THE HIGH COURT

[2004 No. 6652 P]

BETWEEN

OLIVIA KEARNEY

PLAINTIFF

AND

EITHNE McQUILLAN AND NORTH EASTERN HEALTH BOARD

DEFENDANTS

JUDGMENT of Mr. Justice Ryan delivered the 23rd March, 2012

1. The plaintiff is a married lady who is now aged 60 years and who has one grown-up child, a son who was born in 1969 at Our Lady of Lourdes Hospital, Drogheda. The first defendant is the nominee of the owners and occupiers of the hospital at the relevant time. The case against the second defendant had been struck out before the hearing.

2. The plaintiff became pregnant in early 1969 and in September of that year her general practitioner referred her for ante-natal care to Our Lady of Lourdes Hospital, Drogheda. She attended there on the 18th September, 1969, and on a number of subsequent occasions before being admitted to the hospital on Thursday afternoon 16th October. The plaintiff was aged 18 years at the time.

3. Labour was induced by rupture of the membranes at 3 am on Friday the 17th October. However, the plaintiff did not progress to a natural, vaginal delivery. There were two problems: the baby was in a position in the womb that made natural delivery impossible and labour was not progressing. The baby's head was flexed backwards and there was inadequate cervical activity. If there had been normal progress of labour the contractions of the cervix might have altered the baby's position to one that was conducive to normal delivery. In the result, the consultant obstetrician Dr. Connolly decided to deliver the baby by caesarean section.

4. The baby was born at 12:10 am on the 19th October. Shortly after birth he had some breathing difficulties and was transferred to the special care unit. He eventually made a full recovery.

5. Dr. Connolly's note of the operation gave brief details. They included the fact that it was an emergency lower segment caesarean section "for p.o.p. and failure to progress". POP means persistent occiput posterior which described the baby's presentation in the womb.

6. At the end of his short note the doctor wrote: "Symphysiotomy performed before closure." Symphysiotomy is the surgical enlargement of the pelvis by dividing the fibro-cartilaginous joint between the pubic bones. There was of course no need to do a symphysiotomy because the plaintiff's baby had been successfully delivered using an appropriate treatment option. This controversial procedure is the central issue in the case.

7. Another piece of information about the plaintiffs treatment is contained in the hospital's Clinical Report for 1968/1969 which, using a number code for the patient, recorded the reason for Ms Kearney's caesarean section operation as: "9031 - incoordinate uterine action. Remarks -none."

8. On the 28th October, the plaintiff had x-ray pelvimetry which showed normal pelvic. measurements.

9. The plaintiff's evidence was that she was in excruciating pain after the operation. She had a bandage around her abdomen and hips. She did not get out of bed until the sixth day after giving birth when her husband brought her in a wheelchair to see her baby. The sutures were removed on the 27th October and she was discharged home on the 29th October.

10. Mr Roger Clements, Consultant Obstetrician, summarised in his report the plaintiff's account of subsequent events. For the first three months she spent most of the time in bed. Her mother-in-law helped with the baby and the plaintiff had little interest in him. Movements of her pelvis, particularly opening her legs, were painful. The pain spread all over her body. It took a year before she was fully mobile and able to return to work. She did not bond with her baby. She did not attempt sexual intercourse for the first year and after that only with great difficulty. She suffered severe sexual dysfunction and reproductive loss. Her enjoyment of sex disappeared. From about 1974 until 1999 she had sex very infrequently, once every two or three months. Since 1999 she has had no sexual intercourse. Over the years she sought many forms of treatment for back pain, difficulty in moving and lower abdominal pain. She suffered severe locomotor problems. She was depressed.

11. The plaintiff said that she did not know that he had had a symphysiotomy until she heard a radio programme in 2002 when women were describing their experiences following such operations. She looked for her medical records from the hospital and discovered that that is what had happened to her. The discovery that she had undergone a symphysiotomy at the time of giving birth to her son in 1969 resulted in further psychological trauma and depression.

12. The plaintiff sued. She claimed damages for what she alleged was a wholly unnecessary and unjustified operation that had disastrous consequence for her health and enjoyment oflife. But the case was old. Potential witnesses, including the doctor, were dead or missing. The first defendant sought in a preliminary motion an order striking out the claim by reason of inordinate inexcusable delay in instituting proceedings. It was argued that the first defendant was prejudiced. The High Court [2006] IEHC 186 granted the relief sought.

