the injury is caused either by direct pressure on the nerve by retractor blades or by impingement of the psoas muscle and the femoral nerve against the lateral pelvic wall by retractor blades, causing ischemic injury.*
>
> *Prevention*
>
> *Because of the possible long-term problems from femoral nerve injury, effort should be directed toward the prevention of this complication. Retractors should be of the appropriate blade depth and should not impinge on the psoas muscle. Folded laparotomy pads should be placed between the lateral blades and the pelvic wall. Some authors recommend palpating the femoral artery after placing the retractor, with absence of pulsation indicating excessive pressure on the external iliac artery and femoral nerve. Some authors contend, however, that since the external iliac artery lies medial to the psoas muscle, it could escape compression while the psoas muscle and femoral nerve are compressed. Release and reinsertion of the retractor blades for a few minutes is recommended when surgery time is greater than two hours. Finally, the length of the transverse incision should be minimised to keep the retractor blades from the vicinity of the nerve."*

81. Prof. Bonnar was asked in cross examination what he alleged the defendant did, that no other gynaecologist would have done if exercising reasonable care. He replied that no other gynaecologist would have put in a self-retaining retractor and kept this in position for over two hours. In his view, that was not appropriate care.

82. In the course of his evidence, Prof. Bonnar stated as follows in relation to the need to release the pressure on the retractor periodically during the operation:-

> *"Q. So we are down to the length of time that the self-retaining retractor was kept in position?*
>
> *A. Yes, because duration of compression is a factor in injuring the femoral nerve. I think, my Lord, I should just add, removing the cervix also carries with it further use of retractors. So I am not questioning, my Lord…I agree entirely with what Mr. McGrath is saying…the actual surgery that was performed is reasonable and I am pleased that he has been able to give some further information which I didn't have about when the bleeding was and where the difficulties were, but still allowing for these, we cannot escape the fact that the retractor should have been released probably three or four times and that massive pressure on the lateral and on psoas should not have happened and it is possible the retractor was not put in appropriately in the first instance.*
>
> *Q. So there are two elements then that you believe were not correctly addressed by Dr. Hermann: one the length of time for which the retractor was left in position without being released, and secondly, you are now suggesting, as I understand it for the first time that the retractor may not have been correctly positioned in the first instance; is that right?*
>
> *A. Well when you are putting in a retractor, my Lord, the first thing you do is put your finger down and check that the lower end of the retractor hasn't caught the psoas muscle. In other words, your retractor is to retract the abdominal wall not to be exerting pressure on the posterior part. So this is the only criticism I would have of the…I am not saying you can't use a retractor, by all means use the self-retaining retractor, but be careful how you put it in and make sure you don't have pressure on constantly over a protracted period, release it, let the blood supply back in to replenish and prevent ischaemia and by all means put the pressure back on again.*
>
> *Q. But you are saying release it even though it has been put in position correctly in the first instance; is that right?*
>
> *A. I am saying that release it off its…remember it's tight, it's holding back the organs under pressure and there is a clip to keep it tight. You press the release button and let it come in for a few minutes, a couple of minutes, tie it up again, check that it is in the right position and not catching the psoas muscle and exerting pressure on the femoral nerve that's my major criticism …"*

83. Prof. Bonnar stated that even if the retractor was placed in the correct position, it should still be released to take the pressure off the structures that are being pulled apart. Notwithstanding that the retractor was placed in the correct position, there was the potential for it to cause damage. It was advised when using self-retaining retractors for a prolonged period that the retractor should be released. He would not leave the retractor in place for two hours because this would run the risk of femoral nerve palsy.

84. Prof. Bonnar stated in cross examination that he had never used a self-retaining retractor in a benign hysterectomy and he had probably done 4,000 – 5,000 of such operations. He also stated that he teaches gynaecological surgery and he does not allow his students use self-retaining retractors due to the risk with them of compressing the psoas muscle. However, he did not criticise the defendant for using a self-retaining retractor particularly where she did not have a number of trained assistants to assist her in the operation.

