THE HIGH COURT

[2012 No. 9849 P.]

BETWEEN

ANDREW MCENEANEY

PLAINTIFF

AND

CENTRAL REMEDIAL CLINIC

AND THE HEALTH SERVICE EXECUTIVE

DEFENDANTS

JUDGMENT of Ms. Justice O'Hanlon delivered on the 23rd day of February, 2018

Background to the case/evidence of the plaintiff

1. The plaintiff, a student, was born on the 17th day of February, 1994 and resides at Kilcurry, Dundalk, Co. Louth with his parents. He is the youngest of seven children.

2. The plaintiff's case is that there was a failure on the part of the defendants to properly or adequately monitor him in the context of what is described as a "known risk" and a failure to respond to what are described as "red flag" incidents which, it is alleged, ought to have given rise to precautionary x-rays. It is alleged that such x-rays would have disclosed the presence of either a hip dysplasia condition or what subsequently evolved or developed as subluxation or dislocation of the hip. The plaintiff's case is that the focus of the CRC and HSE was on the question of spasticity being a central feature of his condition and that the defendants ignored the risks in relation to hip dysplasia and hip dislocation.

3. At two years of age the plaintiff was referred to the Central Remedial Clinic by physiotherapists employed by the North Eastern Health Board and subsequently the second named defendant, the Heath Service Executive. It is common case that an x-ray of the plaintiff's hips at aged two showed that they were entirely normal. At that stage there was a diagnosis of cerebral palsy but of an atypical type. Both the plaintiff and his parents were critical of his care in that, while they were aware that cerebral palsy of an atypical type was the diagnosis at that time, and while they were told that the plaintiff would need a lot of physiotherapy to keep him mobile, the general complaint of the plaintiff was that there was no discussion of the possibility or risk of hip dysplasia or of hip dislocation before 2009.

Evidence of Mrs. McEneaney, mother of the plaintiff

4. The plaintiff's young life saw him as walking with the aid of tripods, after a period with a walking frame. His mother believed that he was great at walking until aged nine or ten years when he began to get slower on his feet and he found it more difficult. By twelve years of age he was in a wheelchair and that that was necessary for him to get around his secondary school at speed and his mother described him as getting weaker and weaker.

5. The plaintiff noted that he was complaining of shortening in his leg and his mother did recall referring to Anne Kennedy physiotherapist and to Professor Damien McCormack about this. This witness indicated that in Mount Hamilton the occupational therapist and physiotherapist had shown concern about his condition but her contention is that matters continued as they were and nothing happened. It is not disputed however that in December, 2008 in the CRC there is a note of examination with a finding of "short RLL" which is understood to be "short right leg" and it is accepted that that note was entered by Dr. Docheray. In March, 2009 an incident occurred were the plaintiff was transferring from his chair to his bed and he slipped down and dislocated his knee and that gave rise to his being examined and x-rayed in Our Lady of Lourdes Hospital, Drogheda, Co. Louth, where a dislocated hip was noted on the x-ray and it was noted that that condition had existed for some time.

6. In September, 2009 following a decision by Professor McCormack to carry out surgery on the knee cap in Cappagh Hospital, that operation was successful. The plaintiff's mother recalls discussing in April, 2009, different options and one of them would have resulted in removing a piece out of the bone in the knee which was the cause of the pain but would have left the plaintiff with a floppy leg. The plaintiff was very anxious to continue to be able to use his bicycle and stand in his frame and walk with his tripods and his family were unwilling, as was this plaintiff, to have such surgery.

7. They requested a hip replacement at that time but Professor McCormack was unwilling to do a hip replacement at that time and the Professor's note indicates, as of April, 2009 "his parents were not keen on any surgical intervention at this time". He further added "I will keep an eye on it, ultimately, he may come to an excision arthroplasty". The plaintiff's mother described everyone, including herself, being happy about the outcome of the operation on his knee in September, 2009. Professor McCormack was unwilling to carry out the hip replacement because the plaintiff was too young and believed that it would be better to wait until he was older.

