Neutral Citation Number: [2010] IEHC 51

THE HIGH COURT

1999 6193 P

BETWEEN

TERESA BUCKLEY

PLAINTIFF

AND

COLM O'HERLIHY AND THE NATIONAL MATERNITY HOSPITAL

DEFENDANTS

JUDGMENT delivered by Mr. Justice O'Keeffe on 26th day of February, 2010

1. In this case, the plaintiff claims damages for negligence alleged to have occurred from a sterilisation operation carried out by the first named defendant on 14th October, 1997 at the second named defendant's hospital in Dublin. In particular, she complains about a complication that arose during the course of the operation which was caused to one of her blood vessels.

2. The first named defendant is the Professor of Obstetrics and Gynaecology at the second named defendant's hospital.

3. Counsel for the plaintiff stated that the plaintiff's case can be summarised in two ways: firstly, the plaintiff was not warned before she underwent the surgery of the risk which such surgery carries of inadvertent injury to a blood vessel. Secondly, when complications occurred, the plaintiff's problems arising from such complications were not competently dealt either in the immediate aftermath in hospital, or in the events that ensued subsequently.

The plaintiff's evidence

4. The plaintiff was born on 15th April, 1960 and married Tony Collison on 30th March, 1985. She had three children who were born between June 1988 and October 1992. In 1997, she was a mainstream class teacher in a boy's school in Terenure. Her husband is a qualified secondary school teacher. The first named defendant attended the plaintiff for the birth of her three children. She subsequently had two miscarriages, one in June 1995 and the other in September 1995. She consulted the first named defendant in a follow up to the second miscarriage. Following the second miscarriage she discussed with the first named defendant having a sterilisation and he recommended that she should come back to him in six months time. She and her husband subsequently discussed it and thought about other methods of contraception. They went to two different clinics as they contemplated that her husband might have a vasectomy. She referred to pain being a complication of that procedure and they decided on sterilisation. They felt the procedure would be easier – a simple one day off work procedure.

5. She signed a consent form on 30th May, 1997 when she visited the first named defendant with her husband. At this consultation he said the procedure would be irreversible, that it was not foolproof, that there were possibilities that it might not work. There was a very slight possibility that she could become pregnant after the operation. He discussed the option that her husband may have a vasectomy. He explained to her that the procedure would be keyhole surgery, that the procedure would take place in the day ward and that she would go in and out on the same day. She would have to be picked up going home. She said that the first named defendant did not mention any other risks associated with the procedure.

6. She said that if mentioned to her that the procedure would carry a risk of an injury to one of her blood vessels even if the procedure was properly carried out, she would not have had the procedure as it was not necessary for her as they had used condoms and it was a procedure she did not need to have.

7. The consent form is a pre-printed form headed *"Tubal Ligation. Consent by Patient".* It stated that the plaintiff consented to undergo the operation of Tubal Ligation and that the nature and purpose of such operation had been explained to her by the first named defendant. It confirmed that she had been told that the intention of the operation was to render her infertile and incapable of becoming pregnant. It stated she understood that there was a small failure rate. It consented to the administration of a general, local or other anaesthetic. She understood that the procedure was not reversible. No assurance had been given to her that the operation would be performed by any particular surgeon. The form was dated and signed by herself and her husband. The form continued in the following terms and was signed and dated 30th May, 1997 by the first named defendant:-

"I confirm that I have explained the nature and purpose of this operation and during the consultation I discussed the following:

✔		*Alternative methods of contraception including vasectomy*
✔		*Pregnancy may occur in cycle in which operation is performed*
✔		*Risks of the operation/Risk of laparotomy if laparoscopy not feasible*
✔		*Possibility of subsequent menstrual disorder*
✔		*Later need for hysterectomy*

✔		Other matters discussed – specify

Irreversibility

Failure rate 3/1000

I am also of opinion that Tubal Ligation is appropriate in this case."

8. In relation to the matters which the form states were discussed by the first named defendant with the plaintiff, she stated that the first named defendant had discussed alternative methods of contraception including vasectomy and that a pregnancy could occur in the cycle in which the operation was performed. There was no discussion, she said, on the risks of the operation/risk of laparotomy if laparoscopy was not feasible. Neither did she hear mention of a risk of possible subsequent menstrual disorder or a later need for a hysterectomy. She agreed that they had discussed irreversibility and the failure rate but did not recall a number being discussed. Whilst the procedure was originally to take place during the summer holidays it was subsequently arranged for 14th October, 1997.

9. She attended the day care centre around 8am on 14th October, 1997 and it was intended that her husband should pick her up from the day ward at 5pm on the same day. When she attended the day care centre, she signed two further consent forms. One was entitled Gynaecological Day Care Centre and her signature was witnessed by M. Jacob, a nurse in that department employed by the second named defendant. She also signed a second form entitled "Consent Form". That form was signed by a medical practitioner. There was no mention by that doctor of any risk associated with the procedure of laparoscopy.

10. She was brought to the operating theatre. The medical records indicate that the operation was carried out at about 9am and that between 9.30am and 10.30am she was in the post operative area and at approximately 10.30am she was returned to the day care centre. She felt very tired that day sleeping on and off.

11. She recalled going to the toilet attached to the day care centre at around 3pm. She made her own way to the toilet and in the toilet she became nauseous and vomited. At the same time, blood spurted from her stomach area from her belly button area. She said it sort of spattered onto the walls behind the toilet from her bellybutton area. She was surprised and alarmed, she went outside the toilet and met a sister or a nurse and told her what had happened. She asked her to go back to the bed and lie down and said that she would call the first named defendant. He subsequently attended her and she conveyed her concern to him. She had no idea that event could possibly happen. As she was very concerned about what had happened she said she spoke about her husband who was due to collect her at 5pm and she did not want to leave. The first named defendant said that he would deal with the matter and that her husband could wait whilst he dealt with it. He said that he was going to put a stitch in. She said she knew from hindsight from talking to people that the first named defendant did put a stitch into the wound but she is not sure whether she was given any local anaesthetic prior to the stitch. Shortly after, the first named defendant had treated her, her husband arrived to drive her home.

12. She cannot remember getting any particular advice from the first named defendant before she went home other than to come back for a scheduled check-up.

13. On her way home she felt very unwell and faint. When she arrived home, she sat on the couch in the sitting room feeling tired and unwell. Later that evening, she realised that some blood had seeped through from the operation wound. She showed it to her husband who put another dressing on top of it. She went to bed around 10pm or 11pm feeling unwell and there was a lot of pain at that stage in the abdomen area. It was a sort of constant pain and very severe. She had not experienced this pain level earlier. Pain developed between 10.00pm/11.00pm and by midnight it was bad. She could not sleep and was in agony in the bed. The site of the laparoscopy wound as a result of the procedure was just below the bellybutton.

14. She informed her husband of the pain. Her husband made the telephone call downstairs to the second named defendant's hospital. Following this he gave her medication for the pain which he said was the advice which had been given to him on the phone by the hospital. She could not remember whether the painkiller was a prescription given to her or whether it was something she had at home but it eased the pain and she slept.

15. The following morning she said to her husband that she needed to go to the bathroom and she was again in pain. He went to bring the children to school. When he was gone out she walked out on her own and fainted onto the bed and lay there until he came back.

16. She told her husband what had happened. Her husband made a further phone call to the hospital, following which he gave the plaintiff painkillers. During that day she was weak and tired. She could not recall pain that afternoon. Later that evening she recalled getting up off the couch in the sitting room to go to bed and climbing the stairs and she felt what she was wearing appeared to be wet on the outside. She knew straightaway it was blood on the outside of what she was wearing. There seemed to be a lot of blood coming through her bellybutton area. The time was approximately 9pm on 15th October, she asked her husband to phone an ambulance. The blood was pumping out at that stage, very fast. The ambulance was summoned and arrived at around 9.30pm. The ambulance went first to St. Michael's Hospital in Dun Laoghaire and then to the second named defendant's hospital. The records indicate that she arrived at the hospital at 9.45pm. She met the first named defendant who explained to her what he proposed to do. She was given a general anaesthetic. She recalls having pain following the operation. She had a wound from her bellybutton and down to the vaginal area.

17. On 16th October, she was treated with morphine. She was intubated whilst in the second named defendant's hospital. On Friday, 17th October, she was transferred from the hospital to St. Vincent's Hospital. The records indicate she was brought to the Intensive Care Unit of St. Vincent's Hospital on the afternoon of 17th October. She had a urinary catheter in place which was extremely uncomfortable. She was ex-tubated on 20th October and moved from the Intensive Care Unit to a ward in St. Vincent's Hospital. She remembered the last few hours in intensive care and wanted to be out of there. On 21st October, she was brought back to the second named defendant's hospital. Her whole abdomen was very sore across the lower abdomen. She could not get out of bed without assistance. She was discharged on 25th October. She experienced soreness on her abdomen. It was a very bad pain and it lasted for some weeks. She was able to return to work shortly before Christmas.

18. By January 1998, when she was back fully to work the pain was beginning to subside and was confined to the right hand side. The pain came and went. Exercise brought about the pain. The pain was like a spasm and it did not last for a long time. She had the pain now once or twice a month. The pain was as severe but not as frequent. She had a scar that went from her bellybutton down to the vaginal area as a result of the laparotomy operation and a small scar below her bellybutton as a result of the laparoscopy.

19. In her evidence, she also recalls seeing some weeks later, the red mark on the seatbelt of the car and she thought it may have

occurred as a result of bleeding on her way home from the hospital on 14th October.

20. She was cross examined by counsel of behalf of the first named defendant in relation to various matters raised by the first named defendant with the plaintiff at consultation. These matters were encompassed by a formula known to the first named defendant by the letters F-I-L-L-M-V. She agreed under the heading F that the possibility of failure was discussed. Also, irreversibility was explained to her. There was discussion of laparoscopy but there was no discussion about laparotomy (which required the opening of the abdomen). She denied that the first named defendant had discussed with her the risk of a laparotomy and it was put to her that the first named defendant told her that there would be a 5% chance of a laparotomy having to follow on from a laparoscopy as there was the chance of something unplanned happening as one could not see the tubes fully when doing a laparoscopy. She denied that the first named defendant had raised the fact that menstruation problems might follow. She also agreed that under the heading V of the formula that a vasectomy as an alternative to laparoscopy was discussed.

21. In relation to the bleed she experienced in the toilet after the operation she was unsure how do define the word which was like flecks of blood against the wall. She was not sure it was "spatted" or "splatter". The blood came from the wound at the umbilicus where the laparoscopy had been performed. She told a Sister what had happened in the toilet. She did not describe what had happened in detail because the Sister could see that she was bleeding and the Sister told her to go back to the bed and lie down. She did not remember discussing with the first named defendant the type of blood or whether there had been a spurting or a splattering or flecking. She was examined by the first named defendant and cannot remember whether bleeding was taking place at the time the first named defendant examined her. She could not recall any bleeding like that which occurred in the toilet at the time when the first named defendant was treating the wound. Her recollection was that the Sister was quite alarmed when she (the Sister) saw there was blood when she came out of the toilet and she saw the blood. The Sister who had seen the blood and who was attending the first named defendant was the same person. The first named defendant told her to return to the hospital after a number of weeks for a check-up. She denied that he advised her to report back to the hospital or inform them if there was any recurrence that afternoon of the bleeding. She had also been advised not to drive in returning home.