13. The plaintiff appealed to the Supreme Court. On appeal, her counsel reformulated her claim and contended that the principal issue

was that there was no justification whatever, in any circumstances, for the performance of a symphysiotomy on the plaintiff at the time it was performed and following successful delivery of her baby by caesarean section. The Court observed:

> "This reformulation of the case was done in order to meet what would otherwise be a very strong claim on the part of the first defendant to have the action dismissed against it on the grounds of prejudice arising from prejudice arising from delay. While the court does not have to decide the question of whether the action would indeed have been dismissed on that basis had it proceeded as originally formulated, we have no hesitation in saying that this was a very real risk quite justifying the advice given to the plaintiff as a result of which the case was reformulated as above."

14. The Supreme Court allowed the appeal, holding (1) that the reformulation of the claim removed the prejudice to the defendant and (2) that the plaintiff could be defeated if the first defendant could establish any circumstances prevailing in 1969 which would have justified carrying out a symphsiotomy. On a hypothetical basis, the first defendant could defend the case by establishing by means of credible evidence some realistic reason for the carrying out of the procedure in the actual circumstances which prevailed in relation to the plaintiff in 1969. In light of the reformulation of the case, the Court held that no prejudice affected the first defendant by reason of the death of Dr. Connolly and the other doctors mentioned. As Hardiman J. said in delivering the judgment of the Court:

> "In particular, the court is satisfied that the first defendant will continue to have available to it the defence suggested by the second of the principles laid down by Finlay C.J., in *Dunne (an infant) v. National Maternity Hospital* [1989] I.R. 91, at p. 109. This is as follows:-
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> > 'If the allegation of negligence against a medical practitioner is based on proof that he deviated from a general and approved practice, that will not establish negligence unless it is also proved that the course he did take was one which no medical practitioner of like specialisation and skill would have followed had he been taking the ordinary care required from a person of his qualifications.'
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> "It appears to the court that, by reason of the reformulation of the case, the first defendant is relieved of the necessity to establish specific indications, perceived by Dr. Connolly, and justifying the carrying out of the symphysiotomy. It is enabled to defend the case by establishing in credible evidence some realistic reason for the procedure in the circumstances actually prevailing in relation to the plaintiff in 1969. The most immediately relevant of these circumstances would appear to me that, prior to the symphysiotomy, her baby had been delivered by caesarean section."

15. The action proceeded only against the first defendant; the claim against the health board had previously been struck out.

The Expert Evidence
16. Expert evidence was given by three consultant obstetricians/gynaecologists: Mr. Roger Clements, Dr. Gareth Thomas and Dr. Declan Meagher.

Mr. Roger Clements
17. Mr. Clements' evidence was that there are certain very limited circumstances in which symphysiotomy is a relevant procedure. There are however major risks and there is considerable morbidity. In a case where the pelvis is too small to permit the baby's head to go through, it can be an option, if caesarean section cannot be performed. That is why it has uses particularly in developing countries where anaesthetic and surgical facilities are not available. However, his point was that the circumstances which could have led to symphysiotomy being relevant in this case were simply not present.

18. There was not disproportion. Nor was there any evidence to suggest disproportion. Disproportion, Mr. Clements said, meant that the baby's head could not get through the mother's pelvis. There was nothing in this case to suggest any such condition. Therefore, the theory that a future pregnancy might be facilitated as to delivery of the baby by performing symphysiotomy was untenable.

19. The difficulties in this pregnancy were a failure to progress and the O.P. presentation. A baby in that attitude is rare in multiparous labour and is a phenomenon of first labour. It was most unlikely to happen again. In the circumstances, therefore, to carry out a symphysiotomy was gratuitous, improper and unjustifiable. In fact it turned out subsequent to the procedure, although of course Dr. Connolly was not to know this at the time, that Ms. Kearney's pelvic measurements were normal.

20. Mr. Clements said in his report that he could find no justification in the literature of the time - 1969- for the operation:-

> "There is no report in the literature for symphysiotomy as an elective procedure. There is outright condemnation of symphysiotomy in a patient who has already had a Caesarean section. In the circumstances of Ms. Kearney's delivery it would not therefore be possible to justify the operation of symphysiotomy, in any event".

21. Hardiman J. cited this criticism when delivering the judgment of the Supreme Court. Mr. Meenan S.C. for the defendants challenged Mr. Clements as to the words, "outright condemnation". Mr. Clements was not aware of articles by two Irish obstetricians, Dr. Barry and Prof. McVey, in the Irish Journal of Medical Science which Mr. Meenan produced. He also put to Mr. Clements a passage from Chap. 24 of Munro Kerr's *Operative Obstetrics* (7^{th} Ed.) dealing with symphysiotomy in which the following appears:-

> "Some Dublin workers have attempted to make a case for the partial division of the symphyasis in the course of a Caesarean operation, (minor degree of disproportion), regarding it as a means of ensuring an easy vaginal delivery on future occasions. To my mind the indication of this form of operation, symphysiotomy on the way out from Caesarean section it is termed, is also too nebulous to warrant serious consideration."