85. In the course of the cross examination, Prof. Bonar was asked what it was that he alleged that the defendant should have done during the course of the operation. He was asked whether he alleged that it was standard practice that should have been adhered to by the defendant to release the retractor from time to time during the two hour period:-

> *"Q. I am trying to find out from you in simple terms, Prof. Bonar, what you're saying Dr. Hermann failed to do that she should have done. I want to know are you saying that this was standard practice that should have been adhered to by her to release the retractor from time to time during the two hour period?*
>
> *A. That is the recommendation of the gynaecology.*
>
> *Q. Show me now.*
>
> *A. Most of these operations, my Lord, are in cases performed by gynae-oncologists who are specifically trained in radical pelvic surgery. She wasn't in that category.*
>
> *Q. Yes.*
>
> *A. I accept that. But I still take the view that using a self-retaining retractor compression is a risk factor that comes in and that should…and the only way I know of avoiding that, according to the literature, is not to have constant pressure on it for two hours. It does take long prolonged pressure, and it's got to be very strong pressure to occlude the blood supply to the nerve."*

86. Prof. Cardozo gave evidence on behalf of the defendant. She stated that it would have taken the defendant about fifteen to twenty minutes to prepare the site before inserting the self-retaining retractor. At the end of the operation, when the intra-abdominal part of the operation had been finished and the vaginal vault had been closed, and all of the pedicles had been secured and there was no excess bleeding, then normally the packs would be removed, the retractor would be taken out and the abdomen would be closed in layers. It would be normal to, at least, close the rectus sheath and the skin. Some people close other areas as well and a drain would often be left in the pelvis after the retractor had been withdrawn. The length of time that would be taken in closing up would depend on the number of layers that the surgeon closes and the difficulties which may be encountered in closing the abdomen. Some surgeons would close the peritoneum, then the rectus sheath, then the fat and then the skin and a dressing would need to be applied, which may take more than 25 minutes. Most people would take fifteen to twenty minutes to close up the operative site.

87. In relation to the question of releasing the self-retaining retractor, Prof. Cardozo stated that she had never released a self-retaining retractor apart from if she wished to send a specimen for histological examination, or if she was awaiting the arrival of a

colleague to assist in the operation. She stated that if the operative procedure was going to be stopped for some reason then one might let down the retractor, cover the abdomen and wait for whatever results were required. Under normal circumstances, one would not want to release the pressure on the retractor, because if one did, all the abdominal structures would collapse into the middle and then one would have to repack the abdomen and reinsert the retractor and that would be quite a timely process. She was not aware of any of her colleagues, who undertake quite prolonged oncological procedures, to let down the retractor and put it back up during the course of an operation.

88. She was asked whether she would have expected the defendant to be aware of the practice of releasing the self-retaining retractors in her role as a consultant gynaecologist. The professor stated as follows:-

> *"A. I have no reason to believe that she would have been aware of the necessity of it. I have operated for a long time in the pelvis and although I know that prolonged retraction of tissues can cause damage, usually the reason the procedure is prolonged is because it is difficult, and the last thing you want to do is prolong it further by closing the abdomen to all intents and purposes by closing the retractor and then repacking it all, and then reinserting the retractor, because during that time, not only are you wasting time but you could have considerable bleeding.*
>
> *Q. What are the risks of having considerable bleeding?*
>
> *A. Blood transfusion, more difficult to stop the bleeding because you can't see what is happening, the risk of disseminated transvascular coagulation with heavy blood loss and, of course, prolonging the surgery with its attendant risk of thromboembolic phenomena in the post-operative period and haematoma formation in the pelvis.*
>
> *Q. Are you aware, Prof. Cardozo of the existence of any body of opinion among reputable gynaecologists that a retractor should be released periodically during the process or course of a two hour operation?*
>
> *A. I don't believe that there is any evidence to show, when, if or for how long a retractor should be released during the course of an operation.*
>
> *Q. Now subject to whatever his Lordship, the judge may decide at the end of the case Prof. Cardozo, Dr. Hermann is to be judged by the standards of a medical practitioner of equal specialist skill to herself and the standards of such practitioner acting with ordinary care and I want you to say whether adopting that standard, was the non-release of the retractor by Dr. Hermann, a breach of the standard of care which you would expect of someone acting with ordinary care in her position?*
>
> *A. I don't know of any generalists in gynaecology who would expect to release a retractor under normal circumstances during the course of a hysterectomy."*

89. In cross examination, Prof. Cardozo was asked whether she disagreed with the practice of easing off the pressure on the self-retaining retractors during the course of a surgical procedure. She was asked whether she agreed or disagreed with that practice as a professional proposition. She stated as follows:-

> *"A. I have never done that, apart from when there has been a delay in the surgery for some reason other than normal surgical procedures, in other words waiting for a frozen section report from the histopathology lab or awaiting a colleague to help with some part of the operation, then you would release the retractor and assume that you have to repack the bowels and reclear the operation site but unless that was the case, then I would not release the blades of the retractor, nor do I know any colleague who, in an operation of this length would release the blades."*

90. Prof. Cardozo did not agree that the operation was a prolonged one. It was a difficult operation and it took longer than an average hysterectomy, but was by no means outside what one would expect for an operation as complex as this. She did not agree that any normal practicing gynaecologist would release or ease a retractor during an operation of this length.

