THE COURT OF APPEAL

Neutral Citation Number: [2015] IECA 251

[Appeal No 2014/108

Article 64 Transfer]

The President
Kelly J.
Finlay Geoghegan J.

BETWEEN

MARY HEALY

APPELLANT

AND

BRENDAN BUCKLEY AND THE BON SECOURS HOSPITAL,

BON SECOURS SYSTEM

RESPONDENTS

JUDGMENT of the Court delivered by the President on 17th November 2015

Introduction
1. This is an appeal by the plaintiff, Ms. Healy, against the dismissal by the High Court of her claim for negligence against the defendants. The first defendant is a consultant endocrinologist who treated Ms. Healy between 1995 and 2001, during which period she received treatment in the second defendant's hospital.

Background Facts
2. The plaintiff was born in 1946 and is a married woman with three adult children. In September 1982, she was diagnosed as having a pituitary tumour. This misfortune was discovered following her admission to hospital in a distressed state with severe pain, headache and photophobia. Neurological examination revealed significant pathology and a CT scan showed an enlarged pituitary intra-sellar tumour extending to the left side with evidence of haemorrhage. A carotid angiogram showed a large central mass effect with distortion of the internal carotid and middle cerebral arteries.

3. On 29th September 1982, a left frontal temporal craniotomy with biopsy of the pituitary tumour was performed. Because of the vascularity of the tumour, only a very limited biopsy was taken and this showed a small amount of infarcted tissue.

4. The plaintiff's condition improved. She was continued on the medication that had been prescribed for her prior to the surgery – Bromocryptine – and she was also put on a drug for temporal lobe seizures that had developed as a result of the pressure of the tumour.

5. Up until 1992, the plaintiff was under the care of her neurosurgeon, Mr. Feely, who had carried out the craniotomy and biopsy. Although Mr. Feely had removed only a very small sample of the tumour tissue for testing and had left the large, troubling growth otherwise unaffected, the plaintiff believed that the opposite was the case. She formed the impression that Mr. Feely had removed almost all of the pituitary tumour, leaving only a tiny amount behind. This is relevant to the state of mind of Ms. Healy at the time when she was under the care of the first defendant, Dr. Buckley, in the circumstances that give rise to the proceedings.

6. Mr. Feely left his post in 1992, and thereafter Ms. Healy came under the care of another neurosurgeon, Mr. Marks, and subsequently of Dr. Teresa Mitchell, consultant endocrinologist.

7. In 1994, the plaintiff underwent a radical course of radiation of the tumour. In 1995, she left the care of Dr. Mitchell and her General Practitioner referred her to the first defendant, Dr. Buckley, another consultant endocrinologist. He admitted her to the second defendant's hospital and also arranged for an MRI scan in Dublin. He reviewed her medications and continued her on existing therapy plus another medication. Dr. Buckley continued to treat Ms. Healy over the subsequent years and decided in mid-2000 to admit her to the second defendant's hospital for tests to assess the status of the tumour. She was admitted on 14th August 2000.

8. On 15th August 2000, the plaintiff underwent an MRI scan at Cork University Hospital. The radiologist did not have the 1995 scan, nor the report, and on this occasion concluded that the plaintiff had a very large enhancing pituitary mass involving the left cavernous sinus and that the appearances were consistent with recurrence of her tumour. In fact, all the witnesses accepted that the August 2000 MRI scan did not show any significant change compared with the one in 1995.

9. On 5th September 2000, Dr. Buckley received the result of another test, IGF-1, that had been done during the plaintiff's admission. This was reported as reading 514 in a context where the normal range is 107 to 310.

10. Following her discharge from hospital on completion of the various tests, the plaintiff had been telephoning Dr. Buckley enquiring about the results. At around tea-time on 5th September 2005, in possession of the results, Dr. Buckley phoned Ms. Healy at home. The trial judge made a number of factual findings about this telephone conversation which he described as most unfortunate from the point of view of the professional relationship between the parties. He held that a very large part of the difficulties stemmed from the plaintiff's mistaken belief that Mr. Feely had removed the great bulk of the tumour, leaving only a very small part behind. Thus, it came as a great shock to her that she had a tumour of the size disclosed in the MRI scan. She took from that the incorrect information that the tumour had begun to grow again and was progressing rapidly. The judge was quite satisfied from the evidence that Dr. Buckley did not tell Ms. Healy that the tumour was progressing or growing, but he did tell her that it was very unsatisfactory. He also told her about the excess secretion of growth hormone, as revealed in the IGF-1 test. These two pieces of information were

sufficient to cause the plaintiff to be alarmed about what she thought was a severe deterioration of her health.

