Neutral Citation Number [2009] IEHC 189

THE HIGH COURT

2004 459 P

BETWEEN

JOHN ENGLISH

PLAINTIFF

AND
THE NORTH EASTERN HEALTH BOARD
AND
URSULA MULCAHY

DEFENDANTS

JUDGMENT of Mr. Justice Charleton delivered on 23rd day of April, 2009

1. The plaintiff claims damages against the defendants, the first representing Louth County Hospital and the second a general surgeon, for damage to his left hand arising from three operations under a general anaesthetic on 19th June and 16th July, 1996, and on 27th April, 1999. The second of these operations was to amputate the little finger on his left hand. The first and third were to correct Dupuytren's contracture, a condition which pulls fingers into a clenched position. The plaintiff claims that his left hand has been rendered practically useless due to the negligence of the second named defendant in not properly dealing with this condition of Dupuytren's contracture in the first operation. He claims a similar lack of care in healing the same condition in the ring finger of his left hand in respect of the third operation. The claim was abandoned as to that third operation during the course of the trial. However, it is still relevant to the issue of credibility.

Test

2. The second named defendant is not to be judged against the standard applicable to a specialist hand surgeon. At the time of these operations, there were four or five such specialists practicing in the State. The second named defendant did not refer the plaintiff to one of these and that, in itself, was pleaded as a ground for liability. The standard of care which the plaintiff was entitled to expect at Louth County Hospital was that which a careful and competent general surgeon, engaging from time to time in hand surgery, could give. The relevant test is set out in *Dunne v. National Maternity Hospital,* [1989] I.R. 91 at 109-110 as follows by Finlay C.J., approving the previous decided cases on this:-

> "There was no argument submitted to us on the hearing of this appeal which constituted any form of challenge to the correctness of the statements of principle thus laid down, although there was controversy concerning their application to the facts of this case. The principles thus laid down related to the issues raised in this case can in this manner be summarised.
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> 1. The true test for establishing negligence in diagnosis or treatment on the part of a medical practitioner is whether he has been proved to be guilty of such failure as no medical practitioner of equal specialist or general status and skill would be guilty of if acting with ordinary care.
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> 2. If the allegation of negligence against 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.
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> 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.
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> 4. An honest difference of opinion between doctors as to which is the better of two ways of treating a patient does not provide any ground for leaving a question to the jury as to whether a person who has followed one course rather than the other has been negligent.
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> 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.
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> 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.

In order to make these general principles readily applicable to the facts of this case, with which I will later be dealing, it is necessary to state further conclusions not expressly referred to in the cases above mentioned. These are:

> "(a) General and approved practice" need not be universal but must be approved of and adhered to by a substantial number of reputable practitioners holding the relevant specialist or general qualifications.
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> (b) Though treatment only is referred to in some of these statements of principle, they must apply in identical fashion to questions of diagnosis
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> (c) In an action against a hospital, where allegations are made of negligence against the medical administrators on the basis of a claim that practices and procedures laid down by them for the carrying out of treatment or diagnosis by medical or nursing staff were defective, their conduct is to be tested in accordance with the legal principles which would apply if they had personally carried out such treatment or diagnosis in accordance with such practice or procedure".

In developing these legal principles outlined and then applying them to the fact of each individual case, the court must constantly seek to give equal regard to both of these considerations"

3. The essential allegation made by the plaintiff against the second named defendant, and vicariously against the first named defendant, by the plaintiff has been that the standard of treatment shown in the three operations was such that it deviated from the

standard applicable to this context.

The Plaintiff
4. The plaintiff is now fifty-two years old and comes from Dundalk. After leaving school he worked first as a chef and then did time as a general mechanic. He became particularly good with hands, so that at a later stage in his life he was able to venture setting up his own independent garage. He complains that since the operations concerned, his left hand has become useless for mechanical work. Consequently, he has become depressed and, for a period of years, took very heavily to drinking. In practical terms, he claims to have found himself unable to work since 1998. Although no figures have been presented to the court, he claims damages on the basis of the loss of the amenity of being able to leave his house everyday and go to work and do a meaningful job. I recognise this as a general head of damages in respect of which he would be entitled to compensation should his claim succeed. A general lowering of mood also allows for the award of damages but alcohol consumption, as a voluntary act, in my view does not. A plaintiff cannot validly claim that an increasingly gloomy personality resulted from anything other than his own choice is over-indulge in a mood department, which alcohol clearly is.