22. It does seem to me that this comes close enough to outright condemnation because of its tone of imperious dismissal of something that does not warrant serious consideration in the opinion of the author. It is course true, as the first defendant's closing submissions make it clear, that the National Maternity Hospital appeared to be out of kilter with such thinking.

23. Mr. Clements in his evidence said that there were two problems; the baby was facing the wrong way - he was deflexed and labour was not progressing. Progress in labour was measured by dilatation of the cervix and descent of the baby's head and they were not happening.

24. He said that there was no probability of benefit in the operation and there was a distinct possibility of harm. And Mr. Clements' view is that the latter is actually what happened.

Dr. Gareth Thomas
24. Dr. Thomas's evidence was that Ms. Kearney required a caesarean section for a series of reasons which were not likely to recur:-

> "There was no evidence of outlet obstruction (and subsequent pelvimetry has shown a normal size and shape of pelvis).
>
> The claimant was subjected to an unnecessary procedure which she will say has caused her many years of pain and suffering.
>
> There was no indication, even in the environment of Dublin in 1969, for symphysiotomy to be carried out 'on the way out' from a lower segment Caesarean section."

25. It was known in 1969 that a lower segment Caesarean section carried much less risk of rupture in subsequent pregnancies than was the case with the classical longitudinal incision and a woman could have many more of the former than she could of the latter.

26. In this case, on the balance of probability, the failure to progress was due to the persistent occiput posterior which was a non-recurring condition seen more frequently in first and induced labours.

27. Dr. Thomas said that there was no evidence of absolute outlet disproportion.

28. Dr. Thomas referred to the Clinical Report of Our Lady of Lourdes Hospital in Drogheda for 1970/1971 which said about symphysiotomy that "the operation now is nearly always done in the second stage of labour and never electively or during closure of the abdominal wound after a Caesarean section".

29. Mr. Meenan put to Dr. Thomas as he had to Mr. Clements that Dr. Declan Meagher in his report had suggested that Ms. Kearney's labour "was complicated by cephalopelvic disproportion due to a contracted pelvis" and Dr. Thomas replied: "Well, there is no evidence of that at all". This was a similar reply to that of Mr. Clements. And it does appear that Dr. Meagher was speculating that there might have been such a condition because there is as Mr. Clements and Dr. Thomas have said absolutely no evidence of it and Dr. Meagher did not point to any evidence of it.

Dr. Declan Meagher
30. Dr. Declan Meagher gave evidence for the first defendant. He had a distinguished career in Irish obstetrics. He said that the principal impact of the Catholic ethos was to avoid the necessity for a woman, particularly a young woman, to have a major operation i.e. a Caesarean section every time she became pregnant. The course of the plaintiffs labour and the recorded findings "raised the possibility that there might have been a limited capacity for the head to come down". "It would raise the question of disproportion". He said that foetal distress was not recorded but there was good reason to deliver the baby.

31. He said that before doing a symphysiotomy, you would first have to diagnose disproportion. He was asked if he believed that Dr. Connolly was thinking of disproportion, even though he did not note it in his operation report and replied: "I have little doubt, yes. I can't see any other reason for performing a symphysiotomy". He said that there were features of the case that raised the possibility of disproportion. They included caput and marked moulding of the head. However, that did not furnish a basis for a diagnosis. Referring to the reasons stated in the report for performing the caesarean section, Dr. Meagher said:-

> "Emergency LSCS for p.o.p [persistent occiput posterior] and failure to progress". Attitude is a term we use. Here it is described as "p.o.p,", the occiput is posterior. When the occiput is posterior and there was delay, he would say: 'Well, maybe it is not the small pelvis, maybe it is just the position of the head,' p.o.p. or o.p. Failure to progress can refer to either failure of the head to descend or failure of the cervix to open to allow the head to descend."

32. Counsel for the plaintiff, Mr O'Donnell SC, referred Dr. Meagher to the Clinical Report of the hospital in which the entry for the plaintiff said:-

> "9031 - incoordinate uterine action. Remarks none."

Dr. Meagher agreed that disproportion is a different things to incoordinate uterine action. Mr Meenan SC, for the first defendant, objected to the use of this report, claiming prejudice because he was not in a position to adduce evidence as to the accuracy of the information at this remove of time. The significant point was not merely the description of Ms Kearney's operation and the reason for it but, in addition, the contrast with reported information about five other women who had had caesarean sections in the relevant period. In their cases, the entries said " disproportion", "obstructed labour due to disproportion", "alleged disproportion","disproportion" and "disproportion". I disallowed the objection. It seemed to me that the report was prima facie evidence of its contents and there was no reason to suppose that its information was not properly compiled.