22. In relation to the consent signed by her on 30th May, 1997, she said she did not recollect the possibility of subsequent menstrual disorder being discussed. The later need for hysterectomy was not discussed. In relation to the failure rate, she did not remember a number but she recollected that there was very minuscule failure rate. She was referred to the post-operative notes of the second named defendant entered on the consent form of 14th October, 1997 which read *"Seen by Prof. O'Herlihy. Laparoscopy site oozed. Suture put in before discharge in GDC (Gynaecological Day Care Centre)".* These entries were signed by Staff Nurse Jacob. She disagreed with that part of the note which used the word *"ooze".* The spasm which she experienced at the time of the hearing, lasted for a number of seconds (around 10) and would occur about once a month approximately. She had resumed her sporting activities. In response to, counsel for the second named defendant she said she was the private patient of the first named defendant. She could not recollect whether she was given a prescription or given painkillers when she was leaving the hospital but she had painkillers at home.

23. She did not recall the first named defendant advising her to return to hospital if the bleeding continued. Had the advice been given, she would have returned. She had Ponstan painkillers at home. She recalled her husband saying to her following one of the phone calls that the nurse said *"give her more of whatever she is on"*. She had taken Ponstan before her husband phoned the hospital and the pain was still severe. She had serious pain up until she took the extra Ponstan at midnight on 14th which enabled her to sleep until the following morning.

24. The plaintiff agreed she received a booklet of written instructions before the date the procedure was first planned. A document was produced in court entitled *"Instructions Booklet"* but she could not identify it as the one she got. She accepted that parts of the Instructions Booklet were similar to the one she had read and which she had received from the first named defendant through his secretary or receptionist.

Mr. Collison's evidence

25. The plaintiff's husband, Mr. Collison gave evidence of himself and his wife investigating a vasectomy as an option to an operation for sterilisation. They decided not to go ahead with a vasectomy because of side effects and/or continuing pain. He gave evidence of the discussion with the first named defendant concerning irreversibility of the procedure and that there was a slight chance that the plaintiff might become pregnant after the procedure, that a vasectomy was an alternative and he did not remember any of the other matters being discussed.

26. When he arrived to take the plaintiff home that evening, the first named defendant was dealing with the bleed that had occurred. His wife was subsequently discharged. She was very tired and generally lethargic. Later in the evening he applied a pad over the dressing on his wife's wound where blood had come through. At about 9pm his wife went upstairs to bed. When he went up to her she was in a lot of pain. She had taken Ponstan that evening. They decided that he would telephone the hospital. The time for this call is at 12:07.36 with the duration of four minutes, fifty six seconds as per Eircom records. He was speaking to a Sister and told her of the pain of his wife and the brief history of what had happened that day, that she had the particular procedure and that her abdominal pains were quite bad and that she had taken Ponstan or a painkiller. When asked what exactly she had taken he had to go to get the container and read out to the Sister what it was. He did not know what particular painkiller it was. She advised him to give more of the painkillers to the plaintiff and she was specific in the number she told him to give. He gave her the painkillers and she was able to get some sleep that night.

27. On the following morning, he returned after bringing the children to school. His wife informed him she had fainted on the bed. She was on the bed in a very weak state. They decided to phone the hospital and the call was made at 08:57.41 on the morning of 15th October and lasted some six minutes and fifty one seconds. He spoke to a female person in the hospital. He explained the situation fully and understood the person to whom he was talking understood the situation. He told the person in the hospital what had happened on the previous day and the fact that his wife was then unwell in terms of being weak and faint. He was advised by the person that the situation would improve, to give it time and to continue with the painkillers. Whilst there is a further record of a phone call being made at 3.10pm on the same day lasting five and half minutes, Mr. Collison has no recollection of such a phone call. There was no reason why his wife would not return to hospital had it been suggested to him. Later in the day of 15th he saw his wife going to bed upstairs. His wife told him that she was bleeding. An ambulance was called which came to the house very quickly. Before she went into surgery in hospital she was very weak, faint and pale and did not communicate much, he said.

28. When he visited his wife on 17th, she was alarmed and not making sense and very confused. He was subsequently told that she had been transferred to Intensive Care in St. Vincent's Hospital. When he visited her that evening she was intubated. She was ex-tubated on Saturday, 18th October after which she communicated and seemed to be getting better. On 20th she was moved from the Intensive Care Unit to a ward at St. Vincent's Hospital. She was moved to Holles Street Hospital on 21st and was discharged on 25th October.

29. In further evidence, Mr. Collison said that the plaintiff had not informed him she had pain when she was leaving the hospital. He knew that there had been some bleeding that required her to receive a stitch. It was around midnight when she first communicated she had pain to him.

30. In relation to the second call, in the morning, he was not certain that he mentioned pain but did mention the fact that the plaintiff felt faint.

31. The advice he had received from the hospital in respect of the second call was that the situation would improve, to give it time. It was put to the witness by Mr. Meenan for the hospital that whilst the hospital had not identified the person who received the call, the hospital would say that it would be standard practice when calls of that sort were made (such as that at 8:57) that he, the witness, would be told *"if you have any concern bring your wife back in"* and it was put to him that that was said to him. The witness said it was not said to him.

Mr. Clements's evidence

32. Expert evidence was given on behalf of the plaintiff by Mr. Roger Clements, Consultant Obstetrician and Gynaecologist. He had ceased obstetric practice in January 2001 and gynaecological practice in 2006. He had considerable experience in giving expert evidence in medical negligence litigation. In relation to the plaintiff he furnished a report on 30th November, 2005. In her discussions with him, the plaintiff told him she did not remember being told of any specific risk of the operation. She certainly positively remembered that she had not been told that should the laparoscopic approach fail she would need a laparotomy. He said as the operation notes state the procedure is correctly described as a laparoscopic tubal clip occlusion. He said that the procedure was described as keyhole surgery as the surgeon does not have a direct view of the inside of the abdomen. In order to do the operation the surgeon must have two separate portholes into the abdomen, one through which he can view the internal organs and another which allows him to manipulate them and to apply the clip. He said the portholes were made with a sharp stick, that is a metal trocar with a very sharp end. With a blind insertion there is a risk of occasionally striking something unintended. He referred to the first named defendant's operation notes which recorded *"good view"* and to a camera. He noted that the records of the first named defendant stated:-

> *"Single filshie clip applied to the medial tube bilaterally. Satisfactory occlusion confirmed by assistant."*

33. He said that the amount of post-operative pain following a laparoscopy is usually trivial and usually dealt with by the kind of drug that people keep in their cupboard. One such drug is mefenamic acid and its other name is Ponstan. The plaintiff was given one dose of Ponstan at 2.30pm. He was unable to see whether she was given any other pain relief either in the hospital or to take home.

34. In her interview with him, the plaintiff described the incident of blood spurting from her abdomen all over the lavatory when she vomited. She informed him of how she had reported it to a female member of the nursing staff. He referred to the note of the first named defendant which stated:-

> *"16:30 umbilical incision resutured ooze with Dexon satisfactory haemostasis. Report if bleeding occurs this pm."*

35. He described how the records show the plaintiff's readmission to the second named defendant's hospital at 22.45 on 15th October. The records showed a diagram of the bruising on the lower abdomen and it was recorded:-

> *"Transferred from St. Michael's Hospital with bleeding ++ from umbilical incision. Shocked; on arrival pale…"*

36. It was noted that the abdomen was very bruised and that there was an active external bleeding from umbilicus. The record of the haemoglobin level at 22.00 was 4.5gm which in his opinion indicated that the plaintiff had lost something of the order of 3 litres of blood which was suggestive of a blood loss of about two thirds of her circulation. He noted the operation notes of the first named defendant in respect of the laparotomy which was performed at 11.00pm on 15th October by the first named defendant. It read:-

> *"Laparotomy*
>
> *Evacuation INTRA PERITONEAL HAEMATOMA"*
>
> *Indic: Collapse post laparoscopy*
>
> *Abdominal wall haematoma*
>
> *c ooze – clear urine*
>
> *Lower midline incision*
>
> *Arterial bleeder at rectus sheath at laparoscopy trocar site ligated*
>
> *Intra peritoneal haematoma evacuated*
>
> *No obvious intra abdominal bleeding point*
>
> *Bowel, liver, tubes, ovaries, uterus normal – clips in situ x 2*
>
> *Abdomen closed in layers – maxon*
>
> *- SC prolene*
>
> *Satisfactory haematosis etc"*

37. He referred to the abdominal wall haematoma and said it was a big bruise, a big collection of blood in the abdominal wall and the pressure from the blood caused some of it to seep through the thin membrane into the peritoneal cavity. The note stated the majority of it was in the abdominal wall. The arterial bleeder he said was a vessel with a pulse. If one of the vessels is cut the blood spurts out as it follows the beating of the heart. In this case, if an arteriole in the sheath was hit it bled, this is what the first named defendant found and tied off as set out in his notes. In his view, the haematoma was located outside the peritoneum. In his opinion, it was an abdominal wall haematoma with some seepage into the peritoneal cavity as described by the first named defendant. He said the notes

recorded that the plaintiff received some five or six pints of blood which restored her haemoglobin to about 9g. The records indicated that initially the plaintiff was doing well after the operation during 16th October she was in receipt of morphine. On 17th October, the records indicated that she became confused and cyanosed which indicated that she was not getting sufficient oxygen to keep all her blood pigment red. At that point she was transferred to St. Vincent's Hospital. He said the records from St. Vincent's Hospital set out a brief summary of her condition and treatment, it was as follows:-

> *"She sustained an intra abdominal bleed day one postoperatively and was readmitted to Holles Street. At this time she had collapsed and her haemoglobin was 4. She was resuscitated in Holles Street. A laparotomy was performed which relieved an arterial bleed in the rectus sheath. This was ligated and an intra abdominal haematoma was evacuated. Post operatively she became quite confused and cyanotic and was therefore transferred to the Intensive Care department. The impression at this point was of sepsis. She was commenced on Flagyl, Gentamicin and Augmentin.*
>
> *She made a quick recovery in ICU and continued to do very well. She was discharged to the ward on 20th October, 1997. At this point she had made a good recovery and her haemoglobin was 11.1 and her white cell count was normal."*

According to her wishes she was transported back to Holles Street for further care.

38. When interviewed by Mr. Clements, the plaintiff complained about the large scar which she had as a result of the laparotomy and she had expected only to have a tiny laparoscopy scar. She told him she had for some months abdominal tenderness, discomfort in the scar but when he saw her it had ceased. She also experience abdominal wall spasms particularly on the right side. The scar she has runs from the umbilicus to the pubic hairline.

39. In Mr. Clements's opinion no blame attaches to the first named defendant for injuring the blood vessel. It is a hazard of the blind insertion, there is nothing that can be done about it. In carrying out a laparoscopy procedure there is a risk of haemorrhage he said. There are four types of haemorrhage. Most of them do not concern the instant case and of the four types this is the least common. He said:-

> *"It's a very very rare injury. There are inadvertent haemorrhages that can occur. Haemorrhage can occur with due care and skill for instance to a vessel in the mesentery. Because when the trocar goes in, you can't see the trocar strike to that vessel. And that would mean opening up and securing the vessel. That is much more common than this injury. An arterial bleeding in the rectus sheath is extremely rare."*

40. He had no comment to make on the procedure adopted by the first named defendant at the end of the operation. It might well be that the bleeding was not evident to the first named defendant at the very end of the operation. This was because such small arterial bleeders are in spasm at the end of an operation. He said that at the end of the laparoscopy procedure the vessel may not have been bleeding because it was everybody's experience that some small vessels like this small artery will not be bleeding when looked at the end of the operation but when the patient's blood pressure changes and her position changes when she moves about afterwards, the vessel ceases to be in spasm and starts to spurt. He attached no blame to the first named defendant in respect of the initial procedure between 9.30pm and 10.00pm on 14th. In his opinion, when the first named defendant was called back to see the plaintiff at 16.30 on the afternoon, he ought to have taken a history to examine the patient and then decide what need to be done. The first thing he needed to ascertain was how much bleeding was there. He had two possible sources of information. He could have asked the plaintiff. It was some seven hours since the general anaesthetic and she was probably in a condition which she could have a conversation with him. She had been out to the toilet. He could have been asked how much bleeding she had and she could have told him. If he felt that she was not in a proper condition to give a proper account, he could have asked the nursing staff, either way he should have ascertained how much bleeding there had been.