11. In this conversation, Dr. Buckley positively recommended the drug Sandostatin LAR which had relatively recently become available and which was effective in reducing excess growth hormone levels and he hoped it would also reduce the size of the tumour. Dr. Buckley's view was that the IGF-1 test was the indication for the use of the drug. This was an opportunity of using active treatment to alleviate Ms. Healy's condition. Ms. Healy had a distaste for injections and had previously had radiation. The use of a different form of this particular drug had been rejected previously, but now it was available in this long-lasting form which involved an injection once a month.

12. Ms. Healy agreed to take the drug and the doctor sent her a prescription. She had her first injection, given by her General Practitioner, on 8th September 2000, but soon afterwards, she began to experience vomiting and diarrhoea. She saw Dr. Buckley in his office on 18th September 2000, when he reduced the drug dosage by half.

13. At the beginning of October 2000, Ms. Healy had her second injection. She had a hospital admission for an unrelated matter, but the hospital notes do not indicate any complaint of gastrointestinal problems at that time. Ms. Healy had her third injection, as planned, four weeks later. On 30th November 2000, she was admitted to the Bon Secours Hospital for another different unconnected medical procedure, and again, the hospital notes do not disclose any complaint. However, by the end of December 2000, the plaintiff had become very ill and was referred to hospital by her General Practitioner and admitted to the Bon Secours on 2nd January 2001. She was complaining of severe vomiting and diarrhoea, exhaustion, headaches, cramps and muscular spasms. During this admission, there was a meeting or an encounter, as the trial judge described it, between Ms. Healy and Dr. Buckley which was the subject of controversy during the trial. The plaintiff reacted badly to a suggestion by the doctor that she might have been suffering from depression.

14. During Ms. Healy's period in hospital on this occasion, it was noted that she was suffering from hypothyroidism and it appears that this was the reason for her deterioration in health. It was not then appreciated, but is now known, that hypothyroidism is a side-effect of this form of the drug. The plaintiff did not have the injection of Sandostatin LAR due in January 2001, but she did have injections at the beginning of February and also at the beginning of March 2001.

15. The plaintiff attended at the Cork clinic on 20th February 2001, when she saw Dr. Buckley in the presence of her husband. Thereafter, she decided to discontinue being treated by Dr. Buckley and her General Practitioner referred her to another endocrinologist.

The High Court Judgment

16. The trial judge identified two essential issues that arose in the case, which are also the heart of this appeal. The first is whether Dr. Buckley was negligent in prescribing Sandostatin LAR for Ms. Healy in September 2000 and thereafter. The second is whether the plaintiff's consent to accept the treatment was vitiated by lack of sufficient information or misrepresentation concerning her condition and the appropriateness of the particular drug as a treatment for it. The judge also addressed other criticisms of Dr Buckley including his management of the patient during the time when she was on the drug treatment that he had prescribed.

17. Having identified the issues to be considered, the trial judge turned to an analysis of the evidence. He considered in detail the expert evidence in relation to the various criticisms that were made of Dr. Buckley's prescribing of Sandostatin LAR for Ms. Healy. The plaintiff's experts were a consultant in clinical oncology and a consultant neurologist but the trial judge took the view that the defendant's two experts, each of whom was a consultant endocrinologist, were more qualified to give evidence and he generally preferred their evidence. Neither of the plaintiff's experts had ever actually prescribed the drug in question in this case, whereas the defendant's experts were familiar with its use in clinical practice.

18. The judge went through the different criticisms and considered the evidence of the experts and rejected in turn the various allegations made on behalf of the plaintiff against Dr. Buckley. He introduced the consideration of the case by quoting the tests for medical negligence, as outlined by the Supreme Court in *Dunne v. National Maternity Hospital*, and he also cited the drug prescription sheet issued by the manufacturers.