33. Unhappily for the defendant, the introduction to the report is signed by Dr. Connolly.

Submissions for the First Defendant
34. The first defendant submits that the plaintiffs claim must fail if the defendant establishes by credible evidence a hypothetical explanation as to why the symphysiotomy was carried out on the plaintiff. Although the explanation must be realistic in light of the plaintiff's circumstances and the relevant medical environment in Ireland at the time, it does not have to establish specific factors perceived by Dr. Connolly to justify the procedure.

35. The submissions refer to the Catholic ethos that prevailed in Ireland in 1969 and was espoused by a number of senior obstetricians, including Dr. Connolly and some Masters of the National Maternity Hospital. This body of opinion was anti caesarean section. The reason for that was apparently that a woman could only be expected to undergo a relatively limited number of operations and it was assumed that she would probably need to have quite a few of them because it was anticipated that a woman was going to have a lot of children. If doctors were to perform caesarean sections more or less as required, there would come a point at which they would have to advise a woman that she should not have any more children and that would lead to the consequence that she might be tempted to use artificial contraception or she might even look for sterilisation or some other means of preventing a pregnancy. This consideration or these thoughts were sufficient to justify the doctors' hostility to caesarean section. This led them to be favourable to symphysiotomy, which facilitated future pregnancies as to delivery of babies.

36. This mode of thinking and of practising medicine is mercifully a matter of history but Mr. Meenan submits that it did represent a significant body of opinion in the Irish medical world in 1969.

37. But even assuming the validity of these opinions, the question still arises whether there was actual disproportion in Ms. Kearney's case. It is nowhere suggested that symphysiotomy should be performed in cases where disproportion does not exist. And although Dr. Meagher says a little puzzlingly that disproportion was grossly over-diagnosed, there still had to be some basis for diagnosing it. The fact that the baby was in the OP attitude and that the labour was not progressing in this pregnancy gave no indication or no basis for believing that such would be the case in future.

38. All of the experts were agreed that in order to justify symphysiotomy there had to be disproportion. And it is absurd to suggest that this condition might have had some meaning other than the pelvis being too small to accommodate the baby's head, because that is the only condition that would be repeated in a future labour.

39. The defendant submits that the Supreme Court judgment means that the defendant does not have to prove that the caesarean section was done because of and in order to deal with disproportion. The defendant is not liable if it is able to adduce credible evidence that Dr. Connolly "may well have thought he was dealing with a case of disproportion".

40. The submissions say that Dr. Meagher's evidence was that Dr. Connolly might have come to the conclusion that there was disproportion because of a failure to progress because of the long labour, the cervix being not more than three fingers, the large caput and excessive moulding. However, the furthest that this expert went was to say that those features could have given rise to the possibility of disproportion. The first defendant proposes therefore that there was credible evidence that Dr. Connolly may well have thought he was dealing a case of disproportion.

The Plaintiff's Submissions
41. The contemporary medical records and the Clinical Reports of the hospital do not provide evidence of any medical justification for the symphysiotomy on the plaintiff. The evidence is actually to the contrary- the operation was for failure to progress and the OP. There was no indication of obstruction or pelvic deformity. The records are re-affirmed by the hospital's annual report for 1968/69 and the inference that arises from the plaintiff's entry compared with the five where disproportion is noted.

42. Symphysiotomy was developed to deal with obstructed labour or absolute disproportion. It was not possible for Dr. Connolly to diagnose the need for future operations or that the plaintiff would not go to full dilatation and a normal delivery in subsequent pregnancies. The plaintiff's pelvis was normal.

43. In respect of the first defendant's expert evidence of Dr. Meagher, the submissions highlight the fact that he agreed that a medical justification had to exist for symphysiotomy and the only one to justify it was a diagnosis of disproportion.

Discussion
44. The experts were agreed that there were circumstances in which symphysiotomy was appropriate. It was also accepted that the essential indication for the operation was disproportion. There was debate in the case as to the difference between absolute and relative disproportion; the English experts held that the only justification for the procedure was absolute disproportion. For the defendant, Dr. Meagher did not make the distinction in the same terms as his English colleagues but I do not think that there was any material difference on this point.

45. Dr. Meagher made a circular argument. He said that the only possible justification for the operation was disproportion. Therefore, if Dr. Connolly did the operation he had to have made that diagnosis. But that leaves open the question whether there was actually evidence on which the doctor could have made the diagnosis. It is clear that absent the diagnosis there was no justification whatsoever for the procedure.