Mr. Dermot McEneaney

8. Mr. McEneaney confirmed that he was the father of the plaintiff and he said he wouldn't have attended the physiotherapy clinics in the Health Board but as regards as the CRC he would have been up very regularly with his wife and son because he drove them there. This witness said he was at 99%, or the vast majority of meetings with Professor McCormack. This witness confirmed that the plaintiff complained from time to time of pain in the hip and that his legs were stiff obviously and he was asked how he knew that there was shortening in one leg and he said that he just noticed that the plaintiff was leaning over to one side in the chair and he demonstrated with his own body. He said he presumed something wasn't right but he didn't know his hip or any part of his frame was irregular.

Evidence of Professor Damien McCormack

9. On 20th August, 2012 Professor Damien McCormack and Mr. Kevin Mulhall both orthopaedic surgeons, carried out pioneering surgery on the plaintiff as a constrained hip alternative. Professor McCormack described this as like a walking adult with a standard hip but that it is an inter position device which prevents pain, gives mobility, and is stable describing it like a tooth filling which could last for ever. Professor McCormack's point is that if one looks back at how this evolved and in relation to what the outcome would have been if, for example, a girdle stone operation had been done earlier ? He contends that the excision arthroplasty removes a lot of femur and quite a lot of muscle and that one cannot bear weight on such a hip and it is short so that the patient is left with a short useless leg and cannot transfer on that leg and is forced to transfer on the other leg which is weak and may also lose power and explained that, for those reasons, an earlier hip replacement operation was contraindicated for the plaintiff.

10. It is not necessary for this Court to go through the minutiae of the examination of the notes which occurred during the course of this trial save to note the following:

> The plaintiff is described as having been too weak for minor surgery and a decision was taken not to touch his Achilles tendons because of that weakness.
>
> The plaintiff has a diagnosis of HSP (Hereditary spastic paraplegia) by reference to the notes of 24th July, 2000. A distinction is made in the evidence between cerebral palsy as a non progressive neurological condition described by Professor McCormack, a hit to the brain in a baby, like a small stroke and is non progressive by definition, compared with a diagnosis of HSP which is a progressive muscle weakness, which is long term which puts the plaintiff "off his feet" and into a wheelchair in the longer term. In the shorter term one would accelerate that if one were to have operated on this patient.

11. Professor McCormack gave evidence of his own very significant qualifications and experience to this Court and gave extensive evidence about the pioneering surgery which was carried out on this plaintiff in this case by himself and Mr. Mulhall and that it had had a wonderful result because this patient can still transfer. In essence, it is clear from the evidence that despite an initial diagnosis of cerebral palsy at aged two of an atypical type, the notes show that there was open mindedness about this until it was confirmed in the year 2000 that there was a diagnosis of HSP and the implications of that diagnosis were explained extremely fully indeed.

The evidence of Professor Damien McCormack

12. Professor McCormack is paediatric orthopaedic surgeon who trained in Ireland and went on fellowship to the United States with a special interest in disability surgery and hip surgery in children. He was appointed to the Mater and Temple Street, Cappagh, Holles Street and CRC to look after cradle to grave children and children's problems in adults and in that regard he also has an adult practice. He indicated that his job requires him to be an expert in paediatric and paediatric orthopaedics of the spine and hip. He has developed and published on several surgeries around the paediatric hip which are somewhat novel and he said that that puts him on the international scale with a reputation for innovative surgery and research. He described his working relationship with Mr. Kevin Mulhall Orthopaedic Surgeon, who is a specialist in hip surgery and described their working together on complex pelvic osteotomies as they are the only two surgeons who do some of the procedures in this country. An example of this was there work on the constrained hip here which previously not done on a paediatric population. They felt that this operation would have a role with a small category of people for example, marginal ambulatory patients and as an alternative to an excision arthroplasty and they developed that very successfully in a few patients.

Expert evidence of Mr. Cosgrove, on behalf of the plaintiff

13. Mr. Cosgrove, Consultant Orthopaedic Surgeon attached to the Royal Belfast Hospital for Sick Children, gave evidence as a medical expert for the plaintiff. He described himself as a consultant in Belfast for the last 21 years. In his evidence this witness treated the plaintiff as having cerebral palsy and his evidence is as predicated to a large degree on that diagnosis. His thesis was that sometime between 1996 and 2008 the plaintiff's hip did come out but he says we don't have a record of radiology or a clear record of examination although in the year 2000 there were some examinations which showed good abduction.