19. The judge was satisfied first that Dr. Buckley was correct in prescribing the drug in its long-acting form on the basis that the plaintiff was hyper-secreting growth hormone at the time and was biochemically acromegalic. Secondly, he held that Dr. Buckley complied with the therapeutic indications in the data sheet issued by the drug manufacturer. Thirdly, it was appropriate to use the LAR form of the drug as opposed to the subcutaneous injection version. Fourthly, and finally on this issue in the case, the judge held that there was not any failure on the part of Dr. Buckley in monitoring the plaintiff after the treatment commenced in September 2000.

20. On the consent issue, the judge found that Ms. Healy's consent to treatment of Sandostatin LAR was a valid informed consent which was not vitiated by a lack of sufficient information concerning her condition at the time or the appropriateness of Sandostatin LAR as a treatment for it. Dr. Buckley did not breach his duty of care to Ms. Healy in the information and advice given to her and there was no failure to give warnings concerning the harmful risks or potential side effects from her treatment such as to vitiate her consent. Dr. Buckley did all that was necessary to procure from Ms. Healy an informed consent to treatment.

21. The judge held that Sandostatin LAR was a therapeutic option which was correctly and appropriately offered to Ms. Healy. She was told of the likelihood of the main then known side effect of the drug, namely gastrointestinal upset including vomiting and diarrhoea. Dr. Buckley's conduct in dealing with Ms. Healy over the phone did not constitute a failure on his part to observe a standard of care appropriate to his status and specialisation. Notwithstanding the fact that the appellant's tumour was stable there was no doubt as the judge considered that it continued to have a potential to do great harm to her health and it would have been unacceptable to do nothing if a treatment option was available.

22. Given the success rate of 60% to 65% of Sandostatin in reducing excess growth hormone levels, Dr. Buckley was not only entitled but was professionally obliged to present the treatment and offer positive encouragement to undergo it. Dr. Buckley could not have told her about the risks of developing hypothyroidism as a side effect because it was not known then and did not fail in his professional duty of care to mention a risk of interference with hepatic function or of gallstones. Ms. Healy undertook the treatment with full knowledge of the side effects.

23. The judge held that Dr. Buckley was not aware of Ms. Healy's misunderstanding about her tumour and could not be blamed for the deficiencies in her knowledge of her condition. There was no evidence to support fixing Dr. Buckley with blame for Ms. Healy's lack of awareness of the true state of her tumour. The problem that emerged in the professional relationship stemmed not from anything inappropriate said or omitted by Dr. Buckley but from the state of mind of Ms. Healy at the time concerning her condition.

The Appeal

Grounds
24. The Notice of Appeal lists 42 grounds, some of which have many paragraphs and subdivisions.

25. Ground 1 is a general allegation that the trial judge did not have regard to evidence given by Dr Buckley and his expert witnesses in cross-examination. Grounds 2 (a) to (d) for the most part cite facts which the judge is criticised for failing to find but which were not in dispute or are implicit in the judgment or are irrelevant to the issues or are matters of comment. These are not proper grounds of appeal.

26. The grounds in respect of informed consent are numbered 3 to 21. The essence is that Dr. Buckley knew that Ms. Healy believed that only a small remnant of her tumour remained after the surgery of 1982; he failed to tell her that the tumour was stable and had not changed for some 18 years; that the radiation treatment she had had previously would become operative over a future period of years and so she might adopt a wait-and-see attitude. The doctor thereby conveyed to the patient the impression that her condition had deteriorated alarmingly, as a result of which Ms. Healy agreed to the proposed drug therapy. The doctor also failed to convey other relevant factual material to the plaintiff about her condition, about the prospects of successfully using the drug and about complications in addition to the potential gastro-intestinal side-effects that he did describe. These grounds reflect a detailed analysis of the findings made by the learned trial judge in his judgment and a challenge to each one by reference to the evidence that the judge did not accept or rejected in favour of other evidence or because the judgment does not contain an express reference to the testimony favouring the plaintiff's case.