46. Disproportion had to be absolute in the sense that the English doctors used it. The relevant condition --the only relevant condition -- was that the baby's head could not fit through the woman's pelvis. If that was not the case there was no justification for the operation. If the condition that gave rise to the need for delivery by caesarian section was not the incapacity of the pelvis to accommodate the baby's head passing through it, there was no point in expanding the width of the pelvis. Equally, if the problem was that the presentation of the baby in this pregnancy was unfavourable and dictated delivery by caesarian section, that did not mean that a future pregnancy would give rise to the same problem.

47. In this case the baby's head never got to the pelvis because the cervix had not dilated sufficiently. The baby was in the OP attitude. There was no reason to believe that that situation would arise in another pregnancy. Neither was there anything to indicate any disproportion. And we know from measurements subsequently carried out that the plaintiff's pelvis was normal. It was suggested that the procedure itself would have resulted in some increase in the size of the pelvis but the English experts rejected that and I believe they were correct in doing so and I accept their evidence. There might have been some marginal adjustment but no more than that and nothing significant enough to discount the measurement as providing valuable information. Of course, Dr. Connolly did not have this measurement but it does establish objectively that disproportion did not exist. Disproportion, that is, that could be dealt with by carrying out a symphysiotomy.

48. Dr. Connolly did not have any information on which he could have based the diagnosis of disproportion. It is also clear from the available information that there is no reason for thinking that Dr. Connolly himself believed or could have believed that this was a case of disproportion that could be dealt with by carrying out a symphysiotomy. His operation note does not mention disproportion. It could be said that while he might be faulted for not making a fuller note that does not mean that he was negligent but the fact remains that the logic that performing this operation obviated the need for future caesarian sections is undermined because the reasons for the section were not likely to be repeated in a later pregnancy.

49. The information in the hospital report covering the year 1969 is confirmation that this operation was not carried out because of perceived disproportion. It makes no sense to think that in a formal document issued to the public the hospital would not take care that the entries were accurate. Looking at the five cases in which disproportion is mentioned and the distinctions between them, it is not reasonable to propose that the plaintiff's case was actually one of disproportion but the hospital mistakenly put it into a different category.

50. In delivering the judgment of the Supreme Court, Mr. Justice Hardiman said that the first defendant could defend the case "by establishing in credible evidence some realistic reason for the procedure in the circumstances actually prevailing in relation to the plaintiff in 1969." He went on to say: "The most immediately relevant of these circumstances would appear to me that, prior to the symphysiotomy her baby had been delivered by caesarian section". The court was therefore focusing on the fact that the plaintiff's baby had already been delivered at the time when the obstetrician went on to perform a procedure that was quite unnecessary in the circumstances.

51. The expert witnesses for the plaintiff, Mr. Clements and Dr. Thomas, were of the view that the operation could not be justified after the baby had been delivered by the section operation. Mr. Meenan SC for the first defendant produced articles in Irish medical journals to show that there was indeed a school of thought among Irish obstetricians that supported what Dr. Connolly did. The persons who held this belief occupied senior positions in the Irish medical world. It is not a case of a doctor deviating from a well-settled practice, which was what Finlay CJ was dealing with in Dunne v National Maternity Hospital [1989] Irish Reports 91 at 109. It is rather a case of a doctor who pursues a policy that a minority adhere to but which enjoys a certain respectability because of the status of the people who share the opinion.

52. The evidence does not establish that Dr. Connolly followed a general and approved practice.

53. And even if the practice had enjoyed more general approbation, it was attended by obvious inherent defects, being wholly unnecessary and having significant morbidity. As Finlay CJ said:-

> "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."

54. On any basis, the operation required an essential justifying circumstance of pelvic disproportion which was absent.

55. It follows that "in the circumstances actually prevailing in relation to the plaintiff in 1969" the symphysiotomy operation was wholly unjustified and the plaintiff must succeed.

Damages Issue

56. The plaintiff suffered over the years with severe physical problems. In his medical report of the 9th September, 2004, Dr. Frank Chambers diagnosed sacroiliitis, a condition of the sacro-iliac joint with associated reactive depression. In another report from 2004, Dr. David Moorhouse, a consultant neurologist, concluded that the symphysiotomy operation was the cause of the plaintiff's back problems. This is wholly consistent with the view of Dr. Chambers and the involvement of the sacroiliac joint puts the matter beyond doubt. She also had psychological features, including failure to bond properly with her baby son, distress at not being able to have any more children and feelings of personal inadequacy and of having disappointed her husband. These features of the plaintiff's condition are not in dispute. There is argument, however, about the admissibility of the events of 2002.