5. The plaintiff asserts that when he went first to Ms. Mulcahy, the second named defendant, his little finger of his left hand was bent at an angle of about 90º and was causing him problems. His ring finger was then perfect, and this is not disputed. He claimed that he could make a fist with his left hand. He said that this problem with his little finger had gone on for a year and, in consequence of getting in the way during his work as mechanic, he was referred by his general practitioner, Dr. O'Reilly, to Ms. Mulcahy. On examination, she diagnosed Dupuytren's contracture. He claimed that the possibility of referral to a hand specialist was not offered to him and nor were any complications that might arise from the surgery explained to him. When he awoke after the first operation, on 19th June, 1996, his finger was entirely bent over into a clenched circle with a roll of gauze holding it up from his palm. His knuckle, he said, was scarred all around. There was only, he claimed, one incision. His finger felt dead over the next few weeks, lacking feeling from the knuckle to the tip. On consultation two weeks later, Ms. Mulcahy told him that she would have to amputate the finger because, as he recounted it, she said that "the joint is frozen". Again, he complains of a lack of explanation sufficient to ground a valid consent to the procedure. The finger was amputated in the second operation of 16th July, 1996 and the skin was closed. He complained that afterwards he experienced shooting, cramping, throbbing feelings, like as if the wound was still open. That complaint continues to the time of trial. He did not see Ms. Mulcahy again after the stitches were taken out. He found that he now had no grip for ordinary mechanical work. For small intricate work, like springs and clips, he found himself bereft of dexterity. At this stage, he was engaged in a FÁS course as a groundsman and, in his spare time, he was working for a friend, Dermot Gregory, who owned a garage in Crossmaglen and was keeping himself busy with part-time work. Mr. Gregory in evidence said that this work was "hands on" and that as the plaintiff now needed another man with him, even for simple tasks, he was no use to the business. In consequence, he was let go.

6. What happened next was that Dupuytren's contracture started to develop in the palm and finger of his left hand ring finger. This started to pull the finger down, making it tighter and tighter. He was again referred to by Dr. O'Reilly the second named defendant. She indicated that she would try to straighten it. Again, he said there was no proper explanation of the nature of the operation and no option of referral to a specialist hand surgeon offered to him. The operation of 27th April, 1999 was to try to achieve good function in the finger. After it, the plaintiff claimed a bad result. When he came out of the general anaesthetic he found his finger was still bent. He complained there was no proper surgical incision on his ring finger, for the purpose of removing the growth. He went to the second named defendant and complained bitterly as to the state of his hand. According to him, she told him that the condition was the best that could be done.

7. About two years later he was transferred from Dr. O'Reilly to Dr. Gleeson as his general practitioner. Because he was having problems with his shoulder he was on on-going pain killers. He had also had an accident in a car some years previously and, in consequence, had lost the sight in one eye. So, he must have been going to his family doctor from time to time. The plaintiff told me that Dr. Gleeson examined his finger and said to him:-"that woman should not have done that job – she wasn't qualified". In consequence, he went to a solicitor and proceedings were issued. A specialist medical report was obtained, laying a foundation in negligence against the defendant, and a statement of claim was served.

8. The plaintiff's right hand has now developed Dupuytren's contracture in the ring finger. His left ring finger is now noticeably bent. He claims that this was the result after the third operation. The plaintiff awaits an operation on both hands and, with competent care, he expects a good result in respect of both ring fingers on the right and left hands.