41. Secondly, he should have examined the wound to determine what type of bleeding he was facing. There were two possibilities, one that it was just an ooze and that it was from capillary bleeding. He should have checked to see whether or not the bleeding was an ooze, that is capillary bleeding which does not bleed in a pulsatile way. Such bleeding stops because of the clotting mechanisms of the body. Seeing bleeding, the first named defendant should have looked to see where the bleeding was coming from. He suggested that this was not possible in the conditions in which the first named defendant examined the plaintiff. He did not have precise information as to how and where that was because the plaintiff cannot remember but he believes that it was not in the operating theatre but in a recovery bed. In his opinion, had the first named defendant examined the plaintiff he would have found the bleeding vessel. He said that the incision would have been a small one and without a good light one could not examine the wound properly. He said this was the vessel that caused the bleeding was identified by the first named defendant on 15th October. In relation to the stitch applied by the first named defendant, the first named defendant simply opposed the two skin edges to conceal the bleeding. The stitching of the two skin edges he said did not deal with the problem which was in the deeper layer of the rectus sheath. The stitch merely provided an obstacle to the blood escaping freely.

42. He would have an objection to a doctor putting a skin stitch to deal with the problem of oozing blood seven hours later. Capillary bleeding would long since have stopped.

43. In relation to the first named defendant's note in the records *"report if bleeding recurs this pm"*, he understood that it meant that the plaintiff was told by the first named defendant to report bleeding (although she informed Mr. Clements, she had no recollection of so being told by the first named defendant).

44. He further stated in his opinion that the plaintiff should have been told to report bleeding, pain or other symptoms of illness as recovery following this procedure is usually relatively straightforward and painless. In his view, such a warning to report as in the note would not have been a competent warning.

45. Mr. Clements stated that if the plaintiff had been returned to the operating theatre at 16.30 on the afternoon of 14th October, that the first named defendant would have found the bleeding and that one/two stitches through the rectus sheath to close the skin would have been sufficient. He would have had to enlarge the opening a little bit. There would have no further bleeding and no need for a laparotomy and respiratory distress that subsequently developed. In relation to the scarring, the tiny incision at the umbilicus might have to be enlarged by 50% to get a view. Opening of the skin edges would have revealed the bleeding as the blood would have been welling up from a deeper layer. Blood coming from the bottom of the wound would be visible and when the fat was parted the same bleeder would have been found in the rectus sheath as was found the following day as the trocar must have caused the bleeding.

46. In relation to the telephone call which Mr. Collison had with the personnel of the second named defendant at midnight on 14th/15th October, in his view, he should have been advised by the hospital staff to take the plaintiff back to the hospital as pain

beyond domestic analgesia is very unusual following a laparoscopy and might signal a lot of different pathologies. He was referred to the instruction booklet issued by the second named defendant which the parties thought would have been in use and given to patients. At para. 10, this booklet said:-

> *"Following discharge, should you feel unwell or suffer any excess pain, contact the gynae day care centre or Unit 4 at anytime. To this end it is important to have access to a telephone, either your own or a neighbours."*

47. In his opinion this instruction was good advice. If the plaintiff had pain more than she thinks she should be having, the advice should be to bring her back to hospital. At that stage her wound would have been properly investigated probably by bringing her to the operating theatre with a general anaesthetic. It is likely there would have been blood loss of a few 100mls of blood which could have been evacuated. The hole would have to be a little bit bigger but it would not have required opening the peritoneal cavity and not have required a laparotomy that is opening the belly so as to open the peritoneal cavity. The blood loss at that time would not require to have been replaced and it was not a life threatening condition.

48. When asked does laparoscopic surgery carry with it a risk of injury to blood vessels he said all surgery carries a risk of haemorrhage, laparoscopy included.

49. In relation to the post operative haemorrhage which occurred, he said that he had never seen it nor read about it and it was very rare. Such an injury by the trocar which caused the injury was an extremely rare thing to happen. One would not be expecting to cause injury to an arteriole in this location. He said he had never seen a haemorrhage of 3 litres of blood from a rectus sheath. It was put to him that the first named defendant had done over 3,000 procedures of this type and had never seen an injury to an arterial vessel. He accepted it was very rare and could not recall seeing one in his own experience from about 4,000 such procedures. The second scar was directly inline straight down from the first porthole scar, some 10cms from the first scar.

50. He found it surprising there were no hospital records of the blood splattering incident.

51. Mr. Clements said that his recollection of talking to the plaintiff about the events when the first named defendant visited her at 4.30pm was that she was not terribly clear about what happened as she could not recall much of the occasion when the first named defendant came to see her. He found it plausible that her blood should spurt out in the manner in which she described as by that time the small blood vessel had been pumping blood into the deep layers of the wound, and had been contained to some extent by the dressing over the wound and the suture that was already there. In his opinion when the blood was discharged by her there was space for bleeding to go on underneath and particularly, after the skin stitch. Eventually, later on in the evening it seeped through the dressing when Mr. Collison put on another dressing, so that the pressure from above was increased and the tendency would be for the blood to go deeper.

52. He said it was improbable there were two causes of the bleeding, one superficially near the surface and the other being the vessel which was pulsing. In his view, it would have been bizarre to have two pathologies, it would be an amazing coincidence. He agreed that the injury to the arteriole was unique, it was unforeseen and non-culpable. When the first named defendant closed the wound he was unaware of it because it was not at that stage bleeding. Subsequently, it did bleed. It was bad luck that it was not bleeding at the end of the operation so as he could see it but in his opinion, it was incompetence that he failed to see it later. He agreed that at the end of the procedure there may not have been bleeding. He did not know when it started. He would not agree that there was an ooze at 4.30pm as ooze carries the connotation of a capillary bleed and it was not that. He rejected the idea that there were two sources of bleeding. If there was capillary oozing by 4.30pm (seven hours after the operation) a patient with normal blood clotting, the ooze would have stopped because a dressing was on the wound. What does not stop is an arterial bleeding underneath.

53. He ought to have taken the plaintiff back to the theatre with the benefit of good light, opening the wound in the theatre would not have required enlarging the wound at that stage. He did not think a laparoscopy at this stage was remotely likely. In his opinion, the blood was not oozing from the capillaries of the fat. At 4.30pm the first named defendant would not have had to make a big longitudinal incision. He may have had to enlarge the wound in the same direction it was going.

54. It was Mr. Clements's view that the blood was going predominantly upwards into the abdominal wall and not predominantly downwards into the peritoneal cavity. This blood had escaped from the umbilicus throughout the history of the case when the patient vomited and splattered blood, when the first named defendant looked at it and when it escaped all over the plaintiff's floor.

55. He was informed that for the purposes of the examination at 16.30 by the first named defendant that he had the benefit of a light from the window and a light over the bed and that he stood in the position when he was away from the window so that no shadow was falling across the plaintiff at the time. Mr. Clements stated that this was insufficient and that the daylight was not and could not be equivalent to the circumstances of an operating theatre.

56. The pain relief she was given in the hospital would normally be all that a patient would require.

57. In questioning from counsel for the second named defendant, he said that at 16.00, no laparotomy was required, at 9pm on the evening of 15th, it would have been required. His estimate from midnight 14th/15th, it would have been possible to get away without a laparotomy. It was becoming increasingly difficult to say from this time on wards.

58. He disagreed with counsel that the response of the second named defendant to the telephone call at 9.00 on 15th that he should continue the same treatment and that she would improve during the day was an appropriate response. The response should have been to bring her in.

The First Named Defendant's Evidence

59. The first named defendant has been a Consultant Obstetrician Gynaecologist in the second named defendants since 1984 and in the Mater Hospital, Consultant Gynaecologist since 1988. He is Professor of Obstetrics and Gynaecology at University College Dublin. At the time of this procedure he had carried out some 2,000 laparoscopies and by the time of the hearing some 3,000.

60. He described that the procedure comprises of an incision made just below the umbilicus because that is the thinnest part of the anterior abdominal wall, and in normal circumstances the one where there is least chance of any other structure being affected by the insertion of the trocar. He normally made a transverse incision.

61. The first step is the inflation of the abdomen with carbon dioxide to blow out the abdominal cavity, the peritoneal cavity. After that, the trocar is inserted. On the first insertion a telescope is inserted, either by direct vision or with a camera attached. The camera is broadcast onto a screen within the operating theatre. The second incision is made under direct vision as the telescope is in

the abdomen. He then makes a transverse incision at the level of the pubic hairline. The procedure would normally take 20 minutes from start to finish – five minutes to insufflate the abdomen, five to ten minutes to perform the manipulations and a few minutes to induce anaesthesia and to reverse anaesthesia at the end of the procedure. He said that the instant case was unique in his experience.

62. He described how following miscarriages the plaintiff discussed with him the possibility of not wishing to conceive again and he suggested that she defer a permanent decision for some time until she had further thought about it. He raised with her the option of male sterilisation, an alternative to female sterilisation, and the plaintiff decided not to avail of the vasectomy option. The consent form dated 30th May, 1997, for tubal ligation was signed by the plaintiff and her husband and also signed by him. He said that he ticked each of the boxes as the matters were raised with the plaintiff. He pointed out that pregnancy may occur in the cycle in which the operation was performed. He also discussed with the plaintiff the risk of a laparotomy if the laparoscopy was not feasible. He said that he cited a risk of 1% possibility that laparotomy may be necessary in gynaecological laparoscopy, but for tubal sterilisation he cited a risk of 5%. He did this in the instant case. He cited a higher risk for tubal sterilisation for three reasons. Firstly, in some cases it is for technical reasons not possible to insufflate the abdomen properly so that the trocar can be safely inserted and a small laparotomy procedure has to be done to apply the clips. Secondly, in laparoscopy sometimes the tubes are not visible and it may be necessary to do a mini operation or a small laparotomy procedure to apply the clips. The third reason, which applies to all laparoscopies, is the possibility of some unforeseen complication of the procedure. The two major circumstances where this can occur is where there may be trauma to the bowel or to a blood vessel in the abdomen which would necessitate the abdomen being opened by laparotomy and the trauma, if such had occurred, being repaired. It is a much smaller risk than 1%, but 1% is the usually cited risk so that the patient can understand. The risk of 5% is the risk level that he cites for tubal ligation for the three circumstances. He also discussed the possibility of subsequent menstrual disorder and the later need for a hysterectomy should the menstrual disorder become a major problem. A matter discussed was the issue of irreversibility and a failure rate of 3/1000. He said that following the meeting of 30th May, 1997, the plaintiff would have received an information leaflet for day-care procedures as many of the matters raised in the leaflet pertained to matters that she would need to do before the operation. The leaflet which was given to the patient was a standard leaflet given or mailed to all gynaecological day-care patients in the second named defendants' hospital. The procedure was first scheduled for 12th August but later changed. The day-care ward was neither a public or private ward.