57. Ms Kearney testified that she found out in 2002 that she had had a symphysiotomy and that this discovery had a profound effect on her. She became more severely depressed than she had ever been previously. She was referred to a consultant psychiatrist, the late Dr. Michael Corry and she is currently under the care of Dr. Brendan McCormack. In his evidence he described the very severe psychiatric illness that has afflicted the plaintiff since she discovered the facts about the symphysiotomy. She has a number of serious conditions which are secondary to a major depressive disorder with delusions. The condition is grave, the plaintiff needs ongoing psychiatric treatment and she is likely to suffer symptoms indefinitely into the future.

58. On any view of the case, the consequences of the symphysiotomy operation have been devastating. The plaintiff was 18 years old when Dr. Connolly carried out the procedure and she has been suffering since. It is also clear that there was a watershed event in 2002. Ms Kearney was referred to a psychiatrist for the first time in 2003. Dr. McCormack attributes the grave psychiatric illness to the discovery by Ms Kearney of what happened to her back in 1969. Therefore, while the case would be a serious one for which substantial damages would be appropriate even without the events of 2002 and thereafter, the addition of the major psychiatric illness that is ascribed to Ms Kearney's discovery at that time and her reaction to it then and subsequently puts the case into a higher category again of compensation. This is the background to an issue in the case concerning damages.

59. The first defendant submits that the evidence of Dr. McCormack and by necessary implication that of Ms Kearney in relation to the 2002 discovery and its consequences on her mental health must be disregarded because of the reformulation of the case and the Supreme Court judgment. The evidence of this psychiatric injury is predicated on Ms Kearney's state of knowledge as of2002. Dr. McCormack's diagnosis is that she sustained a severe shock which precipitated the depression and other conditions. Obviously, she could not have undergone a shock on discovering that he had had a symphysiotomy in 1969 if she was already aware of what had been done to her.

60. The defendant argues that damages should be assessed "on the basis of the injuries which can be related solely to the sequelae from the operation in 1969 to the exclusion of injuries depending on issues of consent or the plaintiff's state of knowledge in 2002." The written submissions point out that there was no claim in respect of psychiatric injury originating in 2002 when the case was considered by the Supreme Court. The Statement of Claim is dated 14th of May 2004 and does not contain such a case. Neither does the amended Statement of Claim dated 30th of June 2011. The defendant's motion to have the plaintiffs claim struck out on grounds of delay was heard by this Court in March 2006 and judgment was delivered on the 31st May, 2006. The plaintiffs appeal to the Supreme Court was heard on the 25th March 2010 and judgment was delivered on the following day. Dr. Brendan McCormack's report is dated the 4th day of January, 2011. It says that he saw the plaintiff on a number of occasions between June, 2010 and November, 2011. He had seen a report prepared by the late Dr. Corry which is dated the 29th July, 2004. It appears therefore that it was only some two months or more after the Supreme Court heard and determined the appeal that Dr. McCormack saw the plaintiff for the first time.

61. The defendant did not apply for an adjournment of the case in order to have the plaintiff examined by a psychiatrist. Neither did counsel argue that his client was taken by surprise by Dr. McCormack's evidence. The objection is put on the basis and only on the basis that such evidence is inadmissible having regard to the judgment of the Supreme Court.

62. The preliminary issue that came before the Supreme Court was the first defendant's motion that the claim should be stopped because of delay resulting in prejudice to the defence. The judgment records that the defendant had also sought the trial of an issue as to whether the action was statute barred but did not proceed with that application. The claim as presented and as considered by the Supreme Court was that the symphysiotomy was carried out without the plaintiff's knowledge or consent, in which case obviously it would have constituted an assault. The prejudice that the defendant asserted was that almost all the relevant witnesses were dead or missing. It was clearly important in the consideration of the matter in the Supreme Court that it was impossible for this defendant to establish what information the plaintiff was given before Dr. Connolly operated on her. In those circumstances, the Court recognised the prudence of the plaintiff's advisers in acknowledging the real difficulty that existed and in proposing the reformulation of the case in terms that obviated the element of prejudice.

63. But what the plaintiff was told after the operation is a different matter. That could have formed the basis of a plea that the case was statute barred. It could perhaps have been argued that her date of knowledge was 1969 or some time after that when she might have discovered that a wrongful act had been done to her.

64. How is the plaintiff's knowledge relevant to whether the event or events of 2002 can give rise to a claim? Granted, if Dr. Connolly were still alive, he would be able to say -- perhaps -- that he remembered telling Ms Kearney that he had done a symphysiotomy after delivering her baby by Caesarean section. Or he might say that he could not remember but that it was his invariable practice to do so and therefore he must have done so on this occasion. Then it would be a matter for the court to decide between the two accounts as to which was correct on the balance of probabilities. That problem can occur in any case, whether or not there is a long delay or any question of the Statute of Limitations. A witness may die or be unavailable or forget or notes may be lost. The fact that a person is not around to offer some possible rebuttal is not a reason for rejecting testimony that is otherwise admissible.