14. This witness referred to his report of the 12 March, 2014 with regard to the issue of general screening and he said that while this practice is not universal and all centres do not have such a policy in place, it would not be considered negligent not to do so routinely and his thesis was that when the shortening in the right leg became apparent he would have investigated it further with an x-ray. Likewise, regarding the observation that the plaintiff was tilting to one side, he said he would be looking at x-rays of the spine as well as the hip. Mr. Cosgrove did accept the distinction between a cerebral palsy diagnosis and a diagnosis of a hereditary spastic paraplegia but he felt that even though the HSP case is likely to be progressive rather than cerebral palsy, his evidence was that that was irrelevant as to how as an orthopaedic surgeon would treat them.

15. Mr. Cosgrove indicated that the by the time the dislocated hip was diagnosed or detected, a surgical approach to relocation was contraindicated and his contention was that with early surgery one could have gotten a very good result . He however accepts that there were abnormal forces acting upon the plaintiff's hip but he felt that, overall, early corrective surgery would have meant that the plaintiff would not have faced hip replacement surgery until much later. This witness accepted that Professor McCormack has a huge reputation in paediatric orthopaedics and both their practices are similar and the type of patient they work on is similar. The significant points of dispute on the medical evidence as expressed in the evidence of Professor McCormack.

16. Professor McCormack profoundly disagrees with the thesis of Mr. Cosgrove with regard to the x-ray issue and he says that with this patient population, if there is a diagnosis of HSP there is no point in carrying out x-rays continuously and in this particular case especially, because of the weakness in the muscle tone and tightness of muscle which was a real problem for this plaintiff. There was absolutely no question of carrying out even a minor surgical procedure for the simple reason that it would put the plaintiff "off his feet". He said that if this plaintiff had some other condition or was normal, Mr. Cosgrove's thesis in relation to surgery might be correct and he said that if the plaintiff had had mild cerebral palsy it would be absolutely correct. However, with a progressive muscle condition, even early intervention, a simple operation around the hip had a high risk of putting the patient off his feet and he would not contemplate that because the risk was that it would terminate ambulation.

17. Professor McCormack emphasised that we can't be optimistic, we have to be pragmatic and take responsibility for our mistakes and failures and he said some surgeons might say "I have to normalise the x-ray, that is my job", but they are technicians and he said that in the case of disability surgery, one cannot do that.

18. This witness went on to explain that early surgery means cutting muscle, cutting the adductor muscles . Furthermore if the reason the hip is migrating is a progressive muscle weakness disease, then cutting muscle is only going to weaken the area further and he said it is highly likely to fail in the short or in the long term and that meanwhile the child is not walking and this would be a completely negative scenario and one they strive to avoid.

19. In response to going through the notes and records and the evidence of Mr. Cosgrove who was quite convinced that the words "RLL Short" on the notes indicated that there should ordinarily be an x-ray examination to see what was going on, Professor McCormack argues that he cannot understand why Mr. Cosgrove continues to refer to this plaintiff as having cerebral palsy which is a non progressive condition whereas in fact what he had was a progressive condition, a totally different condition.

20. Professor McCormack drew a comparison between cerebral palsy as a static condition and the progressive muscle disease which this plaintiff has, where the muscles involved are the muscles that he uses to ambulate, the muscles that give him continence, the muscle that drives his heart, that drives diaphragm. He said this is a progressive muscle disease and of invariable severity. This witness took the view that the family have enough to deal with without irrelevant conversations about possible surgery on a possible

dislocation of a hip in the future. This witness was asked again in relation to the notes which showed deterioration and the situation as of the 30th November, 2005 referring to "tight lower limbs" and further notes showing a deterioration, and he said that again he repeated that the x-ray was not clinically relevant, with regard to the particular diagnosis in the plaintiff.