63. He said that when the plaintiff attended for the procedure at 8.00 hours she was interviewed by the nurse in charge of the day care centre, Nurse Jacob, she would also have been seen by the gynaecological house officer and the anaesthetic house officer.

64. Therefore, in relation to the procedure itself the plaintiff had first a general anaesthetic and he performed the procedure. She was transferred from the operating theatre to the recovery room and on gaining consciousness was returned back to the day-ward. It was his general routine to see every patient that he operated on in the gynaecological day-care centre prior to her discharge. His own consulting room records confirmed he said that he had discussed the matters which were raised in the tubal consent form with the plaintiff. He used a mnemonic setting out these matters – FILLMV "The LL" is laparoscopy versus laparotomy, that is the 5% possibility that laparotomy may occur and that the patient was prepared for that eventuality. There was also an entry of 12th August, 1997, which was the planned date for the procedure which did not go ahead. The notes also recorded in his own handwriting *"14th October, 1997, laparoscopy clip TL (tubal ligation) extra suture to bleeding umbilicus"*. His records also noted "advised to return if bleeding continues see NMH notes". He said that this referred to the hospital notes and that the definitive operative note is the note in the patient's hospital chart, which notes also recorded *"15th October, 97, admitted shocked because of massive intra-peritoneal bleed"* with an arrow pointing to laparotomy. It also stated in his own handwriting *"arterial bleeder in abdominal wall ligated transfused four units. ICU, SVH (St. Vincent's Hospital) because shock lung, recovered in five days".* His records indicated a further meeting with the plaintiff on 14th November, 1997, in his own writing as *"well wound ok, a bit tender because subcute bleeding resolving".* The notes indicated he recommended Voltarol for the abdominal wall discomfort.

65. When putting the trocar in to make the initial incision he went at an angle between 30 and 45 degrees to the horizontal rather than sticking the sharp trocar straight in. The first incision was across the inferior surface of the umbilicus and required a suture because of its length. He normally sutures it an absorbable Dexon suture. This usually closes the skin adequately. A lower incision can either be glued or sutured if it is bleeding slightly. The second incision in respect of the plaintiff was in the midline of the pubic hairline.

66. He said that he was informed by a nurse (Jacobs) that there was oozing coming from the umbilical incision. When he looked at it, the skin was separated and there was bleeding from the skin incision. Although the original stitch he had put was there, it was not completely opposing the skin edges as the skin edges were not completely closed he decided to close them with a small stitch. As the nurse had adverted to the fact there was some ooze from the umbilicus, he specifically examined the umbilicus and looked at the wound at the umbilicus. It was not a severe bleed and it was not pulsatile. The bleed, in his opinion, was not pulsatile. He said all doctors were aware of the importance of treating arteriole bleeding and that if a blood vessel was spurting the blood vessel needs to be specifically closed to stop the bleeding. He said it was not a particularly heavy ooze or profuse bleeding. It was coming from the edge of the skin and the tissue underneath the under surface of the skin. He decided to put a further stitch in to make sure that the wound was closed. He put in one stitch part of the length of the incision where the skin edge was separated. He worked with a light over the bed and from the window. He was standing on the left hand side so as to maximise his vision. The window was on the plaintiff's right hand side. The purpose of the stitch was to close the skin edge so as the bleeding would stop. An additional stitch was not unusual in that the skin may need an additional suture before the patient was discharged. The original stitch which was inserted at the time of closure was a light stitch and can often become loose or inadequate after the procedure is completed. This was the correct procedure for the plaintiff at that time. It was by no means the first time he had done this, that is putting in a stitch at the trocar site when there would be an ooze of blood or bleeding.

67. The first named defendant's notes recorded *"16.30 umbilical incision re-sutured because ooze with Dexon"*. The there is an arrow and then it states *"satisfactory haemostasis"*. He said that the ooze, the bleeding from the skin edge was stopped. He makes note in his handwriting and recorded which marks *"report if bleeding recurs this PM".* These words meant that he would have advised the plaintiff that if significant bleeding recurred she should report back to the hospital. Whilst he had no specific recollection of saying those words to her, the note suggested to him that he would have said this to the plaintiff.

68. He was subsequently informed by Dr. Winfield, an Assistant Master at the hospital after 9.30pm or 10.00pm on 15th October that the plaintiff had been transferred back to the second named defendant's hospital that she was in a shocked state, her blood pressure was low, she had bleeding from her umbilicus and that she appeared to have lost blood. Her abdomen was extended. He immediately went into the hospital and decided to perform a laparotomy. In his notes, in relation to the laparotomy, it was recorded at 11.00pm and recite:-

> *"Evacuation of intra-peritoneal haematoma base Indic (which means indication) collapse post laparoscopy abdominal wall haematoma with ooze-clear urine lower midline incision. Arteriole bleeder at rectus sheath ligated. Intra-peritoneal*

haematoma evacuation."

69. There were lumps of blood clot and liquid blood in the peritoneal cavity. He concluded from his examination that there was no damage to a major blood vessel in the abdomen within the peritoneal cavity.

70. The plaintiff subsequently developed respiratory complications consequent on the large volume of blood transfusion given to her to replace the loss of blood. As the second named defendant did not have an Intensive Care Unit, she was transferred to St. Vincent's Hospital.

71. The first named defendant said that at the time of the procedure he had done some 2,500 procedures and 3,500 by the date of the trial and he had never experienced a previous significant vascular injury in a laparoscopy. In his opinion, it was an incredibly rare site for a vascular injury. The reason why he made the trocar incision in the midline was because blood vessels in general do not cross the midline and this is the thinnest area of the abdomen and it is supposed to be avascular where one does not expect to find a blood vessel. The bleeding vessel occurred when the trocar had penetrated the rectus sheath. He was able to ligate the bleed from the inside as the bleeding was on the inner surface of the rectus.

72. He confirmed that it was his understanding in retrospect that the plaintiff had two source of bleeding, firstly a surface type of bleed and secondly, bleeding from the arteriole.

73. In answer to counsel for the second named defendant said that if there was an arteriole bleed at 4.30pm, he would have recognised as an arteriole bleed because the same is unmissable in practical terms because it is pulsatile and it is bright red blood because it is blood coming directly from the heart or on the first pass around the circulation. Such a bleed would be spurting from the area of the wound. If such had occurred, he would have had to extend the original wound considerably. If it had been arterial, he would have had to bring the plaintiff back to the operating theatre for general anaesthesia. She would have required a further surgical procedure of some degree and he would have had to make an extension incision downwards under general anaesthesia which he felt that in practical terms would have been comparable to a laparotomy from the plaintiff's point of view. If he did not find an obvious arterial bleeder then the most likely vascular injury would have been within an artery which was possibly within the abdomen and therefore he might well have had to perform a laparotomy. If a procedure had been carried out at 4.30pm, it would have a more extensive scar than the initial laparoscopic procedure. It would have been at least half the length of her ultimate laparotomy scar and probably more. He would have expected that if the plaintiff was concerned about the bleeding from the umbilicus during that evening and following his advice that he would have expected that she might have returned to the hospital.

74. Having regard to the advice she was given on the phone to take an increased dose of Ponstan, it was very hard to say in isolation in respect of the details of the pain to say whether the advice given by the hospital was appropriate or not. He said that at the time of the telephone call, if the plaintiff was experiencing severe pain or had begun to experience severe pain the advice to take an increased does of Ponstan might not necessarily have been the sole advice that might have been given.

75. The first named defendant produced a booklet *"Gynaecological Day Instruction Booklet"* which he said was applicable to persons in the day care ward at the time. It was his opinion, that this booklet would almost certainly be the one which the plaintiff said that she got. At para. 10 it stated as follows:-

> *"Following discharge should you feel unwell or suffering any excess pain contact the gynae day centre or unit 4 at any time. To this end it is important to have access to a telephone either your own or a neighbours."*

The purpose of this statement and the advice that would have been given by the nursing staff in the day ward to patients when they were going home was that if they felt unwell or concerned or had any excess pain that they should contact the gynaecological day centre. Unit 4 is the 24 hour gynaecological department of the hospital which would be staffed by nursing staff who would be specifically experienced and trained in the post operative management of gynaecological procedures.

76. He would have expected the nurse who handled the call with Mr. Collison at midnight would discuss the pain and put some choices to Mr. Collison or ask to speak to the plaintiff directly. She might have asked about associated symptoms to assess the degree of seriousness. If there were no associated symptoms she might have said *"take analgesia and call us back if the pain does not resolve"* or if she was concerned if the pain was very severe she might have said *"come directly to the hospital and we will reassess you"*.

77. He said damage to the bladder or damage to a blood vessel as happened in this case could have caused the pain at midnight. He said that if the patient is experiencing progressive or worsening symptoms in the hours after discharge after laparoscopy, the best way to adequately assess those is to represent and be re-examined in the hospital. He said that as an experienced gynaecologist he would not have been comfortable without seeing her but he did not know the status of the person who was on the other end of the telephone who advised to take more analgesia. He said the only person who on the nursing side who would be in a position to give the appropriate advice in the circumstances was the nurse in the unit 4 as was specified in the instructions. There was no indication that the plaintiff received advices from the nurses in the gynae department.

78. He said that the arterial bleeder at the rectus sheath which was bleeding was a small blood vessel, not one of the main arteries. It was a pulsatile bleeder. He described the haematoma which he found in the rectus sheath as a collection of clot and blood and he described the intra-peritoneal haematoma as enormous.

79. The haematoma was lower down in the abdominal wall, down near the supra-pubic area which was corresponding with the discolouration noted by Dr. Winfield in the admission note. He assumed the blood had come from the arteriole bleeder in the rectus sheath. The blood in the abdominal wall not extensive but the amount of blood in the peritoneal was extremely large. He denied that the bleeding experienced by the plaintiff in the afternoon of 14th October was from the bleeding vessel in the rectus sheath. If it had been so it would have been obvious and would have been pulsatile. It would have been continuing and would not have stopped by putting a small Dexon suture through the skin where the skin edge was separated as he had found at 4.30pm. He said that arteriole bleeding was not stopped by stitching the skin.

80. He said the bleeding from the bleeding vessel in the rectus sheath may not necessarily have started at 9.30am approximately on 14th October. The vessel could have gone into spasm as claimed by Mr. Clements. The bleeding started sometime between the initial damage and when he found it 36 hours later. He would not have seen the bleeding at the time he was withdrawing the laparoscope as the canula or tube would have been compressing the artery. He said the vessel could have been in spasm at the time the canula was removed. The bleeding probably started between the end of the procedure and the plaintiff's discharge from hospital.

81. However, it was Nurse Jacob who told him that there was oozing from the wound. She was the nurse in charge of the day centre

and was the only nurse in the day care centre. She asked him to have a look at the wound. He thinks she said that she noted some oozing from the umbilicus but he cannot be certain of the words. The plaintiff told him that there had been some bleeding from the umbilicus and he asked her to lie down so as he could examine the bleeding. In relation to why he did not ask questions in relation to the bleeding, he said that he would have been relying on the information he was getting from the nurses if they were concerned and if there was abnormal bleeding during the day. As he had not been told about any event of concern, there was no reason for him to suspect that there was excessive bleeding preceding his examination. He had no reason to suspect that there had been heavy bleeding during the afternoon. The plaintiff did not tell him there was any excessive bleeding during the afternoon. She told him she had bleeding from the umbilicus. He wanted to examine her before she was discharged. He was not informed by Nurse Jacob that there was any significant quantity of bleeding. There was no note made by Nurse Jacob who was performing repeated assessments and examinations of the plaintiff. There was no reference to any unusual bleeding and therefore it was not unreasonable for him to look at the note and to note that blood pressure and other observations were normal and to deduce that the bleeding which he saw was the bleeding that there was.