9. I must point out two problems that I have with the plaintiff's evidence. The first is that while his evidence as to what Dr. Gleeson had told him about the qualification of Ms. Mulcahy to do the hand operations was clearly hearsay, it is also markedly coloured against her. Under cross-examination he merely referred Dr. Gleeson as having said "that shouldn't have been done". Secondly, the plaintiff's complaint as to the state of his left ring finger following the operation of 27th April, 1999 is contradicted by the evidence. Following a meeting in May, 1999 with Ms. Mulcahy, she wrote a report to his G.P., Dr. O'Reilly. This reads, in part:-

> "I saw this patient at outpatients on 13th May. He tells me that his finger is now useless. On examination the wound has healed and the finger is straight. I have advised him to exercise the finger. There appears to be a full range of movement and no obviously loss of function of the finger. There is still some swelling in the palm. I think that this is probably residual haematoma following the operation and this is what is causing anxiety.".

10. For legal-medical purposes, the plaintiff was referred to Mr. Owen Brady, an orthopaedic surgeon. He reported by way of letter to Dr. Gleeson, and this document dated 10th October, 2001 reads, in part, as follows:-

> "On examination he has some evidence of Dupuytren's type tissue involving the palm of his left hand. He has an amputation through the metacarpal phalangeal joint of little finger. There is no evidence of neuroma formation. He has good grip strength and his has full range of movement of his ring finger. I have explained to him that I do not feel any further surgery is warranted in his hand".

11. To that I must add that I am not taking into account the plaintiff's complaint of soreness at the site of his little finger following the operation. That I ascribe to a mistake that is easy to make. That soreness is due to the recent growth of a neuroma, or sensitivity due to growth in a cute nerve. Dr. Kanbiz Hashemi, the medical specialist called on behalf of the plaintiff, examined him in 2003 and in 2006. It was only his examination of 2006 that there was evidence of neuroma formation at the site of the scar of the amputation of the little finger of his left hand. I cannot be impressed, in context by the reference to Dr. Gleeson's alleged opinion on Ms. Mulcahy and by the complaint of a bent finger resulting from the third operation when that was not the case.

Dupuytren's Contracture
12. I have heard a lot of evidence about Dupuytren's contracture and I now want to give a concise summary of it. This condition is

caused by the thickening of the normal fibrous bands which run from the palm of the hand into the fingers. Those fingers which are most likely to be affected are the ring and little fingers. The tightening of the fingers, and occasionally their contracting into an oval or clenched shape is the result of the condition. The fibrous bands shrink, binding the skin to the coverings of the finger tendons and then pulling them into a deformed position. If not treated, the fingertips may become fixed into the palm. As with a lot of other diseases, it is important to catch its progress early. If it is found to be slow in progression, no treatment may be necessary. The only treatment available, however, is an operation. This involves opening the skin, usually under general anaesthetic and following the application of tourniquet to stop bleeding at the site of surgery. The surgeon then excises, the fibrous material allowing the finger to straighten.

13. Dr. Hashemi gave evidence that amputations were rare. Dr. Hashemi is a specialist hand surgeon working in a hand clinic, albeit in the context of his having responsibilities as well, more broadly, in trauma cases. According to Dr. James Murphy, a consultant surgeon called on behalf of the defence, reliable articles on the internet surgeons reveal that amputations can run at a level of about 9%. According to one article, if there is severe flexion deformity then either fixing the joint or amputation should be considered as a viable option in the place of procedures to regain motion by cutting away fibrous material.

The Negligence Alleged
14. Dr. Hashemi asserted that, on his reading of the relevant medical notes, a number of problems were apparent with all of the operations conducted by the second named defendant. Firstly, he said that there was no evidence that a tourniquet was used. If it had not been, then bleeding at the surgery of site could have rendered the operation much less efficient, and certainly more difficult. Secondly, he said that there was insufficient cutting away of fibrous tissue and that this was explained by a failure to properly incise the palm and finger so as to expose the operation site. Lastly, he claimed there was significant damage to the flexor tendons and digital nerves at the level of the incision of the first operation. This last claim was made only on the basis of what the plaintiff had told him of the condition of his hand following on the first operation. In summary he claimed that if the first operation had been conducted correctly, then the second operation of amputation of the left little finger would have been unnecessary.