21. This witness felt that often x-rays don't ally parental anxiety that the parents just worry more about what is happening. He felt that while he is not the boss in the clinic, the parents are informed and that they are part of the decision making process and that every time he met the parents from the beginning he asked "what can I do for you, what do you want?". The context of this is that the response is established years before the time of not doing the minor surgery, that he knew they were never going to offer major reconstructive hip surgery because that quite possibly would put the plaintiff down or "off his feet" and the parents wanted him to keep walking.

22. This witness described two problems the plaintiff suffers from, spasticity which is increased muscle tone and muscle weakness. Medically one could deal with the spasticity and if one could medically reduce his spasticity, that would reduce the pain or the onset of pain because pain is due to this constant tight contraction. In cerebral palsy is a little bit easier to address these things because there is reserved power but unfortunately they had to put the knife away with the plaintiff for fear of putting him off his feet.

23. The court is aware and it became clear in the evidence of Professor McCormack that the plaintiff's mother understood from earlier discussions in or around 2002 and 2003 with regard to the possibility of cutting cords, when the point of leg shortening was noted in the records. While he could not recall the full ambit of his discussion with the mother, she agreed that it had been made clear that his evidence would be that we have to be really careful in relation to what surgery we do if it is something which puts the plaintiff "off his feet" and she had agreed with that. She agreed that at that time she understood from the discussion, the risk of putting the child "off his feet" if one performs surgery, the risks with an anaesthetic, his having to lie down for a number of months to recuperate from even very minor surgery and that he might simply not get back on his feet and that there was that risk. The mother accepted that she was aware of that and she accepted that and that it was discussed carefully with her and she accepted that her son was most anxious to keep mobile and that the parents were equally anxious. Professor McCormack made a number of points about x-rays. Firstly, that there is no point in doing them if one is not going to operate anyway, and in this case he was not going to operate unless absolutely necessary because of the muscle weakness. He said that the average person has a muscle strength of five out of five but that this patient had a muscle strength of three out of five and had a progressive condition. In addition he said that by law one is not allowed to expose children to x-rays unnecessarily which would have been the case here and even if an x-ray is taken some short time later there can be a problem with the hip and an x-ray is not going to prevent its dislocation. In addition he felt that doctors may carry out x-rays by way of defensive medicine, but he said that the disadvantages of carrying out such x-rays from the family point of view is that it raises concerns that may never occur and puts pressure on a family already concerned about the child's medical condition.

Evidence of Mr. Jacques Noel, expert witness called on behalf of the defence

24. This witness confirmed that the fact that he is a consultant paediatric, orthopaedic and spinal surgeon. He outlined his qualifications to the court, that he went to the Irish Resident Training Scheme, undertook the intercollegiate examination in trauma and orthopaedics. He also took the European Board Certification in trauma and orthopaedics and holds a master degree in bio-engineering with a special interest in prosthetics and orthotics. This witness indicated that he undertook a two year fellowship training in paediatric orthopaedics and surgery of the paediatric and adult spine in the United States of America. He confirmed his status as paediatric orthopaedic surgeon in the Children's Hospital Crumlin and Tallaght Hospital and in the Coombe Hospital Dublin. This witness confirmed that he had studied the salient parts of the notes on the plaintiff and that he had a clinical diagnosis of cerebral palsy, made at the time and was referred to the Central Remedial Clinic and came under the system there. However, at that stage his presentation was felt to be unusual, as documented in the notes, particularly the normal perinatal period with no precipitating factors and with a normal MRI scan which would not be the norm for cerebral palsy. He confirmed from the notes that there was no abnormal birth history that would indicate a rational reason for cerebral palsy and he said the MRI scans were normal and you would expect abnormal MRI scans with scarring, periventricular leukomalacia to indicate a diagnosis of cerebral palsy and he said it would be unusual to have normal scans. This witness confirmed that the brain and spinal cord performed in 1997 were normal and that he had progression to upper limb hypertonia by the end of 1997 and he was referred to the combined spasticity clinic and saw Professor McCormack first in October 1999 and that there was a question at that stage given the normal MRI findings that he might have a hereditary type paraplegia which is the hereditary spastic paraplegia that Professor McCormack had referred to.