82. The absence of a note to say there had been bleeding was important information in itself.

83. The first named defendant stated he could infer that there had not been any serious bleeding or any significant or unusual bleeding prior to 4.30pm. Secondly he would not agree that there was never a reason not to take a history. He had already been informed that there was bleeding from the wound. His response was *"let me have a look"*. He looked and he found that the wound was oozing.

84. It was put to the first named defendant that is was not acceptable practice to simply draw a negative inference from the absence of a reference to significant or dramatic bleeding in the note and for that reason to refrain from (a) asking the patient what experience she had of the bleeding; and (b) asking the nurse what she had observed. The first named defendant said that medical diagnosis was a combination of history and particularly clinical examination. Information from history must be confirmed by clinical examination to make any sense of the findings. He agreed that there would be two possible causes for the bleeding. One would be surface bleeding of the skin and the other would be a more deep-seated source of bleeding. He described the bleeding at 4.30pm as venous bleeding that is non-arterial bleeding. He said it was not uncommon that a further dressing or suture had to be applied to an umbilical skin incision after laparoscopy and some hours after the procedure. Some extra closure would be done in 1% of the cases. Sometimes the end of the incision might either slip out of the stitch closure or not be occluded in the first place. The skin would separate over part of the incision and a further suture would have to be applied which was the case in relation to the plaintiff. There were two scenarios where there can be oozing from a laparoscopy wound. The first is the initial closure is not adequate or complete and that will happen quickly. The second is where some of the skin had been opposed or some of the skin and tissues become loosened over part of the hole of the incision and bleeding occurs sometime after that happens. It could be a few hours. The other possibility is that there is bleeding going on at a deeper level.

85. Before giving local anaesthetic, he swabbed the area clear. He looked to see where the blood was coming from. It would be apparent at this stage if there was blood welling up from a centimetre or half an inch below the surface of the incision that would be plainly obvious and it was not necessarily the position in this case. If it were arterial it would be bright red. If it was venous or capillary it would be a darker red. That is the nature of the oxygenation of the blood. Before a stitch is inserted it is mandatory to have a look to locate where the ooze is coming from or the blood is coming from if it is more than just an ooze. Having determined that it was superficial he would put a superficial stitch in the bit that was separated. He said there was no point in closing the surface skin area unless he was sure that there was not blood coming from deeper down. The skin incision that he resutured was on the surface skin on the outside.

86. The blood vessel that was punctured was in the posterior layer of the rectus sheath. Bleeding from an arteriole source in the rectus sheath would go backwards into the line of least resistance into the peritoneal cavity. It would not come up through the rubbery membrane of the rectus sheath, to the surface so that it is visible at the umbilical incision. The only way it would have been possible to identify the vessel that he found it would have been to have opened up the abdomen by a lower midline incision, along the track of where the trocar went in, open up the muscle and the rectus sheath and identify it from inside. When he did ligate and suture it, it had to be done from the inside layer of the abdomen. That area was intact when he examined it at 16.30. It was no surprise to him that he did not see blood swelling up from under the skin at that time.

87. He said the rectus sheath was in a state of contraction. It is very dense in elastic tissue. Holes in the rectus sheath seal over as in any layer of elastic. As a consequence, blood is not going to track up through the trocar point unless the pressure below is very high. It will track downwards and inwards through the defect in the peritoneal membrane into the peritoneal cavity, as happened. That is why the blood tracted inside and did not tract outside until the intra-abdominal pressure reappeared 36 hours later, and was extremely high.

88. He had no knowledge of what the plaintiff said had occurred in relation to bleeding in the toilet. He said that if a history of the bleeding had been relayed to him by the plaintiff or Nurse Jacob and that he would have examined the wound and taken particular care that there was no deep bleeding. He would have used a forceps to separate the skin edge in the way he did to see was there any deep bleeding. Once he was so satisfied, there was no bleeding from below, he would have put in a stitch. He would not have put in a stitch if there had been evidence of blood welling up from inside the abdominal wall.

89. He put the forceps into the aperture in the umbilical incision. He separated the forceps blades. He checked to see if there was blood coming from inside. There was not. The ooze, the blood he observed was coming from the skin edge. He then picked up the skin edge with the forceps and put the dexon stitch in, tied it, closed the skin and satisfied himself that the umbilical incision was adequately closed. He was also satisfied that the bleeding had stopped. The plaintiff was detained for a further period of time and there was no further evidence that the bleeding had resumed and he deemed it reasonable for her to go home.

90. If he had opened the incision which had been made by the trocar by making the incision larger as suggested by Mr. Clements, he would not have been able to visualise the rectus sheath through either of those incisions because of the fat and connective tissue that was in the abdominal wall.

91. He said that if had pulled back the skin and made an incision of some 5cms or 6cms in length going down about half the length of which he did in the end he would have come upon the fat and then would have come upon the connective tissue and then he would have come upon the rectus sheath. If he had done that he would not have seen this vessel. He would have had to divide the rectus sheath as far as the peritoneal surface, which essentially is getting to a laparotomy in practical terms in order to find the bleeding vessel on the inferior surface of the inner layer of the rectus sheath.

92. In relation to the bleeding on the subsequent night of 15th October, the source of the blood that was apparent at that time was

coming through the umbilicus was secondary to a build up of blood within the abdominal cavity which was then forcing blood through the defect in the rectus sheath. The intra-abdominal pressure was high because there was three pints of blood in the abdomen. The vessel that was bleeding was not in the peritoneal but in the rectus sheath on the side of the peritoneal.

93. He said the definitive notes of surgery were recorded in the hospital charts not on his personal records.

94. In relation to the note in his handwriting *"report if bleeding recurs this PM"*, he said that if the bleeding had recurred or continued the advice that the plaintiff should have got that evening or whenever would have been to return to the hospital. This wording as opposed to the wording in his own notes *"advised to return if bleeding continues"* is the same problem he said that needs to be reassessed. If he had been consulted he said he would have advised her to come back to the hospital. He said the damaged artery was, in his experience, in a unique location for an artery. He said that damaging this artery in this site has never occurred before in his experience and in the experience of others. Mr. Clements, he recalled had said that it was a very, very, very rare form of vascular complication of laparoscopy.

95. He had no recollection of giving the specific advice of advising her to report or return in the event of any other symptom other than bleeding. He would have known that the nurse in the day ward would have advised, as all patients were advised and was annotated in para. 10 of the Instructions Book. If the plaintiff had contacted to the hospital or himself and said that she still had bleeding that was staining a pad that was covering the umbilicus, having regard to the fact that he had already put in a second stitch he would have requested her to return for a re-examination.

96. If an incision is made in the rectus sheath it will not bleed. It does not bleed unless it happens to hit an artery when there is a vessel.

97. He said that if there was a bleeding vessel inferior to the rectus sheath, even if surrounded by bruising, it cannot be missed because it is pulsatile, an arterial bleeder and it is clipped internal to the rectus sheath. If he had tried to ligate that artery by putting a clip the superior or outer surface or upper surface it would not have stopped the bleeding.

98. The incision which he had made at the laparotomy ran from the umbilicus to the top of the pubic hair. It was an incision of the entire abdominal wall which meant opening the area from the umbilicus layer by layer. The incision would have gone through the trocar perforation of the rectus sheath. He then opened the rectus sheath and where the trocar had entered there was a pulsatile vessel. He clipped it and presumed there was further bleeding inside. He got into the peritoneal cavity, found the clot and took it out. He found no further blood vessels and the only bleeding arterial vessel was the one he had identified on the posterior aspect of the rectus sheath. He saw the hole where the trocar had gone through with blood welling up through the hole. He opened up the rectus sheath, divided it and saw a vessel on the under surface of the rectus sheath, just under where the trocar perforated the rectus sheath which was pulsatile. He clipped it. That was the only arterial blood vessel that was within the rectus sheath. It was in a site in the midline where it was very unusual to find such a vessel.

99. When it was put to him that it was not possible for him to say that the bleeder was located on the inferior surface of the rectus sheath disagreed and gave the following reasons.

100. Firstly, that the bruising in the abdominal wall around the umbilicus was not significantly extensive. The bruising where the trocar had entered was. It was mostly extensive in the lower part of the anterior abdominal wall. If the vessel that was injured was superficial to the rectus sheath or on the upper surface of the rectus sheath, in other words accessible through the umbilical incision, and if Mrs. Buckley had lost six pints of blood into the superficial layers of her abdomen two things would have happened, there would have been (very early on the evening of her discharge, even before that or soon after her discharge), a massive discharge, of blood through the flimsy sutures that he had in the skin at the trocar insertion. Alternatively, when he saw her on the 15th there would have been an enormous swelling in her abdominal wall with no blood in the peritoneal cavity. This was confirmed by Dr. Wingfield's diagram.

101. The vomiting by the plaintiff in the afternoon of the 14th may have triggered surface bleeding from the wound. The edges of the wound which he found separated could have separated with mobilisation on the afternoon of the operation. He said that it was not known when the skin separated. The activity of vomit that happened might have expelled any minor degree of clot that was around the skin surface and edge of the wound. Mobilisation after surgery was the most likely time when the skin edge slipped and that could have been the time when the plaintiff visited the bathroom.

102. He did not accept that the bleeding was from the arterial because it was not visible and it would have been very deep in the abdomen. If the arteriole had been bleeding there would have been a greater accumulation of blood which would have been obvious to him and it would have been pulsatile at 16.30 when he examined it. The arteriole was not giving rise to any of the ooze that he saw at 16.30. He did not consider it the cause of the bleeding that might have occurred during the afternoon when the plaintiff visited the toilet.

103. If the plaintiff's spurting of blood was due to arterial bleeding in the bathroom, it would have spurted throughout the rest of the afternoon. Some 90 minutes elapsed between it and his examination at 16.30hrs. If the plaintiff had a bleeding source when it spurted all around the walls of the toilet it would not have stopped of its own accord if it was an arterial bleeder.

104. It was put to him that Mr. Clements's view was that blood accumulated in the area of the trocar insertion and when the plaintiff vomited the muscles contracted violently, and the blood which was accumulated expelled violently. The cavity which was being filled with blood was now empty of blood again and the same process started again. On this occasion the blood was accumulating slowly, not pulsating from the surface because it is not close to the surface. In addition, to bleeding up to the surface it was spreading through the abdominal wall slowly and gently.

105. The first named defendant disagreed and said that the bleeding did not spread around the umbilicus because there was no staining in it. Furthermore, there was no evidence of any collection of blood under the skin at 16.30hrs, around an hour to an hour and a half after the event which suggested that there was "splattering" of blood. He found no evidence of bleeding around the umbilicus. If there was a bleeding vessel which had accumulated enough in order to produce a splattering of blood on the wall of the toilet, it would have continued to bleed, continued to ooze blood and to produce blood welling up from deep in the wound. He did not find that.

106. It was put to him that he should have opened and divided the wound to inspect it having had a history of spurting or spattering and bleeding rather than simply inspecting it from the surface or on a day bed using a plastic forceps. The first named defendant said that without any evidence of bleeding coming up deep from the wound, it would have been a gross intervention that would not have

been justified by the clinical situation that he found. He had seen the bleeding and had the history and saw that the bleeding was coming from the skin and not deep in the wound and, therefore, to subject the plaintiff to a virtual laparotomy or an extension of the wound would be in effect a laparotomy. The incision would have to be at least 5cm or 6cm down in order to expose the hole in the rectus sheath and then to divide the rectus sheath. This would be some 3" down as it would have to be below where the defect in the rectus sheath would have been. To expose the blood vessel he would have to do a virtual laparotomy. This was more than a 1/7,000 possibility and it did not occur to him as he could see no blood welling up from the deeper layers of the small umbilical incision apart from the ooze from the skin and subcutaneous tissue.