91. In the course of her evidence, the plaintiff's counsel put to Prof. Cardozo an article written by Kuponiyi *et al* in a journal issued by the Royal College of Obstetricians and Gynaecologists entitled *Nerve Injuries Associated with Gynaecological Surgery*, published in 2014. In particular, the witness was referred to the following extracts:-

> *"A thorough and complete understanding of the anatomy of the lumbo sacral and brachial nerve plexuses by the surgeon is absolutely integral to minimising the risk of nerve injury during gynaecological operations. Also crucial in preventing nerve injury is the preoperative identification of patients who are more prone to neurological complications. Studies have shown that patients who have a thin body habitus, ill defined abdominal wall muscles or narrow pelvis are more at risk of retractor blade associated nerve injury. Such patients are at further risk if the operating time exceeds four hours. A large number of iatrogenic lumbo sacral nerve injuries during gynaecological surgery can be attributed to the incorrect positioning of self-retraining retractor blades. The gold standard of correct positioning is for the self-retractor blades to cradle the rectus muscle without compressing the psoas muscle underneath.*
>
> *When positioning the retractors, the surgeon must check visually and by direct palpation that the psoas muscle is not entrapped between the blades and the pelvic sidewall. Furthermore, the shallowest retractor blades sufficient to provide adequate exposure should be chosen as it has been suggested that the degree of nerve injury is proportional to blade length. Rolled up laparotomy pads may be used to cushion the retractor blades against the pelvic sidewall as a precaution. Retractor blade position should be monitored intermittently during the operation and re-adjusted accordingly.*
>
> *The authors recommend undoing the retractors and re-positioning at regular intervals to relieve blade pressure against the pelvic sidewall if a lengthy operation is being undertaken. As hand-held retractors will only exert intermittent as opposed to continual pressure on retracted tissue, they should be selected over self-retraining ones wherever possible."*

92. Prof. Cardozo pointed out that the figure given for post-surgical neuropathies seemed much higher than 0.2% quoted earlier for the incidence of femoral neuropathy. This could be explained by the fact that the article was looking at all neuropathies occurring in gynaecological operations. Damage to the femoral nerve would only be a small proportion of the total number of neuropathies. Prof. Cardozo also stated that for a patient to suffer prolonged or permanent femoral nerve damage was very rare indeed. She had never seen a long-term neurological deficit of the type suffered by the plaintiff. While she had encountered femoral neuropathy before, it had been of limited duration.

93. Mr. Peter Lenehan, consultant gynaecologist and obstritician, also gave evidence on behalf of the defendant. He was of the view that it had been an appropriate decision for the defendant to take to perform the operation. The surgery was carried out by the defendant in a conventional manner. It was complex surgery because the plaintiff had had previous surgery to her abdomen. She had endometriosis and fibroids and was overweight. The main complicating factor in the operation was blood loss. He was not critical of the length of time that the operation took, as the defendant had to deal with the issue of blood loss. He accepted that the injury to the plaintiff's femoral nerve most likely occurred due to compression on the nerve from the self-retaining retractor.

94. In this regard, the evidence of Dr. Counihan, a neurologist retained on behalf of the plaintiff, was unchallenged to the effect that the injury in this case was caused to the femoral nerve at the site of the psoas muscle by pressure from the self-retaining retractor.

95. Mr. Lenehan stated that while some authors did advocate releasing the self-retaining retractors during the course of an operation, his practice in doing that kind of surgery over many years was not to release the retractors. The reason for that was that in most cases if one does that, it interrupts the flow of the operation. If one releases the retractors, the packs which are pushing back the bowel, allowing one to expose the operative field, fall into the operating field and one will have to re-do the whole thing again, which takes about ten minutes or so to do. He stated that particularly in a situation like this where there was bleeding, the priority was to deal with the blood loss. It would not be his normal practice to release the retractors and over a period of thirty years doing extensive surgery, including prolonged surgery, he had not had a femoral neuropathy in a patient of his. He accepted that some people would recommend releasing the retractors but he thought that the priority here was to deal with the bleeding.

96. He was asked to comment on the fact that the defendant did not release the self-retaining retractor in the course of the operation. He stated that he thought that it was perfectly reasonable practice not to do so, particularly with regard to the fact that the operation was timed as lasting two hours and eighteen minutes. The retractor would not have been in for that length of time because there is time spent in opening the abdomen, putting the packs in and then putting the retractor in, which normally takes about twenty minutes or so. At the end of the operation, the surgeon would remove the retractor before closing the abdomen, which could, depending on the complexity of the case, take anything from fifteeen to twenty-five minutes. The present case was not an easy case. He thought that closing the plaintiff's abdomen probably took a fair bit of time. Some people suggested an arbitrary time of two hours to release the retractor. This was something with which he did not personally agree. However, he doubted if in this operation the retractor was in for that length of time.