65. The Supreme Court dealt with liability, not with questions relating to damages. And it is worth remembering that the Court did not actually come to a conclusion on the defendant's motion but somewhat gratefully adopted the reformulation of the case.

66. It would be something of a Pyrrhic victory for the plaintiff to have overcome the challenge to her entitlement to bring proceedings if she were to be faced with another obstacle that would deprive her of compensation for a significant part of the injury to her health that can be traced back to the depredations of Dr. Connolly. It seems to me that the evidence about the watershed event in 2002 is entirely convincing. It is true, as the defendant's submissions point out, that there is some inconsistency in the evidence as between the plaintiff and Dr. McCormack. But I think that the doctor has given a reasonable explanation for that. I think that the plaintiff is a truthful and reliable witness, as is Dr. McCormack. It must be remembered that the plaintiff has undergone a horrendous experience and is suffering from a major depressive illness with delusions and associated disorders. Therefore, what she recalls as a specific and singular event is more likely to have been a series of episodes which occurred over a period of time.

67. Is the plaintiff to be deprived of compensation for her major depressive illness and the other distressing neuroses because of the possibility that she should have known all along that her problems were caused by the symphysiotomy operation in 1969? I do not think that would be just.

68. It also seems to me that a different but legitimate way of approaching this question is to consider another aspect of the 2002 discovery evidence. The plaintiff's shock was as Dr. McCormack explained comprised of a number of elements. In the first place, there was a feeling almost of relief that there was an explanation for all the health problems that she had suffered over the years. There was also the understanding that she had had a symphysiotomy like the women on the radio had described. She had emotions of guilt and anger and confusion. Depression followed and the other psychiatric conditions. It was not, however, the specific fact of the symphysiotomy operation but rather what it represented for her in explaining what she had been going through from the age of 18.

69. The Supreme Court did not give permission for Ms Kearney to bring an action for part of injuries. There is no reason to suppose that the Court intended that her success on the appeal should come at the price of reduction in compensation. I do not think it is for this court to impose on the case a severe and unjust restriction on the compensation that is due to a victim of a serious wrong.

Quantum

70. The plaintiff said that she was in excruciating pain after the operation. She was on strong painkillers and frequent injections. She wasn't able to get out of bed until the 6th day after the baby was born, when her husband took her in a wheelchair to see him. She was discharged after 11 days. She found it impossible to manage during the first 3 months. Martin, the baby, was in hospital for 6 weeks but the plaintiff could not get up to see him because of the pain. She was in bed for those first 3 months. She was in severe pain. Going to the toilet or the bathroom or going to the kitchen caused dreadful pain. She was taking a lot of painkillers.

71. Ms Kearney said that she was unable to look after Martin when he eventually came home. They were staying with her husband's mother who dared to call most of the care of the baby. Her problems were severe back pain, incontinence and depression. She did not bond with the baby because of all the pain. She had trouble with her legs and feet. She had tried various treatments over the years.

72. The plaintiff's problems since this procedure was carried out have been incontinence, which has always been there but she has lived with it because of dreadful fear of being intimately examined again. She has permanent backache. It varied in severity down through the years. She dealt with it by taking over-the-counter medication, prescribed drugs, injections and alternative therapies. She is still taking medication in the form of Difene frequently throughout the day. Sometimes her husband injects the drug.

73. The plaintiff did not bond with her child and felt guilty at not being a good mother. She had wanted more children but could not face that prospect. Sexual relations were very difficult. There were problems with the contraceptive pill. She was depressed and anxious: "I felt it was all my fault. I couldn't give my son a brother or sister. I couldn't get my husband another child. I took the blame for that".

74. Ms Kearney was referred to Dr. Michael Neary, obstetrician and gynaecologist, for incontinence and back pain but she did not find it helpful. She said she was attending a psychiatrist, the late Dr. Corry, from 2003 or 2004 and then she transferred after his death to Dr. McCormack, who gave evidence.

75. Ms Kearney said that the discovery in 2002 that he had had a symphysiotomy affected her very badly. At first there was an element of relief but it was supplanted by other feelings:-

> "Well I was a bit relieved because I thought all my life I was going mad with imaginary pains, nobody believed me. I could now identify what was causing this dreadful backache and incontinence. I was a little relieved and then it was only later on then that I discovered that it was actually done after the section."

76. Dr. McCormack said that there were two phases, the initial phase of realisation accompanied by a constellation of emotional feelings that could be described as acute stress and this was followed by the development of a depressive disorder. It was difficult for the plaintiff to leave the house on her own, she was very nervous and very afraid of people. "There is fear in me all the time".