107. If he had decided to go back to theatre at 16.30hrs, he would have had to extend the incision. In his opinion, the idea that it can be extended through some minor apertures was not feasible. The plaintiff would be under general anaesthetic. There would have to be an incision down some 3 inches. If no bleeding point or source was found, he would have to go down further and eventually to go under the surface of the rectus sheath to find the artery that was bleeding. This would have dealt with the problem at the time. In the absence of evidence of blood coming from deep in the wound and in the presence of seeing blood seeping from the skin edge which had partially separated, it would be a gross invasion or over treatment to have performed a wide opening of the abdomen in those circumstances. When he operated on her he found that almost the entire blood loss was in her abdomen and it had not come to the outside, it was not staining her umbilicus. Some blood had tracked down into the layers of the abdominal wall well below the umbilicus. If the plaintiff was bleeding under the umbilical wound from this trocar wound, and it was supposed to be coming outwards, he questioned why there was no staining of the skin and subcutaneous tissue.

108. He said that the most likely source of the pain at midnight was the blood in the plaintiff's peritoneal cavity which is a source of incredible pain. The amount of blood he found in the abdominal wall was only about a quarter of a pint of a half a pint at the very most, whereas the amount of blood in the peritoneal cavity was approximately five pints. If the loss of blood by midnight had been approximately two pints of blood in the peritoneal cavity, this would still be a cause of her pain. Bleeding started in an arteriole in the abdominal wall and the posterior rectus sheath is the major constituent of the abdominal wall. That is where the bleeding started. It tracked into the peritoneal cavity through the defect made by the trocar. It also tracked down on the inner surface of the abdominal wall to the supra – pubic area where some of it seeped through under the skin, and it stained the skin. Only a minor degree of haematoma was in the supra-pubic compared to the larger amount of clot and blood present in the peritoneal cavity.

109. The bleeding was coming from the abdominal wall. The structure in the abdominal wall from which it was coming was an arteriole in the posterior surface of the rectus sheath and therefore it could not flow outwards, it had to flow inwards into the peritoneal cavity. It was coming from the abdominal wall but the arteriole that was bleeding was on the inner surface of the abdominal wall and because it had the whole rectus sheath in front of it or virtually all of it, it could not get through to the exterior.

110. Of the six pints of blood overall, about a half a pint of blood was in the abdominal wall and the remainder of the bleeding was in the peritoneum. Most of the blood was going into the peritoneal cavity because it could not come back up through the rectus sheath because that was a tight elastic tissue layer with only the trocar defect which is pulled closed when the muscle is contracted.

111. He would not have advised the plaintiff prior to going home, she should have contacted the hospital in the event that she experienced unusual pain or that she felt unwell, as he would have known that this advice would have been given to her by the nurses in the day ward and it was also contained in the leaflet which she would have read. The advice would have been given by the nurse who was running the day ward. The specific advice he gave related to bleeding occurring (this p.m.).

112. He was questioned as to Mr. Clements's view that there should have been a specific warning given by the doctor to the patient.

113. He also referred to day care notes which had provision for a post operative phone call made by the hospital the following day to see if the patient is feeling well.

114. He explained to the plaintiff the risk of the operation of laparoscopy going to a laparotomy. There were three reasons. The first was that it may not be possible to get gas into the abdomen to insufflate the abdomen. This may not have been explained to the plaintiff. The second reason, which was not uncommon, was that the tubes could not be identified via the laparoscope. The third reason which applied to all laparoscopies was the possibility of an unforeseen complication of the procedure which is less than 1%. This could be an injury occurring to an internal organ or to the bladder or the bowel. These last two risks were discussed. He said it has documented that it was discussed. Whilst he could not say that he specified that there would be a vascular injury or a blood vessel could be injured, he usually said the reason for a laparotomy could be if something unforeseen happened if there was bleeding or if there was damage to an internal organ.

115. The circumstances where the plaintiff sustained a vascular injury which required a laparotomy 36 hours later was entirely outside his then experience of 2,500 such procedures at the time of the hearing. It was the rarest of all vascular complications of which he had knowledge. He said that he probably would have said that in dealing with the risks of going from laparoscopy to laparotomy *"some unforeseen event or injury"* might occur but it would have been very unusual for him to specify a vascular injury at the time unless a specific discussion occurred to that effect. He would not have adverted to the possibility of a blood vessel injury being in the abdominal wall because he had not seen it before.

Prof. Turner's evidence

116. Expert evidence was given by Dr. Michael Turner, Professor of Obstetrics and Gynaecology at the Coombe Women's Hospital and St. Vincent's University Hospital, Dublin.

117. Having reviewed the plaintiff's medical records he said the complication which happened to the plaintiff was never experienced by him in almost 20 years in the speciality.

118. A major arterial bleed from the site of trocar insertion is also a highly unusual complication. He quoted incidence of abdominal wall haemorrhage after laparoscopy in 1978 was 1:400.

119. He said that operative trauma to an artery at laparoscopy usually presents at the time of the operation or immediately afterwards. From his review of the medical records, he believes that the consent obtained for the laparoscopic procedure conforms to the highest standards nationally and internationally. He would not have expected the first named defendant to have referred specifically to this rare complication. Highlighting such a rare complication preoperatively, was not in his opinion standard practice. The medical records indicate that the laparoscopic sterilisation was performed properly technically. There was minor oozing from the umbilical site, which was not uncommon and the notes indicate that the first named defendant dealt with this appropriately.

120. He said that a superficial ooze of blood from the sites in the umbilical portal or the supra-pubic portal is not uncommon.

Sometimes it will settle with pressure and sometimes it has to be stitched.

121. In his opinion, allowing the plaintiff to go home the evening with an instruction that if bleeding should recur she should report to the hospital, would be standard practice.

122. His advice to patients would be there were problems when they go home that they should not hesitate to either come back to the hospital or to phone in.

123. He said that if the plaintiff had taken Ponstan around 5.00pm and was complaining of pain around 11.00pm, it would be reasonable to be instructed to take the painkillers again in the hope that she would get a pain free sleep. In those circumstances it was reasonable for the person who received the call not to request the plaintiff to come back to the hospital for review. It also depends on what was said to and by the husband on the phone and to whom he was talking.

124. He said that the peritoneal was very sensitive to blood and so even a small amount of blood in the peritoneal cavity can cause severe pain and tenderness he did not know the precise cause of the pain before midnight. There were several potential sources of pain – the distension of the abdomen, the portals, peritoneal irritation or blood in the abdominal wall.

125. He said that the figures of complications of 1:400 included all intra-abdominal haemorrhages in the pelvic side wall and haemorrhages that involve the aorta/iliac vessels.

126. In dealing with his opinion when he said that he would not expect the first named defendant to have referred specifically to this rare complication of laparoscopic surgery he was specifically referring to abdominal wall haemorrhage. He advised patients about haemorrhage in general, but not specifically.

127. He said that it would be his practice to refer to the risk of haemorrhaging occurring as a result of an injury to some vessel or some part.

128. In relation to whether or not he should have taken a history of the bleeding from Nurse Jacob or the plaintiff, he said the importance of this depends on the circumstances and that sometimes the history was more important and sometimes the examination was more important and sometimes an investigation would be necessary to determine what is going on. The first named defendant had done the operation that morning and in his opinion he said the examination was more important as he can assess for himself the extent of the haemorrhage and see where the bleeding is coming from.

129. The fact that the first named defendant did not ask the plaintiff or the nurse about the bleed in the circumstances conformed to acceptable medical practice, in his opinion. The important information was that there was bleeding from the umbilicus. He should not routinely seek such additional information. He dismissed the view that there may be two explanations for the blood oozing at the umbilicus at 4.30pm and in particular that it was coming from a deeper site in the wound. He had never seen somebody after a laparoscopy bleeding from deep down. If it was, it was more likely to be concealed and into the abdomen. He had never seen it in 27 years experience. In his opinion, the most likely explanation for the bleeding is superficial bleeding from the skin or under the skin at the site of one of the two portals. In his opinion, it was not necessary for the first named defendant to consider the possibility that the blood was coming from a deeper site. When he put in the stitch there was no clinical evidence to suggest that there was another haemorrhage.

130. In his opinion, it was not necessary to bring the patient back to the operating theatre and put up the operating lights to see bleeding from the umbilicus.

131. He disagreed with Mr. Clements's evidence that the incision should have been extended laterally. Taking the scalpel to the portal again to extend the incision would provoke more bleeding and would compound the situation in his opinion. He never had to extend it laterally. Extending it laterally causes more disfigurement. By doubling the size the risk of a subsequent hernia is increased. He had never had to do it nor had he heard of it being done, nationally or internationally.

132. The history of what happened in the cubicle required an assessment and this was carried out by the first named defendant. It did not require to have taken place in the operating theatre. He said that by extending the wound in the same direction as suggested by Mr. Clements, whilst he would have increased and doubled the size of the wound, it would have achieved nothing as he would not have found the bleeding point which was found the following day. It would not, in his opinion, have been possible to ascertain the source of the bleeding by simply parting the walls of the wounds without, in fact, extending it. The only was to see where the bleeding point was to proceed to a laparotomy which meant an incision much bigger and in a completely different direction. If a laparotomy was performed on every patient that bled from the portals they would be doing a lot of unnecessary laparotomies as they would have to have a general anaesthetic for each person and they would have to stay in hospital for four to five days.

133. If the bleeding recurred or persisted the patient should be advised either, come back to the hospital or phone the hospital. In relation to Mr. Clements's view that the first named defendant should have advised the plaintiff that if she experienced pain or felt unwell or experienced any distension of her abdomen that she should report back to the hospital, he said it was not necessary that the plaintiff should be so advised by the first named defendant on the evening of 14th October, if advice had been got from somebody else. He thought it was more important for the first named defendant to highlight the bleeding issue.

134. In relation to the suggestion as contained in Mr. Clements's evidence that in the late night telephone call he should have been advised by the hospital to bring his wife back to the hospital because pain *"beyond domestic analgesia is very unusual following a laparoscopy"*. He said it was not a black and white situation, a lot depended on what information was communicated to the person at the other end of the phone in the hospital. He said that if somebody rings up and said that the patient has severe pain is writhing around in the bed and is not responding to conventional or standard pain killers, he thought it would be prudent to say to bring her back to be assessed. There was a middle course to advise the patient to take extra painkillers and if the pain got better the patient could stay at home and if it got worse and the patient could not sleep it would be wise to come to the emergency room of the hospital to be assessed. In his opinion, his advice and that of the first defendant were the same using different words.

135. He said that his experience and that of Mr. Clements and the first named defendant was about 10,000 laparoscopies and he never saw the complication that arose in the instant case and it is so rare that it is difficult to put a figure on it.