97. Mr. Lenehan stated that there were risks to the plaintiff if the retractor had been released every twenty to thirty minutes. Releasing the retractor interrupts the flow of the operation and in this case, this was already an operation where, if it was assumed that the plaintiff lost two litres or more of blood, this represented over 30% of her blood volume, which was a considerable blood loss at the time of the operation. Blood loss is a life threatening potential complication. So he would have thought that by interrupting the flow of the operation, particularly in these circumstances where blood loss was continuous, the defendant would have been exposing the patient to more risk than by carrying on as she did.

98. In his written report, Mr. Lenehan stated that it was absolutely necessary to use vigorous retraction in order to visualise the whole operative field and prevent further blood loss. He was asked to explain that conclusion. He stated that the increased Body Mass Index of the plaintiff made the surgery more difficult. It is harder to retract the abdominal wall because there is a thickened abdominal wall of muscle and fat and it makes the surgery more difficult and more prolonged, particularly where there is bleeding. Hence the need to use vigorous retraction.

99. Mr. Lenehan stated as follows in his report in relation to the defendant's surgical technique:-

> *"It seems almost certain that the femoral neuropathy occurred due to the pressue from the self-retaining retractor and perhaps pressure occurring due to the use of other retrctors during the course of the operation. It is clear from the notes that this was a very difficult procedure and in my experience there is no more difficult pelvic surgery than that where endometriosis is present. In these circumstances, where there is excessive blood loss, as was the case here, it is absolutely necessary to use vigorous retraction in order to visualise the whole operative field and prevent further blood loss. The prolonged surgical time of over two hours and the plaintiff's increased body mass index may also have contributed, to a small degree to the injury.*
>
> *It is my opinion that in the circumstances of such difficult surgery, the occurrence of the femoral neuropathy is an unfortunate complication of necessary retraction, but does not indicate that the procedure was carried out in the manner that fell below acceptable standards of care. It is my view that Dr. Hermann's surgical technique was appropriate in the circumstances."*

100. Mr. Lenehan stated that he remained of that view in relation to the defendant's surgical technique on this occasion.

101. He was of the opinion that the defendant did not fall below the standards to be expected of a person of her standing and skill. In relation to the issue of not releasing the self-retaining retractor during the operation, he stated that there was plenty of literature detailing that as being a practice that may or may not be recommended but there was no universal agreement as to whether you should release the retractors during an operation and if so, how often you should release them.

102. Before coming to a conclusion on this aspect, it is necessary to have regard to a letter written by the defendant to the plaintiff's GP on 21st December, 2005. It was in the following terms:-

> *"Dear Dr. Keane*
>
> *I saw Mary today for a follow up. From the hysterectomy end she has completely recovered and has no problems whatsoever. However, as you may have received correspondence from Mr. Prasad, Mary has this femoral nerve damage. We are completely at a loss as to where she got that from in the first place but here we are. I read the nerve conducting studies and my reading is that things are on the way to improve. However, and as you know nerve recovery takes a considerable time.*
>
> *Mary asks me also for some work up of her bladder and I will make appropriate arrangements with Mr. Syed Jaffrey, the consultant neurologist.*
>
> *Best wishes and Merry Christmas.*
>
> *Andrea Hermann."*

103. It was put to the defendant that this showed that she was completely unaware of the possible cause of the injury to the femoral nerve arising out of the compression of the psoas muscle during the operation. The defendant said that she had written the letter in those terms as she could not say for certain from where the plaintiff had got the femoral nerve damage; this was not her area of specialty.

104. Prof. Bonnar said that he was disappointed that at that remove from the operation and the suffering of the injury, that the defendant had not looked up the matter and found out from where the injury was likely to have arisen.