25. This witness referred to the x-rays taken of the hip and he said that at that stage the primary concern was tightness of his gastrosoleus muscle in his tendo Achilles with clonus and spasticity. He confirmed that the plaintiff had had injections of Botulium toxin by the neurologist, to deal with those issues at that time and that that was the primary concern from a motor management problem perspective. He confirmed that the aim of that time was to maintain muscle length, control tone and maintain walking which he saw as critical. This witness explained that this child had weakness combined with spasticity and that one of the downsides of Baclofen was that it causes further weakness and where you have spasticity and weakness, control of tone is extremely difficult and he defined tone as meaning spasticity. From the year 2000 on from the notes, the fundamental problem appeared to be in terms of the concerns of the physiotherapist that the patient had gastrosoleus tightness and difficulty maintaining foot position. By 2003 when the plaintiff was nine years of age and he was not mobilising with two tripods and that Baclofen was discontinued and there was a comment on the notes of an unusual pattern of spasticity and this note was by the paediatrician and it was put to this witness that this was in the context of him having progressive disease and he agreed with that.

26. This witness confirmed that according to the physiotherapy and orthopaedic and neurological examinations, the plaintiff had a cogwheel type rigidity which is not normal for cerebral palsy and he described cerebral palsy as a vascular insult or almost a stroke at birth that just gives spasticity or tightness in the muscles but here there was a motor control problem as well, which is what cogwheel rigidity would appear to indicate, and he said cerebral palsy is an isolated single event, a single insult that is not progressive. This witness explained that a progressive neurological condition is treated differently to cerebral palsy. This witness was asked about Professor McCormack's view that if you are not going to do surgery at all that there is no point doing an x-ray and he said that in his mind that was a reasonable decision and he said that it can be hard to understand but, if explained, it is not an unreasonable position to take.

27. This witness was then asked whether another orthopaedic surgeon would consider, for example in applying the *Dunne* test, the plaintiff for surgical stabilisation of his hip at that stage with a high migration index of the hip joint which was picked up. This witness indicated in his response and from his report that when one has a hip which is migrating and coming out, one would generally try to keep it in and stabilise it because it is the optimum for standing, walking and sitting that the hip is in the joint. The outcome has to be better than the natural history and he says if you have a situation where the person is in no pain, it is hard to justify an operation unless you know they are going to come to some harm if you don't operate and you also have to balance that with the problems of potential complications if you do operate.

28. It was put to this witness that back in 2000 when the plaintiff was a marginal walker would he consider doing the surgery that has been suggested but he replied in the negative and indicated that at exactly the same time, he operated on a minor patient with cerebral palsy . This was affecting one side of the body and that child who was a very strong child, took eighteen months to get back to a baseline level of walking and that the mother of the child was very concerned that the child would go "off her feet" and that she was a strong individual with just one leg involved. He compared that case with this particular case, with the neuromuscular diagnosis and a strong likelihood of the child going "off his feet" completely, and felt that in many many instances we will not operate on a child with an underlying weakness in neurological condition until they actually go into a wheelchair and that there are a number of reasons for such a decision.

29. In addition to it being critical to keep a child on their feet, this witness indicated that it was very critical for their own sense of well being psychologically, that you make your bone when you are a child and that it is very hard to put on bone density and bone mass in your twenties, thirties and forties. Your bones need to be stressed to put on bone density so you have to be weight bearing. This witness was asked do the benefits as outlined by Mr. Cosgrove outweigh the risks that Professor McCormack was facing and he said he didn't think so and he said there is not a child in Crumlin Hospital who goes to surgery without a multi-disciplinary review of the cases beforehand and that they present all their pre-operative cases and the post-operative results every week in Crumlin Hospital. He said he has worked there for the last twelve years and is not aware of any child with such an underlying type of diagnosis having a hip reconstruction with a neuromuscular ailment who is still walking. This witness confirmed in relation to the risks, he had identified the risk of the child going off the feet and the potential inability to carry out further surgery, that Professor McCormack described a very high and probable risk of this,. He was asked did he agree with that and he said yes that wouldn't even come into the decision with someone with that degree of weakness, that one would fall at the first hurdle and one would not consider such intervention. This witness described having a minor patient in very similar circumstances to the plaintiff and he said that if you have someone who is a borderline walker what they are told as doctors is "primum non nocere, first do no harm". He said if you know that you are going to put a child into a wheelchair who is a walker, you are not going to operate.