Professor Cunningham's evidence

136. Evidence was given Prof. Anthony Cunningham, Consultant Anaesthetist at Beaumont Hospital and Prof. of Anaesthesia at the Royal College of Surgeons in Ireland. He is also a specialist in Intensive Care. He said that laparoscopic entry access injuries are rare

complications of laparoscopic tubal ligation. Bleeding from the sub-umbilical laparoscopic incision site is extremely rare and would suggest an anatomical abnormality. There was significant documentation in the medical records that a full and frank discussion took place before surgery about the potential complications of laparoscopic tubal ligation including the possibility of conversion to laparotomy. Specific preoperative information about the risk of umbilical instrument entry site bleeding is not warranted because of the extreme rarity. The medical records confirmed that the plaintiff was advised to report further bleeding problems. Her clinical condition seemed satisfactory prior to discharge home. He said the failure of the plaintiff to contact the first named defendant or to seek medical advice or to return to the gynaecological outpatient department in the 24 hours following her discharge when she felt faint and unwell was surprising. He could find nothing in the care provided by the first named defendant to the plaintiff that constituted a breach of duty or negligence. On the contrary he was impressed by the documentation regarding her intra-operative care for the elective procedure and the prompt resuscitation and surgical intervention when she presented the evening of 15th October.

137. If there was a history that a patient had fainted like the plaintiff when getting out of bed on the morning after elective surgery that this would be taken very seriously that if the fainting episode was due to blood loss which he thought was the most likely explanation rather than residual drug effects then the estimated blood loss at around 9.00am would be of the order of 15% to 20% and should be in excess of 1 litre somewhere between 1 litre – 2 litres of blood. It was the sort of blood loss that would cause somebody to faint.

138. When the plaintiff came to the hospital on the evening of 15th, she must have lost in excess of 25% of her blood volume at that stage. There was ongoing blood loss from 9.00am in the morning throughout the day in his opinion. When the plaintiff came to the hospital on the evening of 15th, her haemoglobin was down to 4g. Where haemoglobin is less that 7g in a relatively young person like the plaintiff infusion would take place. It would be standard practice for the anaesthetist to prescribe painkillers when a patient is going home. Whilst he would have used different painkillers, Ponstan is an agent that is frequently prescribed. He would be surprised it was used more than 24 hours after the procedure. The loss of blood was primarily the most likely cause of the faint in his opinion.

139. The plaintiff would have some 3.5 litres of blood in her body on 14th October. 15% to 20% blood loss would be the likely blood loss leading to a faint. If the plaintiff had returned to the hospital at around 9.00am, her haemoglobin level would be at 7g to 9g and her blood pressure was relatively normal, she would not require a blood transfusion. If at 9.00am in the morning and the problem of the bleeding was dealt with, as a matter of probability she was less likely to suffer the respiratory distress which she did suffer. He said, having regard to the significance he has given to the faint when the hospital were contacted by the plaintiff's husband at 9.00am and informed that she was suffering severe pain and that she had fainted, the advice should have been to bring her in immediately.

140. He could not speculate on the amount of the blood loss at midnight on 14th/15th when she went home.

Legal principles

141. The plaintiff submitted that the courts have stated that cases involving allegations of negligence against professional persons have to be regarded as being in a category of their own. The plaintiff relied on the principles established by the Supreme Court in *Dunne (an infant) v. The National Maternity Hospital & Anor* [1989] I.R. 91. The appropriate principles are set out in the judgment of Finlay C.J. at p. 109, he stated:-

> *"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…*
>
> *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.*
> >
> > *(b) Though treatment only is referred to in some of these statements of principle, they must apply in identical fashion to questions of diagnosis.*
> >
> > *(c) In an action against a hospital, where allegations are made of negligence against the medical administrators on the basis of a claim that practices and procedures laid down by them for the carrying out of treatment or diagnosis by medical or nursing staff were defective, their conduct is to be tested in accordance with the legal principles which would apply if they had personally carried out such treatment or diagnosis in accordance with such practice or procedure."*

142. It was submitted that the main issue of negligence in this case was set out at para. 1 above. The court's judgment also sets out

the basis upon which the action against the second named defendants should be considered.

143. The plaintiff submitted that the warning which was given to the plaintiff for the laparoscopy by the first named defendant was inadequate and that she should have been warned of the risk of an inadvertent injury to a blood vessel. She relied on the decision of Kearns J. in the High Court in *Geoghegan v. Harris* [2000] 3 I.R. 536, which summarised the principles considered:-

> (i) The defendant was obliged to give a warning to the plaintiff of any material risk which was a known or foreseeable complication of an operation. Despite the fact that the nature of the risk in that case was extremely remote, it was a known complication and a warning of the risk was required. *Walsh v. Family Planning Services* [1992] 1 I.R. 496 applied (that case involved a vasectomy).
>
> (ii) That the test to be adopted by the court as to what risks ought to be disclosed to a patient before an operation was the test of the reasonable patient. By adopting that test it was the patient, thus informed, rather than the doctor who made the real choice as to whether the treatment was to be carried out.
>
> (iii) That when deciding whether or not, a warning would cause a patient to forego an operation, the court was to first adopt an objective test. That test was to yield to a subjective test where there was clear evidence in existence from which a court could reasonably infer what a particular patient would have decided.
>
> (iv) No category of inquisitive patient existed in Irish law because of the onerous obligations imposed on the medical profession to warn patients of all risks with severe consequences, regardless of their infrequency.
>
> (v) At p. 549, he said in addressing the test to be adopted:-
>
> > *"The application of the reasonable patient test seems more logical in respect of disclosure. This would establish the proposition that, as a general principle, the patient has the right to know and the practitioner a duty to advise of all material risks associated with a proposed form of treatment. The court must ultimately decide what is material. 'Materiality' includes consideration of both (a) the severity of the consequences and (b) the statistical frequency of the risk. That both are critical is obvious because a risk may have serious consequences and yet historically or predictably be so rare as not to be regarded as significant by many people. For example, a tourist might be deterred from visiting a country where there had been an earthquake causing loss of life, but if told the event happened fifty years ago without repetition since, he might well wonder why his travel agent caused him unnecessary worry by mentioning it at all.*
> >
> > *The reasonable man, entitled as he must be to full information of material risks, does not have impossible expectations nor does he seek to impose impossible standards. He does not invoke only the wisdom of hindsight if things go wrong. He must be taken as needing medical practitioners to deliver on their medical expertise without excessive restraint or gross limitation on their ability to do so."*

144. The court in dealing with causation at p. 550 stated:-

> *"Is not sufficient to establish that a warning should have been given but was not given to entitle a plaintiff to recover damages. He must also establish that, had he been given a proper warning, he would have opted to forego the procedure."*

145. At p. 557, Kearns J. considered whether there should be an objective or subjective approach and stated at p. 557:-

> *"It seems to this court that both approaches are valuable in different ways and that both should be considered. In the first instance it seems to me that the court should consider the problem from an objective point of view. What would a reasonable person, properly informed, have done in the plaintiff's position? This is the yardstick against which the particular plaintiff's assertion must be tested.*
>
> *'In the plaintiff's position' can be taken as meaning the plaintiff's age, pre-existing health, family and financial circumstances, the nature of the surgery - in short, anything that can be objectively assessed, though personal to the plaintiff…*
>
> *However, it seems to me that any objective test must sometimes yield to a subjective test when, but only when, credible evidence, and not necessarily that of the plaintiff, in the particular case so demands. While obviously the court must accord due deference to the testimony both of the patient and the medical practitioner, the cases already cited highlight the difficulties each may have in providing an account on which the court can safely or absolutely rely. Wherever possible the court should look elsewhere for credible confirmation."*

146. At p. 558 he stated:-

> *"In determining what a reasonable person would do, it seems to me that the views of medical practitioners as to the statistical likelihood of the risk occurring, are extremely important. A point must come where on medical evidence a risk is so remote that a reasonable person would be unlikely to be deterred by it. This is the evidence of ordinary everyday life where people make journeys by air, sea and road, conscious of a small but nonetheless acceptable level of risk. Indeed, I would guess that any one of the forms of travel mentioned might contain statistically more proximate or serious risk than that identified in the instant case."*

147. In *Fitzpatrick v. Royal Victoria Eye and Ear Hospital*, the Supreme Court in a court that comprised Kearns J. again reviewed the principles in relation to whether a warning should be given or not and considered not alone the *Geoghegan* case but also for the development in common law countries. Kearns J. on behalf of the Supreme Court confirmed that the patient centred test was preferable, and ultimately more satisfactory from the point of view of both doctor and patient alike, than any *"doctor centred"* approach there. He said at p. 6:-

> *"Insofar as the nature of any warning is concerned, this court is not free to depart from the views expressed by a court of five members in Walsh v. Family Planning Services Ltd. [1992] 1 I.R. 496 to the effect that a warning must in every case be given of a risk, however remote, of grave consequences involving severe pain continuing into the future and*

involving further operative intervention. However, that case addresses only a limited category of cases where ongoing severe pain involving further operations is the downside risk. No risk of ongoing severe pain was present in the instant case and I do feel free to distinguish this case - to any limited extent that may be necessary - from the views expressed in Walsh v. Family Planning Services Ltd. [1992] 1 I.R. 496 to offer a somewhat less extreme view of the scope of the duty in cases where ongoing severe pain involving further operations is not one of the known complications.

I would see as more reasonable for those cases the test outlined by Lord Woolf M.R., namely, that if there is a significant risk which would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk. This is still an onerous test and not dissimilar from the requirement enunciated in Rogers v. Whitaker (1992) 175 C.L.R. 479, and in this context I would regard the words 'significant risk' and 'material risk' as interchangeable. In Geoghegan v. Harris [2000] 3 I.R. 536, I suggested that any consideration of 'materiality' would involve consideration of both (a) the severity of the consequences and (b) the statistical frequency of the risk. Putting it another way, a risk may be seen as material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it."

148. I accept the evidence of Dr. Turner when he stated that he advised patients who were undergoing a laparoscopy that there is a risk that either with the various needle or the trocar or other instrumentations that go on at laparoscopy that he might damage a blood vessel. He said (a) he believed that the consent obtained by the first named defendant for the laparoscopy procedure conformed to the highest standards nationally and internationally; and (b) he would not have expected the first named defendant to have referred specifically to this rare complication. Highlighting such a rare complication preoperatively was not in his opinion standard practice. I accept his foregoing evidence as reflecting acceptable medical practice.

149. The first named defendant could not say that he told or discussed with the plaintiff that a blood vessel could be injured. It is clear, however, that he discussed many other matters with her and I accept his detailed evidence of what he said he told her and what he said he was likely to have told (having regard to the passage of time). He conveyed to the plaintiffs that there were many risks associated with the procedure and in particular the risk of laparotomy if something unforeseen happened. There was also possibility of menstrual disorder and the later need for hysterectomy.

150. I conclude that the warning that Dr. Turner stated should have been given to the plaintiff should have been given by the first named defendant.

151. I know have to consider the matter having regard to the principles in *Geoghegan v. Harris* that is applying the test as to what the plaintiff would have done on an objective basis. As the plaintiff never received such a warning, her answer to a question asking how such a warning would have affected her attitude would necessarily be hypothetical. This observation can be given in relation to the evidence which he gave in this issue without any further elaboration.

152. In considering the objective test, the evidence of Mr. Clements, the first named defendant and Dr. Turner as to the absolutely rare nature is extremely relevant. None of them had experienced damage to a blood vessel in the manner and location in which the blood vessel was damaged in this case. There is also the issue of the severity of the consequence. In this case, it was necessary for the plaintiff to have a laparotomy in order to repair the damaged blood vessel. Such a risk (albeit for different reasons) was always attendant to the procedure and indeed, was specifically discussed by the first named defendant with the plaintiff as I find. The primary additional consequences in a laparotomy compared to the consequences of a laparoscopy are in the extended scarring, the recovery from the procedure and a stay in hospital for some additional days. This was always a risk of the procedure and one knowingly assumed as I find by the plaintiff. In my opinion, applying the objective test a reasonable person in the plaintiff' position would not be deterred from proceeding with the laparoscopy procedure if she had been so advised or informed as suggested by Prof. Turner.