Conclusions on Liability

105. The approach which the court is required to take in deciding liability in a medical negligence action has been set out in *Dunne v. National Maternity Hospital & Anor* [1989] ILRM 735, in the following manner:-

> *"The principles thus laid down related to the issues raised in this case can in this manner be summarised.*
>
> *1. The true test for establishing negligence in diagnosis or treatment on the part of a medical practitioner is whether he has been proved to be guilty of such failure as no medical practitioner of equal specialist or general status and skill would be guilty of if acting with ordinary care.*
>
> *2. If the allegation of negligence against a medical practitioner is based on proof that he deviated from a general and approved practice, that will not establish negligence unless it is also proved that the course he did take was one which no medical practitioner of like specialisation and skill would have followed had he been taking the ordinary care required from a person of his qualifications.*
>
> *3. If a medical practitioner charged with negligence defends his conduct by establishing that he followed a practice which was general, and which was approved of by his colleagues of similar specialisation and skill, he cannot escape liability if in reply the plaintiff establishes that such practice has inherent defects which ought to be obvious to any person giving the matter due consideration.*
>
> *4. An honest difference of opinion between doctors as to which is the better of two ways of treating a patient does not provide any ground for leaving a question to the jury as to whether a person who has followed one course rather than the other has been negligent.*
>
> *5. It is not for a jury (or for a judge) to decide which of two alternative courses of treatment is in their (or his) opinion preferable, but their (or his) function is merely to decide whether the course of treatment followed, on the evidence, complied with the careful conduct of a medical practitioner of like specialisation and skill to that professed by the defendant.*
>
> *6. If there is an issue of fact, the determination of which is necessary for the decision as to whether a particular medical practice is or is not general and approved within the meaning of these principles, that issue must in a trial held with a jury be left to the determination of the jury."*

106. The central issue in this case is the allegation made by the plaintiff through her expert, Prof. Bonnar, that the defendant departed from the standard of care which could be expected of her in failing to release the self-retaining retractor a number of times during the operation.

107. Prof. Bonnar said that the defendant ought to have released the self-retaining retractors three or four times during the operation. He himself does not use self-retaining retractors when doing benign hysterectomy operations. He does not allow his students to use them. In support of his contention that it was good practice for a surgeon to release the self-retaining retractor during an operation, he referred to an article and a chapter from an American textbook. In the textbook it was suggested that the retractor should be released if the operation exceeded two hours.

108. However, it would appear that Prof. Bonar was advocating releasing the retractor on a more frequent basis than that suggested in the literature. He said that even if the retractor blades were placed in the correct position, damage could still occur to the femoral nerve. For this reason, it was necessary to periodically release the retractor blades so as to ease any compression that there may be of the femoral nerve.

109. If it took fifteen minutes to prepare the operative site before insertion of the self-retraining retractor and fifteen minutes at the end of the operation to close up after the retractor had been removed, this would mean that the retractor was in situ for a total of 108 minutes. If the retractor was released three times during this period, this would mean that the surgeon would have had to release the retractor every thirty-six minutes. If it was released four times during the operation, it would be released every twenty-seven minutes.

110. As pointed out by the defendant's experts, this would cause a significant interruption in the carrying out of the operation. Where there was extensive bleeding, as in this case, the bleeding would continue during the periods that the retractor blades were released and while the abdomen and other organs were being repacked on each occasion. I am satisfied that the defendant's experts are correct in their conclusion that this practice of periodically releasing the retractor blades would have exposed the plaintiff to serious adverse risks due to the inability to stop the bleeding during the periods when the retractor blades were released.

111. Prof. Cardozo and Mr. Lenehan both use self-retaining retractors in the course of their practices. Neither of them release the retractor during the course of a benign hysterectomy operation. Prof. Cardozo said that she would only release the self-retaining retractor if she was sending a specimen off for histology examination or if she was awaiting the arrival of a colleague to assist in the operation. She was not aware of any of her colleagues who routinely release the retractor during such an operation.

112. Even if one did go along with those who advocate releasing the retractor, the literature was equivocal as to the length of operation where this should be done. In one article it was suggested that it should be done where an operation exceeds four hours, and in another article where it exceeds two hours. The operation in this case lasted for two hours and eighteen minutes. Allowing fifteen to twenty minutes at the start of the operation before the self-retaining retractor is inserted, and allowing a further fifteen to twenty minutes for closing up after the retractor has been removed, would mean that the retractor was in place for less than two hours.

113. The defendant's experts were agreed that in this case, the defendant was carrying out complex and difficult surgery. There had

been extensive blood loss, probably in and around two litres. In the circumstances, the experts were of the view that the defendant acted reasonably in removing the uterus first and then achieving haemostasis before removing the cervix. They were of the view that the defendant's primary concern was to stop the bleeding. If she had released the retractors while bleeding continued, she would have exposed the plaintiff to even greater risks.

114. The onus of proof rests on the plaintiff to prove that in not releasing the retractor, the defendant was following a course which no other surgeon of similar status and skill exercising ordinary care would have done. The plaintiff has not established this.