30. Under cross examination this witness was asked ought not an x-ray have been done sooner and he said essentially that it was a matter of practice but he also said that it was correct to say that the radiological examination would have added nothing. It was put to him was it not the case that if migration was occurring, for example 30% migration, say that had occurred in 2003 when the attention was drawn to the matter by the physiotherapist, that that would have been an irrelevancy. He agreed that that was correct, that if you have a child who can barely walk and you do a big operation on them, they will not walk again so that it does not matter what their hip is doing.

31. This witness agreed that such a situation would be a contra-indication to the operation and he agreed that it is not a contra indication to discussing it with the parents. He imagined that ought to have happened and this witness was asked would the parents not have had an opportunity to have an input as they did when the question of doing the Achilles tendon release as proposed by Professor McCormack prior to this and his response was that they wouldn't' have had an input into the performance of major surgery and that if major surgery is contraindicated that it does not matter what the parents think. You cannot proceed. They will have a zero influence as to whether you perform it or not. They might understand the thinking but they wouldn't influence the decision whether to operate or not because fundamentally you are walking for a child not the parents and if you feel you are going to damage the child by performing surgery then it does not matter what anyone else thinks.

32. This witness disagreed that to allow proper consideration of that question, an x-ray would be relevant and he said the fundamental question you have to think is, whether this child after any form of any major surgery is going to walk again or not? He answered in the negative. This witness indicated that he had an identical case where he is watching the hip come out and is not ordering the x-rays, the paediatricians are ordering the x-rays and watching the hip come out, but the x-ray has zero bearing on his clinical decision because he knows that if he operates on that child the child will go into a wheelchair and will never walk again.

33. It was put to this witness that Mr. Cosgrove's point was that a revision at an early stage or at a stage at least before the dislocation had been frank and established. It

34. would have had reasonable prospect of success and would therefore have avoided a position where it was necessary to do a hip replacement until much later, until Andrew was probably in his fifties or his sixties.

35. This witness described that if you do the hip reconstruction at an earlier stage the chances are that the patient will go off his feet and won't walk again. You don't build up your bone strength, your bones fracture, the physiotherapists are terrified to stretch you and you get progressive contractures and he said he had seen it time and again and it is an awful situation to be in. He said one has to understand the complications with surgeries and problems with fractures and osteoporosis and osteopenia in these children and the damage that can be done. In this case this witness said that hip dysplasia would have presented before the age of two so that if a child has a fully developed dysplastic hip it will be apparent before that age that if the child has normal hip x-rays at two years of age, that child has normal development of the hips, so does not have dysplasia and that the plaintiff did have normal hip x-ray at that age. This witness takes the view that the bottom line here is not the x-ray rather whether the child should have had reconstructive surgery but this witness gave evidence that if hip reconstruction had been performed earlier, the chances are that the plaintiff would have gone into a wheelchair earlier with all the devastating consequences that follow. The data indicates that they are getting 96% 20 year survival rates and this does not mean they will wear out at 20 years it means that 96% of hips that are implanted are still fully functional at 20 years. This witness said that it would be impossible to say how many hip replacements might be necessary and he agreed that Mr. Moore has extensive arthroplasty experience.

Legal submissions

34. The court was referred to by counsel for the defence, to the decision of *William Dunne (an infant suing by his mother and next friend Catherine Dunne), plaintiff v. The National Maternity Hospital and Reginald Jackson* [1985] No. 2015P with reference to the main issue as to whether surgery ought to have been carried out on this child at that time, whether a discussion around the issue of x-rays ought to have occurred. This submission is to the effect that, while Mr. Cosgrave for the plaintiff engages with the *Dunne* test in relation to the x-rays in that he says that the reasonable practitioner and the vast body of practitioners in this area would have done x-rays and that is fine but he doesn't say the same about the surgery. He never said it was negligent or that the vast majority of other paediatric consultants would have done surgery at the earlier stage. This submission is to the effect that the evidence is the other way and that what Mr. Cosgrove did accept was that it is the clinician looking at the situation making the decision and he never put himself in that place because he couldn't. He was looking at a sterile book of notes and records and trying to come to a view about various issues which were brought before the court and the best that he could do was to say that there should have been an x-ray and there should have been some discussion. However, he never went so far as to say there should have been surgery.