153. It is now necessary for me to consider the subjective test. There is a lack of evidence from the plaintiff on this issue. It is also unsupported by any third party evidence. I have already concluded that the plaintiff was informed by the first named defendant of the risk in having a laparoscopy and ultimately a laparotomy might be necessary in the circumstances stated by the first named defendant in his evidence. This would have entailed a permanent scarring for the plaintiff, a longer stay in hospital and inevitable pain and discomfort for a period during which she would have been recovering from the laparotomy. In addition, there was the risk of a hysterectomy again as discussed by the first named defendant. I find the plaintiff's failure to recall these discussions as significant. Since, I have concluded that these matters were discussed it is my further conclusion that notwithstanding these discussions, the plaintiff proceeded to have the procedure and was not deterred by the risks and associated consequences. There is also the rare nature of the occurrence as testified by three very experienced practitioners and I believe if the plaintiff was so informed she would not have been deterred. In these circumstances, I am not satisfied that she has satisfied the subjective test and I believe if the warning had been given, she would have proceeded with the laparoscopy procedure.

154. Finally, I should say that whilst the test set out in the above cases is patient centred, it is significant that there was no expert evidence from the plaintiff to assist the court into determining whether or not there was a material risk in accordance with the principles set out in the above cases. In my opinion, the words of Kearns J. in *Geoghegan v. Harris* are apt when at p. 558, he stated:-

"If the risk is virtually off the spectrum, then I believe a reasonable man might accept or disregard such a risk where it is not in the more serious category and when he has regard to the perceived benefits attaching to the proposed procedure."

155. I conclude therefore that if the plaintiff received the warning (or advice), she would not have opted to forego the procedure.

Conclusions

156. I accept the evidence of the first named defendant that he discussed in detail with the plaintiff and her husband on 31st May, 1997, the nature and purpose of the proposed operation of Tubal Ligation. In particular, I accept his evidence that he discussed the various matters which are set out in the form and in respect of which he has ticked the particular box and the additional matters noted on the form in the manner stated by him. I am also satisfied that he discussed with the plaintiff and her husband the risks of the operation and the risk of a laparotomy if laparoscopy was not feasible. The first named defendant's recollection of discussing these matters with the plaintiff is supported by his entry of the various letters which comprise the mnemonic used by him *"FILLMV"* which is recorded in his own consultation notes.

157. I am also satisfied that the actual operation of Tubal Ligation together with the examination and treatment was carried out by

the first named defendant in the manner stated by him in his evidence.

158. I accept the plaintiff's account of bleeding when she went to the toilet on her own on the afternoon of 14th, sometime after 3.00pm and that she became nauseous and vomited and the blood spattered from her belly button area onto the walls of the toilet.

159. The plaintiff stated that she informed a nurse of this event and I accept her evidence in relation to this. From the evidence in relation to the number of nurses in the day care centre and the other evidence from the first named defendant, it appears that it was Nurse Jacob who was informed of this event and who saw the plaintiff as she came from the toilet. This conclusion is also made having regard to the fact that the second named defendant did not call any evidence, nor did the parties call Nurse Jacob who was a member of the nursing staff of the second named defendant.

160. I am also satisfied that it was Nurse Jacob who wrote the entry into the records of the day care centre that the laparoscopy site oozed and that the plaintiff was seen by the first named defendant who inserted a suture before discharge.

161. I am satisfied that Nurse Jacob informed the first named defendant that there had been an ooze of blood from the laparoscopy site. There is no evidence Nurse Jacob investigated further the circumstances or fact of the bleeding, nor did she make any further entries in relation to this matter in the plaintiff's records. The first named defendant relied on the information and history he received from Nurse Jacob prior to his examination of the plaintiff at 16.30 after which he put in a suture.

162. In my opinion, Nurse Jacob ought to have investigated further the bleeding of the plaintiff in respect of which she had been made aware by the plaintiff when she left the toilet. Further investigation by Nurse Jacob of both the clothes of the plaintiff and the toilet were likely to reveal that the bleeding from the laparoscopy site could have been greater than *"oozing"*. Details of such investigations should have been disclosed in the hospital notes and could also have been relayed to the first named defendant directly prior to his examination. The absence of such communication to the first named defendant entitled the first named defendant to proceed as he did.

163. I find this failure constitutes a breach of the duty of care which the second named defendant owes to the plaintiff, as a patient in its hospital.

164. I am satisfied that the first named defendant's reliance on being informed of material events (to the extent he was by Nurse Jacobs), such as the bleeding as reported to Nurse Jacob by the plaintiff was consistent with acceptable medical practice.

165. I am also satisfied that in the circumstances that having been so informed by Nurse Jacob of the bleeding, that the first named defendant's decision to carry out his examination of the plaintiff's wound on the site of the laparoscopy procedure was consistent with acceptable medical practice.

166. I am also satisfied that to the extent the first named defendant obtained information about the bleeding event from the plaintiff that same was in accordance with acceptable medical practice in particular where the first named defendant embarked on an examination of the site.

167. I am also satisfied as a matter of fact that there was no inadequacy in the lighting, location and conditions in which the first named defendant carried out his examination of the plaintiff prior to her discharge.

168. I am satisfied that accepted medical practice did not require the plaintiff to be brought to the theatre and to have the examination conducted in the manner described by Mr. Clements.

169. As a matter of fact, I am satisfied that the first named defendant is entitled to assume that there was only one source of the bleeding at 16.30 and that was from the laparoscopy site. The bleeding had a superficial origin and was not arterial as described by the first named defendant. The first named defendant's examination and treatment of the wound, the stitching and the bleeding were, in my opinion, consistent with acceptable medical practice.

170. I am also satisfied that if the first named defendant had been informed by Nurse Jacob of the report of the plaintiff's bleeding episode that the first named defendant would have carried out a more extensive investigation than he did. Consistent with acceptable medical practice, such further investigation of the plaintiff would be likely to have left a scar for the plaintiff in excess of one half of the ultimate scar that followed the laparotomy which was performed around midnight on 15th/16th as was the evidence of the first named defendant.

171. I accept the evidence of Prof. Turner that in the circumstances the examination of the plaintiff by the first named defendant was more relevant for him than the actual history on the basis of what he had been told by Nurse Jacob and the plaintiff. In my opinion, this professional view is consistent with acceptable medical practice.

172. I accept the evidence of Prof. Turner and Prof. Cunningham as constituting acceptable medical practice and/or what is an acceptable professional standard for a person of the first named defendant's experience.

173. As a fact, I find the location of the bleeding vessel in the posterior layer of the rectus sheath was outside the professional experience of Mr. Clements, Prof. Turner and the first named defendant.

174. As a matter of fact, I find that there was no evidence available to the first named defendant to conclude when he did his examination at 16.30 that the source of the bleeding was an injury to a blood vessel or that the bleeding was pulsatile.

175. The first named defendant's decision to re-suture the umbilical incision was consistent with acceptable medical practice.

176. The plaintiff had been adequately informed by the defendants to contact the hospital after her discharge should anything untoward occur. Firstly, I find as a fact that she would have received the information booklet which was tendered in evidence and which contained particulars of the advice on para. 10 referred to earlier. Secondly, she was advised by the first named defendant to return if bleeding continued. Thirdly, it was the evidence of the first named defendant, which was not challenged by the second named defendant that there was a general practice in the day care centre, that patients such as the plaintiff would have been advised prior to discharge from the hospital to communicate with the hospital in the event of any complications subsequently arising and in this respect, I accept the evidence of the first named defendant. In the events that happened, the plaintiff through her husband contacted the hospital twice for advice as described in the evidence of the plaintiff's husband which I accept, subject to the qualification that it was not known with what department of the hospital he communicated with or the staff or the experience of the

persons giving advice to him.

177. Having heard the evidence of Mr. Clements and Prof. Turner, I am of the opinion that the manner in which Prof. Turner stated the investigation of the plaintiff would have to be carried out as contrasted with Mr. Clements's evidence was consistent with acceptable medical practice.

178. I accept the evidence of the first named defendant that if there was an arteriole bleed at 16.30 because he would have recognised it as such as it was pulsatile and it was a bright red blood colour.

179. I accept the first named defendant's evidence that if he had found an arteriole bleed at 16.30, he would have had to bring the plaintiff to the operating theatre for a general anaesthetic and would have to extend the wound considerably. Such a procedure would have been comparable to a laparotomy.

180. I find as a fact that the blood vessel that was punctured was in the posterior layer of the rectus sheath.

181. Having regard to my conclusions, it is not necessary for me to address my conclusions in relation to the telephone call made by the plaintiff's husband at midnight and the subsequent call made by him to the hospital on the following morning in relation to the plaintiff's fainting episode. It is true that the advice which she got at midnight through her husband to take more painkillers was the correct advice insofar as it enabled the plaintiff to sleep. The first named defendant gave evidence of certain circumstances in which he might have advised the plaintiff to return to the hospital at midnight, but this was qualified. Prof. Cunningham was of the view that much would depend upon the severity of the pain. He stated that a middle course which would have involved waiting to see if there was a further deterioration might be the appropriate course. Mr. Clements said that they should have been advised to go back to the hospital as pain beyond domestic analgesia was very unusual and might signal a lot of pathologies. He referred to the instruction booklet in paragraph 10. He said that if the plaintiff had pain more than she thinks she should be having, the advice should to be bring her back to hospital. It is clear from all the evidence that there is a different emphasis given by the witnesses as to what the appropriate advice should have been by the second named defendant at midnight. The advice that was given enabled the plaintiff to sleep that night. Were it necessary to conclude on the matter is my opinion that the plaintiff has not discharged the onus of proof in relation to this event at midnight in establishing a failure to take due care on the part of the second named defendant in relation to the advice given to the plaintiff.

182. I next consider the phone call at around 9.00am on 15th following the fainting episode when the plaintiff's husband was told the situation would improve and to give it time and to continue with the painkillers. I accept the evidence of Prof. Cunningham that the loss of blood was primarily the most likely cause of the plaintiff's faint at 9.00am on 15th, that she should have been advised by the hospital to come into the hospital immediately. In such circumstances she may have avoided the respiratory problems she subsequently had. Having regard to the evidence in the earlier phone call at midnight to the hospital, it is my opinion that there was a failure on the part of the second named defendant in its duty of care to the plaintiff in failing at 9.00am on the following morning to advise the plaintiff to return to the hospital. At that stage, a blood transfusion may not have been necessary and the blood loss would not have been as great as what happened later that day.

Decision
183. In my judgment no case of negligence has been established against the first named defendant. The plaintiff has succeeded against the second named defendant.

Damages
184. In relation to damages in this case, I accept the evidence of the plaintiff of the scar she now has and the pain and discomfort which he experienced at the time and continues to experience although much reduced in severity, duration and frequency. Her evidence on this is set out in my judgment. In assessing the general damages I have to have regard to the fact that having regard to the investigation and treatment of the injury to the blood vessel during the laparoscopic procedure for which no complaint can be attached to the first named defendant, the plaintiff would have been left with some permanent scarring as outlined by me had the matter been dealt with on 14th October. In such circumstances she would not have endured the difficulties of 14 – 15th October, the subsequent bleeding, laparotomy and the stay in the Intensive Care Unit of St. Vincent's Hospital. I therefore fix general damages to date at €60,000, with €10,000 for the future and also an amount for the agreed special damages. The judgment will be against the second named defendant.