115. While some surgeons may release the self-retaining retractor periodically during the course of a benign hysterectomy operation, it is clear that other surgeons do not do so. I cannot find that in failing to release the self-retaining retractor in the course of this operation, the defendant departed from the standard of care which could be reasonably expected of a surgeon of the plaintiff's skill and experience.

116. I am satisfied that in the circumstances which presented themselves to the defendant in this operation, the defendant was correct to proceed with the operation and achieve haemostasis, rather than release the self-retaining retractor a number of times during the operation. If she had done so, the plaintiff would have been in more danger from complications caused by loss of blood.

117. I am satisfied that the plaintiff has failed to establish negligence on the part of the defendant in the carrying out of this operation.

Discrete Issues

118. There are a number of discrete issues which were raised in the course of the hearing. They were not germane to my opinion on the central questions of liability in this case. The first issue concerned the letter of 10th May, 2005, sent by Dr. Ní Bhuinneáin to the plaintiff's GP. When writing his letter of referral to the defendant, he sent a copy of the medical records from Mayo General Hospital including the said letter from Dr. Ní Bhuinneáin.

119. The defendant made discovery of documents on a voluntary basis by affidavit sworn on 5th June, 2014. The relevant paragraphs are as follows:-

> *"5. I say that the entirety of the plaintiff's medical records including all clinical entries made by me and any communications received and/or sent by me pertaining to the plaintiff, save those as set out in the second part of the First Schedule are contained within the hospital chart held by the Galway Clinic.*
>
> *6. I say that all of the documents sought are in the possession of the Galway Clinic. Accordingly, I am not in a position to aver to the location or continued existence of the totality of all documentation which has ever been held by the Galway Clinic in relation to this matter.*
>
> *7. I say that as a result I am disclosing documents that were discovered to my solicitors, Matheson by the plaintiff's solicitors, P. O'Connor & Sons Solicitors in affidavits of discovery dated 8th June, 2010 and 28th January, 2011.*
>
> *8. I further say that I have had but have not now in my possession power or procurement documents and electronically stored information relating to the matter in question in this action set forth in the Second Schedule hereto.*
>
> *9. Insofar as the last mentioned documents consist of letters sent by me or my solicitors, such documents were last in my possession, power or procurement or in the possession or power of my solicitors on the date when such letter was posted to the person or firm to whom it was addressed or otherwise delivered in the normal course.*
>
> *10. The letters which are referred to in the last preceding paragraph are, I believe, in the possession of several persons or firms to whom they were addressed and posted.*
>
> *11. To the best of my knowledge, information and belief, I, this deponent have not nor ever have had in my possession custody or power nor have my solicitors or agents, or any other person or persons on my behalf, any deed, account, book of account, voucher, receipt, letter, memoranda, paper writing or any copy or extract from which any such document or any other document whatsoever relating to the matter in question in this suit or any of them or wherein any entry has been made relative to such matters or any of them other than and except the documents set forth in the schedules hereto."*

120. It transpired at the hearing that the version of the letter from Dr. Ní Bhuinneáin to the plaintiff's GP dated 10th May, 2005, which the defendant had, had only one paragraph thereon. The second paragraph was missing. Nobody could explain how this letter came to differ from the original.

121. The defendant stated that she no longer had the documents which Dr. Keane had sent to her in August 2005. This was due to the fact that from about 2007, she employed a person to transfer her paper files into electronic format. This involved creating a file in the computer for each patient and scanning in the paper version of the file for each patient. The original paper file was then shredded.

122. The defendant stated that when she came to swear the affidavit of discovery she simply downloaded whatever was in the computer relating to the plaintiff and she forwarded that to her solicitors.

123. Subsequently, when she was leaving the Galway Clinic she transferred all the electronic files onto a USB stick. That stick was examined during the course of the trial. The version of the letter of 10th May, 2005, which appeared thereon, was the version which contained only the single paragraph. In relation to the history of the file, it appeared that a significant number of the electronic files, including the file containing this letter, had been "*modified*" on various dates. The defendant was not able to say in what way the documents had been modified. She denied that she had at any stage removed the second paragraph from the letter. She stated that any documents she had received from Dr. Keane had been scanned into her computer in or about 2007. When she was asked to make discovery she simply printed off what she had on the computer relating to the plaintiff, and sent it to her solicitor for inclusion in the affidavit of discovery.

124. The defendant did not inform the plaintiffs that the original paper files had been shredded once they had been scanned onto the computer. She could not explain when or how the second paragraph came to be deleted. She was adamant that whatever was on the USB stick was the version which she had received.