35. Mr. Buckley then referred to the evidence from the clinician Professor McCormack who described in incredible detail his major concerns for this particular plaintiff. He agreed that the concept was that one must balance the pros and cons and look at the cons,

the risk of being put "off his feet", the immense psychological/psychiatric distress which would be caused not only to the child but to the family as a whole. He then referred to the evidence of Mr. Jacques Noel who described the stomach churning guilt the parents would have if they set the child "off his feet" by electing to put him through such surgery. Counsel submitted that Mr. Noel's evidence was that even if he did have the operation and twelve to eighteen months later he got back on his feet, that there would be a high probability of failure and then another piece of surgery would be needed leaving him with a floppy hip and he would not be where he is now. He can stand, he is in a wheelchair and he has got a fixed hip and he is doing well. Mr. Cosgrove agrees that that is an excellent outcome.

36. This submission continues to the effect that Mr. Noel, insofar as the "*Dunne* test" is concerned, in his view is satisfied by saying that Mr. McCormack's decision not to perform surgery is in accordance with that and that there is no countervailing argument to that from the plaintiff's side. He points out that regarding the x-rays while it might have been desirable to have done them, it would not have altered the management of this child. This submission draws the distinction between the evidence of Professor McCormack whom he describes as a bit more mellow in his approach, saying he was never going to go there in terms of the earlier operation and Mr. Noel who says that the parents view would not have come into it, that he would not be doing such an operation in such a case .He said that even if they came into him with these x-rays showing a dislocated hip getting worse and worse, he would not be going to do that surgery.

No legal submissions were offered on behalf of the plaintiff

The law
37. Counsel for the defendant relied on the decision of Dunne in the Supreme Court in allowing the appeal in part and directing a retrial on liability and damages in the High Court held,

> (1) that it was well settled that the proper principles applicable to medical negligence were as follows:
>
> (a) A practitioner was negligent in diagnosis or treatment only if guilty of such failure as no other practitioner of equal specialist or general status and skill would be guilty of if acting with ordinary care.
>
> (b) A plaintiff establishes negligence against a medical practitioner by proving his deviation from a general and approved practice only upon proving also that the course taken was one which no other medical practitioner of like specialisation and skill would have followed when taking the ordinary care required from a person of his qualifications.
>
> (c) A medical practitioner who establishes that he followed a practice which was general and approved by his colleagues of similar specialisation and skill is nevertheless negligent if the plaintiff thereupon establishes that such practice has inherent defects which ought to be obvious to any person giving the matter due consideration.
>
> (d) 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 the defendant who has followed one course rather than the other has been negligent.
>
> (e) 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.
>
> (f) Where there is an issue of fact, the determination of which is necessary to decide whether a particular medical practice is or is not general and approved, that issue must be left to the jury.
>
> 2. That for a practice to be "general and approved" it need not be universal but must be approved of and adhered to by a substantial number of reputable practitioners holding the relevant specialist or general qualifications. Where certain statements of principle have referred to treatment "only, those principles must apply in identical fashion to questions of diagnosis.

O'Donovan v. Cork County Council [1967] I.R. 173, *Reeves v. Carthy &O'Kelly* [1984] I.R. 348 and *Roche v. Peilow* 1985] I.R. 232 applied.

> 3. That where negligence is alleged against a hospital by impugning the practices and procedures laid down by its medical administrators for the carrying out of treatment or diagnosis by medical and nursing staff, their conduct was to be tested in accordance with the legal principles which would apply if those administrators had personally carried out such treatment or diagnosis in accordance with such practice or procedure.

Per curiam : In developing the legal principles relating to medical negligence and applying them to the facts of each case, the courts should ever have equal regard to the clear benefit to the common good of advancing medical science without the apprehended burden of frequent and unsustainable legal claims on the one hand, and, on the other hand, the particularly rigorous standards of care required of medical attendants arising from the extent to which their patients must rely upon their care and skill.