Objective Evidence
15. I am entitled to rely on the medical notes as admissions made by the defendants directly bearing on their course of conduct. In doing so, I am in a position where I believe the more reliable historian as to the events as between the plaintiff and the second named defendant is the latter. I found in her evidence no tendency to exaggerate in her evidence or any sign of a determination to excuse her conduct.

Findings
16. Having carefully listened to all of the evidence and bearing in mind that the burden of proof is on the plaintiff to establish a credible case that I can rely on as a probability, I make the following findings of fact.

(1) For the first and third operations, a tourniquet was used to cut off the blood supply to the plaintiff's hand. For the second operation not involving amputation, it was not used because it was not necessary.

(2) A conflict has arisen as to the presentation of the plaintiff's left little finger prior to the first operation. I am satisfied that the plaintiff had a significant problem with his left little finger. The pre-operation notes are, in that respect, correct. The second named defendant writes: "Dupuytren's contracture. Present for years. General health good… [on examination] marked contracture." It is more likely, therefore, that the second named defendant's evidence that the finger was bent over into the palm is correct. The plaintiff's evidence of a lesser problem is not probable.

(3) The plaintiff claimed to have some movement in the left little finger prior to the first operation and, in particular, at the second joint. I do not accept this. I accept that it was a fair exercise of judgment for the second named defendant to examine the finger under a general anaesthetic as well as attempting to treat it. The proximal inter-phalangeal joint was found to be frozen. I accept that, as a matter of good practice, an amputation can be considered in those circumstances.

(4) I am satisfied that the plaintiff wanted an amputation of his left little finger on presenting to the second named defendant on 4th July, 1996. I am satisfied that by this stage it was apparent that the joint was firmly fixed and that the excision of fibrous material from the palm of his hand had not succeeded in producing a good result, and that this not due to any want of care on the part of the defendants.

(5) I am satisfied that sufficient exploration under general anaesthetic, and excision of fibrous material, had occurred in the first operation. I am satisfied that two incisions, as the operation note indicates, had been made and that a small amount of fibrous tissue had been excised from the palm. I am satisfied that it was reasonable to conclude, as the operation note indicates, that the joint was "firmly fixed" and that the plaintiff "will need amputation".

(6) I am not satisfied, in this context, that a failure to offer after operation care would have made any difference. In addition, I accept the evidence of Ms. Mulcahy, the second named defendant, that specialist physiotherapy was not available to her and that the kind of splinting described by Dr. Hashemi was not provided for.

(7) I am satisfied that the amputation of the little finger was warranted in the circumstances. This amputation was done carefully. A reasonable result from all the operations was obtained by the plaintiff. I find it hard to imagine that he would return for a third operation to the second named defendant within three years, should he have had the complaints consequent on that operation of which he testified.

(8) I am not satisfied that the decision to amputate arose in consequence of the second named defendant negligently cutting through nerves and tendons during the first operation. In particular, I note that the statement of claim pleads that following on the first operation he had ceased to be able to move the tip of his little finger. Specifically, the following sentence in the particulars of personal injury out-rules the cutting of nerves and tendons: "The finger felt 'dead' and gradually extension and flexion were reducing".

(9) Finally, I want to deal with the third operation on the ring finger of the left hand, conducted on 27th April, 1999. I am satisfied there was a good assessment and a good result. My reasons, in this respect, have been given previously. I am satisfied that whereas the incisions might be regarded as different to those described as appropriate by Dr. Hashemi, that they were a reasonable choice to make with a view to excising fibrous material. All the documentary evidence, as previously noted, indicates a good result from this operation.

Result
17. In the result the plaintiff has not met the burden of proving as a matter of probability that the second named defendant, and vicariously the first named defendant, have failed in providing the ordinary skill and care appropriate to a general surgeon operating in a county hospital. I might add, that I am not convinced by the evidence that it is probable that the plaintiff would have had a better result, given his condition and the length of time over which Dupuytren's contracture had developed in his left hand, had he been referred to, and obtained, specialist care from a hand surgeon in a dedicated unit.