125. The court is unable to reach any conclusion as to how this paragraph came to be missing from the version of the letter as appearing on the defendant's file. The paragraph in question dealt with the issues concerning the plaintiff's weight and the plan devised by Dr. Ní Bhuinneáin for addressing this pre-operatively. It was suggested that the defendant had a motive for deleting this paragraph because she did not want it shown up that another doctor had put in place a weight reduction plan for the plaintiff when she had not done so. The court does not feel able to come to this conclusion. How the paragraph came to be removed from the letter, remains a mystery. It is not necessary for the court to reach any definitive conclusion on this matter.

126. The second issue concerned whether the defendant removed one of the plaintiff's ovaries in the course of the operation. The plaintiff states that she was told by the defendant after the operation that there was good news in that she only had to remove one of her ovaries. It was argued that this was confirmed on subsequent scans which failed to show any left ovary.

127. The defendant denied taking out one of the plaintiff's ovaries or telling the plaintiff that she had done so. In support of this contention, she pointed to three matters. She said that had she removed one of the ovaries in the operation, the ovary would have been placed in a specimen container and sent to pathology for examination, as had been done with the uterus and the cervix. Secondly, she would have recorded the removal of the ovary in her operation note. Thirdly, she would have mentioned this in her letter to the GP after the operation.

128. Prof. Bonnar stated that he did not have a great difficulty with the defendant removing one of the ovaries in the course of the operation, but it states that it should have been recorded in the operation note. Mr. Lenehan stated that when a woman reached menopause it was easy to miss an ovary on scanning as they had shrunk to a very small size.

129. I prefer the evidence of the defendant on this issue. Accordingly, I find that on the balance of probabilities the ovary was not removed in the course of the operation.

130. Maura O'Tuairisig was the nurse/manager employed by the defendant at her rooms in the Galway Clinic. She had been present at the time of the initial consultation with the plaintiff on 30th August, 2005, and she assisted the defendant with the operation carried out on 20th October, 2005. She was also the person who could give evidence in relation to the transfer of the material from the defendant's computer to the USB stick. During the hearing, the defendant's counsel offered to call Ms. O'Tuairisig as a witness, but on condition that she could only be questioned in relation to issues involving the USB stick. When the court ruled that she could be questioned on any aspect on which she had personal knowledge, the defendant chose not to call Ms. O'Tuairisig as a witness.

131. In her written submissions, the plaintiff asserted that where one party does not call a witness without any good reason for not doing so, the court is entitled to draw an adverse inference from this state of affairs. The plaintiff referred to the decision of the Supreme Court in *Doran v. Cosgrove & Ors* [1999] IESC 74, where Keane J. in the course of his judgment cited with approval the following dicta of Lowry L.J. in *Reg v. IRC, exp Coombs & Go* [1991] 2 A.C. 283 at p. 300:-

> *"In our legal system generally, the silence of one party in face of the other party's evidence may convert that evidence into proof in relation to matters which are, or are likely to be, within the knowledge of the silent party and about which that party could be expected to give evidence. Thus, depending on the circumstances, a prima facie case may become a strong or even an overwhelming case. But, if the silent party's failure to give evidence (or to give the necessary evidence) can be credibly explained, even if not entirely justified, the effect of his silence in favour of the other party, may be either reduced or nullified."*

132. Keane J. then went on to deal with the facts of the case before him in which the plaintiff, a passenger in the first named defendant's car, which was being driven by the second named defendant, suffered serious injury when the second named defendant was attempting to overtake a right-turning van at high speed. The second named defendant was not called to give evidence. Keane J., having referred to the dictum of Lowry L.J. supra, stated as follows:-

> *"Applying that statement of the law to the facts of the present case, it is clear that, even apart from the fact that the first and second named defendants have not sought to contest the finding in the High Court that the driver of the motor car was negligent, no other inference could have been drawn by the trial judge from the evidence actually adduced in the case, in the light of the failure of the second named defendant to give evidence and the absence of any credible explanation for that failure."*

133. The decision in *Doran v. Cosgrove* was applied by Hanna J. in *H. v. St. Vincent's Hospital Trustees Limited & Ors* [2006] IEHC 443, where the defendant had admitted in evidence without formal proof, a note that had been made by a Dr. Christie, but then proceeded to make the case that the note was wrong. Hanna J. had the following to say in relation to the decision not to call the doctor as a witness:-

> *"In this case, the failure to call Dr Christie is highly unsatisfactory and in my view has not properly been justified. I am not satisfied that a credible explanation for not calling her has been proffered. Nonetheless, this has led to an unfortunate situation, as I have said, where a party, who has agreed without formal proof medical records, seeks then to invite me to disregard the note as being wrong. It is difficult in the extreme to understand why Dr Christie's views were not, at the very least, sought if such were the case. The alternative possibility, of course, is that such views were sought and that they were adverse to the interest of the defendants. In the absence of any evidence of this, I will not make any such assumption. I can only infer therefore that a tactical decision was made by the defendants to agree Dr Christie's note and then proceed to rubbish it."*