> 4. That having regard to its settled practice when reviewing evidence before the High Court, the Court on appeal would not intervene with findings of fact based upon the jury's choice between alternate expert testimony and diagnostic inferences properly left by the trial judge to it, so long as such evidence was capable of supporting the particular findings of fact made.

Northern Bank Finance v. Charlton [1979] I.R. 149 applied. *McGreene v. Hibernian Taxi Co.* [1931] I.R. 319 explained.

> 5. That accordingly the Court would not disturb the jury's findings that the plaintiff's brain damage occurred in the latter stages of his mother's labour at the hospital; and that therefore the doctor should have fitted the continuous electronic monitor to the plaintiffs scalp at the earlier time of 1.30 p.m. or 2.00 p.m. and, upon being alerted to foetal distress, should have undertaken to deliver the plaintiff by caesarean section.
>
> 6. That the trial judge's charge to the jury on the practice of monitoring one or both foetal hearts and the appropriate

principles of negligence to be considered by them was inadequate and that they should have been directed:—

(a) that if they concluded that there was a general and approved practice of monitoring two foetal hearts from which the defendants deviated, this did not amount to negligence unless they also concluded that no hospital medical administrator or consultant obstetrician would have so deviated if he were taking the appropriate ordinary care;

(b) that if they concluded that the monitoring of one foetal heart only was a "general and approved practice", this did not amount to negligence unless they also concluded that it was a practice which had inherent defects which should have been obvious on due consideration to a hospital medical administrator or to a consultant obstetrician;

and that therefore a re-trial on the issue of liability would be directed.

7. That having regard to settled principles and the plaintiffs circumstances and the totality of the award, the figure of £467,000 for general damages was excessive and that the appropriate range of general damages to be considered by the trial judge, after taking into account all other aspects of his assessment, would be appropriately found between £50,000 and £100,000.

Reddy v. Bates [1983] I.R. 141 and *Sinnott v. Quinnsworth* [1984] I.L.R.M. 523 followed.

Conclusion

38. This Court finds that the decisions reached in this case would have to be taken by a similar body of doctors acting with ordinary care in this field and it is quite clear from the evidence in this case that the plaintiff's claim must fail. The court has carefully listened to all of the evidence and has considered the medical reports and it is quite clear in applying the *William Dunne (an infant suing by his mother and next friend Catherine Dunne), plaintiff v. The National Maternity Hospital and Reginald Jackson* [1985] No. 2015P test that the plaintiff has had excellent care with a multidisciplinary team and with various other concerned medical and physiotherapy interventions along the way in line with that legal test and that the care and decisions taken, were taken in his best interest and have produced the best possible outcome. The court therefore has no option but to dismiss this claim on the liability issue, applying the "*Dunne*" test and with due regard to the expert evidence adduced.

39. This Court notes that the decision reached by Professor McCormack and his multi-disciplinary team would have been taken by a similar body of doctors acting with ordinary care in this field as it is quite clear from the evidence. It is quite clear that the plaintiff has had top class care with a multi-disciplinary team and with various other concerned medical and physiotherapy interventions over the years. This Court accepts the evidence in full adduced on behalf of the defendant. This Court finds that the care and decisions taken were taken in his best interests and have produced the best possible outcome for the plaintiff and that he has had a successful outcome to what was in fact pioneering surgery, the first of its kind in this country, carried out by Professor Damien McCormack and Mr. Mulhall on this patient and the court notes that this particular operation has been the subject of considerable medical literature. This Court notes that the plaintiff's case is misconstrued. The medical reasoning in relation to not carrying out x-rays which is complained of as a failure, is very clear and cogent, and the court holds that best practice has been applied in this case in that regard. It is more than clear that, had an earlier operation being carried out, the plaintiff would not have been able to enjoy the benefit of the operation which has left him able to transfer, as opposed to being completely non-ambulatory. It is equally clear that there was continuous monitoring by the multi-disciplinary team of the plaintiff and that the plaintiff's parents and the plaintiff enjoyed appropriate consultation and explanation, in line with best medical practice. In accordance with the legal test and in particular referring to the evidence of the expert witness the terms of the test have been well fulfilled in this case and the court dismisses the plaintiff's claim.