77. Dr. McCormack reported that Ms. Kearney would have wanted more children but was frightened of the complications that might ensue. She also complained of an inability to bond with her son in the early years. She experienced a profound sense of shock on reading the medical file. She felt very guilty, she felt that she had done something wrong. One of her first thoughts was that she should kill herself, so it just indicated that it had a very profound effect on her. Over the years this has become quite an entrenched feeling. Even though we all know it is not rational when we feel guilty after something wrong has been done. This has developed into

something of a delusional quality where she feels responsible. She would describe feelings of responsibility for allowing the operation to happen, she would feel that if she had done something different at the time, it would never have happened and she feels responsible then for all the difficulties that she experienced subsequently, with the difficulty she feels in the relationship with her husband, in depriving her husband of having more children and many other issues she feels guilty for. She feels somehow that it is due to some sort of inadequacy in herself and this relates to before she discovered that she had had the symphysiotomy.

78. Ms. Kearney had always felt that there was something wrong with her, that it was something inherently wrong with herself because she had all these physical problems. Then she discovered all of a sudden when she read the file that actually something had been done which caused all this, so she continued to feel that there is something wrong inside her. In fact, the feelings she described were very similar to the sort of feelings that somebody would have following a rape or an assault.

79. Ms. Kearney is completely dependent on her husband or someone else being present because in association with the depression she developed delusional beliefs that somebody is out to get her and is after her. She believes there is a man who drives around in a white van and is planning to abduct her and this sometimes disturbs her even at night. She also developed obsessional symptoms of having been assaulted and damaged inside and that she feels she is dirty inside. To compensate for that she has developed an obsessional neurosis, where she has to wash herself and she has at least six showers a day. Even though at one level Ms. Kearney is able to recognise that this is not rational, she still has the feeling and the compulsion.

80. Dr. McCormack's opinion is stated in his report as follows:-

> "Ms Kearney suffered from an acute stress disorder (DSM IV) when she discovered in 2002 that she had had a symphysiotomy operation. This involved a re-experiencing of symptoms and emotions associated with the original trauma ofthe symphysiotomy. This condition developed into a major depressive disorder with associated delusions. Ms Kearney is also suffering from associated symptoms of severe anxiety and obsessive-compulsive disorder. As a result, Ms Kearney is almost completely dependent on her husband for support and remains at significant risk of suicide.
>
> There is no indication that Ms Kearney would have developed such a condition otherwise.
>
> Given that her symptoms have been present and active almost 10 years, it is likely that these symptoms, or many of them, will persist indefinitely whatever the outcome of the case currently before the court.
>
> In summary, the psychological damage caused by Ms Kearney's experience of the symphysiotomy operation and her subsequent discovery of the fact many years later, has resulted in a severe mental illness which is likely to persist indefinitely."

81. In his evidence, Dr. McCormack painted a picture of a person with an extremely severe mental illness who also has suffered many years of pain and discomfort. He was not surprised that Ms. Kearney had felt depressed prior to 2002, in view of the long history of chronic physical pain. Depression or symptoms of depression are very common in people who suffer from chronic physical pain. He quoted the late Dr. Corry's view when he saw Ms Kearney that "currently she presents as a depressed, angry, distressed individual who is grieving for what she describes as a lost life".

82. Dr. McCormack confirmed that Ms Kearney's discovery in 2002 of what had happened to her presented a mixture of emotions including something of relief at the realisation that there was an explanation for her complaints and at the same time feelings of anger and resentment and shock and depression.

83. My conclusion is that Dr. Connolly altered the course of the plaintiff’s life irrevocably by carrying out this unnecessary operation. Ms Kearney has had a life of pain, discomfort and embarrassment as a consequence. She is an unfortunate example of the morbidity associated with symphysiotomy. Her reasonable expectation of enjoying a normal sexual and emotional relationship was destroyed. Similarly, her desire to have more children was frustrated. Ms Kearney's self-esteem was shattered; she blamed herself for the inadequacies and disappointments that resulted. She experienced victim's guilt. The revelation in 2002 that her life had been transformed by a deliberate act and not by natural causes brought its own extra quotient of misery. In sum, every aspect of Ms Kearney's activities of living has been affected. Her physical comfort, psychological health, family life and emotional well being have been taken away.

84. It is disturbing to consider how close this victim of grave medical malpractice came to being sacrificed on the altar of fair procedures. The case is a salutary proof of the balance that must exist between legal rights and protections in the interest of justice.

85. I assess general damages in the past in the sum of €300,000 and general damages in the future of €150,000.