134. The plaintiff also referred to the decision of Irvine J. in *Dunne (an infant) v. Coombe Women and Infants University Hospital* [2013] IEHC 58, where the learned judge stated as follows in relation to the failure of the defendants to call a nurse who had made a note of certain timings in a chart which were highly relevant to the proceedings:-

> *"195. In coming to my conclusions as to the validity of the times which appear on the drug chart, I did not find it necessary to engage to any great extent with the principles of law which emerge from decisions such as Herrington v. British Railways Board [1972] AC 877 and Hawkes v. St. Vincent's Hospital & Ors. [2006] IEHC 443. However, from those decisions, it is clear that in certain circumstances, a court is entitled to draw adverse inferences from the absence or silence of a witness who might be expected to have material evidence to give on a particular issue. This principle is of relevance to the defendant's failure to call Nurse O'Connor as a witness in the present case.*
>
> *196. From as early as the fourth day in these proceedings which were at hearing for some forty three days, the centrality of the drug chart to the dispute between the parties as to the time at which Dr. Ramesh arrived to the*

resuscitation was blatantly obvious. That dispute is core to the liability issue in the proceedings. No other witness was able to give evidence as to whether the drug chart or any less formal record was kept noting the time at which the various steps were taken during the resuscitation. Nurse O'Connor's testimony, had she been called, was clearly material to the court's decision as to the weight it could attach to the timings on the drug chart and would also have been key to its conclusion as to the reason why the sodium bicarbonate and sodium chloride appeared in the incorrect order on the drug chart, a matter that the defendant sought to rely upon to undermine the timings on the chart. Of even more significance is the fact that while the defendant or one of its servants or agents authored the timings on the drug chart, it pursued its defence of these proceedings based on a timeline which was strongly in the teeth of those timings and in circumstances where it had admitted this document into evidence without the necessity for formal proof. It is further relevant to note that no evidence was led to explain Nurse O'Connor's absence as a witness, notwithstanding the fact that the defendant challenged each and every one of the plaintiff's expert witnesses on the basis that the timings she had recorded in the drug chart were incorrect.

197. In the aforementioned circumstances, it seems to me that it is likely that the defendant made a tactical decision not to call Nurse O'Connor and I think the only logical inference to be drawn is that her evidence was not going to sit comfortably with the case which it was advancing. However, even without drawing any adverse inferences from the defendant's failure to call Nurse O'Connor, I am satisfied on the balance of probabilities that the timings on the drug chart are accurate in respect of each of the actions therein mentioned, with the exception of the sodium bicarbonate and sodium chloride to which I have already referred."

135. In each of the cases referred to, there was a very specific topic on which the particular witness would have been able to give relevant evidence. In two of the cases, it concerned a record made by the particular witness. In the circumstances, it would have been open to the court to infer that the witness would have given evidence which supported the accuracy of their note. In the present case, there is no specific matter on which the witness could give evidence which was contrary to the case made by the defendant.

136. The plaintiff has submitted that the decisions cited allow the court to draw inferences about why the defendant did not want Ms. O'Tuairisig to be cross examined. It was submitted that it was open to the court to conclude that Ms. O'Tuairisig would not have been in a position to give evidence favourable to the defendant in relation to the surgical procedure carried out by the defendant. It was also submitted that the court could infer that Ms. O'Tuairisig was not either skilled or experienced in being a theatre assistant.

137. I do not think that the authorities cited permit the court to speculate as to what evidence the witness would have given contrary to the case made by the defendant. Just because Ms. O'Tuairisig was not called as a witness, does not mean that the court can speculate as to what evidence she would have given in relation to the initial consultation, or the carrying out of the surgery on the plaintiff. It would be different if the witness had drawn up a particular note that was in issue in the proceedings. Accordingly, I decline to draw any general adverse inferences from the defendant's failure to call Ms. O'Tuairisig as a witness at the trial.

138. Finally, the court heard an amount of evidence principally from Dr. Conor O'Brien, Consultant Neurophysiologist, in relation to damage to the plaintiff's pudendal nerve. However, no evidence was led that this damage had been caused by any negligence on the part of the defendant. In the circumstances, the defendant cannot be held liable for any injury which may have occurred to the plaintiff's pudendal nerve.

139. For the reasons set out in this judgment, I dismiss the plaintiff's claim against the defendant.