27. Grounds 22 to 31 cite alleged errors in law and fact in the findings of the trial judge concerning the recommendation by Dr. Buckley of Sandostatin LAR. The plaintiff complains that the judge was not entitled on the evidence to hold that Dr. Buckley was justified in prescribing this treatment having regard to the presenting condition and that he followed the manufacturer's recommendations. Ground 31 returns to the question of consent by proposing that if there was another reputable medical opinion besides the one Dr. Buckley was following, the doctor was obliged to put before the patient the advantages and disadvantages of each school.

28. Grounds 32 to 42 concerned the management of the plaintiff when she was taking the drug.

29. Some comment should be made about the approach adopted by the appellant in this case. There is no question about her entitlement to appeal but the manner in which the appeal is presented is unreasonable and unjustified. Most of these grounds are unsustainable and many of them are clearly excluded by the jurisprudence on appeals in respect of findings of fact by the trial judge. The effect of such a multiplicity of complaints is to undermine the value of any reasonably maintainable complaints. The appellant added a complaint in submissions that the judgment was inadequate because it failed to provide a reasoned decision thereby rendering the trial unfair, a criticism that is itself unfair in respect of the substantial judgment delivered by the trial judge.

Submissions
30. In written submissions, the appellant asserted that the judge incorrectly took the view that the plaintiff did not have the right to choose to make an informed decision in the exercise of her personal autonomy. An informed consent in relation to treatment with a toxic drug could not be obtained from a brain tumour patient by telephone conversation.

31. The appellant submitted that the trial judge failed to have any regard to unequivocal statements of evidence of medical professionals which favoured the appellant's contentions in the action. Moreover, the learned trial judge proceeded on the basis of inappropriate value judgments which were completely inconsistent with the requirement of informed consent to treatment.

32. The appellant submitted that the trial judge failed to address how the plaintiff could have given her informed consent to treatment with Sandostatin LAR when both the plaintiff's experts and the defendants' experts all agreed that there was no necessity for this means of communication and that attempting to obtain an informed consent from the plaintiff by a telephone conversation in a matter of such complexity with the extent of the information which had to be conveyed to and understood by the plaintiff was a departure from the appropriate standard. The trial judge ought to have addressed how the telephone conversation could have resulted in an informed consent to treatment when the plaintiff was fundamentally mistaken as to her clinical condition (to the knowledge of Dr. Buckley) believing it had greatly deteriorated leaving her with no choice but to take the drug when the reality was that her pituitary tumour was stable and had been since 1982, according to the appellant.

33. The appellant submitted that the right of the patient imposed a duty on the medical practitioner to provide her with the information and explanation which was necessary to make an informed choice to accept or refuse the proposed treatment. The duty is not limited to one of providing appropriate information in relation to the proposed treatment because the patient may not understand that information. The duty is to ensure that the patient is informed so she understands and can make an informed decision. The requirement is one of informed consent based on informed choice. For the plaintiffs consent to have been informed she had to know and understand the nature of the condition for which she required treatment, the extent of her need for treatment, the options for treatment, what each treatment option entailed and the benefits and risks of adverse consequences attaching to each treatment option including that of doing nothing.

34. Dr. White, S.C. for the appellant expanded on these arguments at the hearing. He submitted that the Court was not restricted in its approach to the findings of fact made by the trial judge because there are matters of inference on which it was open to the Court to differ. He argued that there was no clinical basis for prescribing the drug and the trial judge was in error in holding that there was.

35. On the question of consent, Dr. White maintained that Dr. Buckley knew that Ms. Healy believed that the great bulk of her tumour had been removed in 1982. The doctor's duty was not just to inform the patient but to ensure that she understood. He also referred to the criticisms of Dr. Buckley in respect of monitoring and supervision.

Dr. White referred in argument to a case from the United States District Court: *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972). The following excerpts are relevant.

> "The root premise is the concept, fundamental in American jurisprudence, that 'every human being of adult years and sound mind has a right to determine what shall be done with his own body. . . .' True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each. The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision. From these almost axiomatic considerations springs the need, and in turn the requirement, of a reasonable divulgence by physician to

patient to make such a decision possible.

A physician is under a duty to treat his patient skillfully but proficiency in diagnosis and therapy is not the full measure of his responsibility. The cases demonstrate that the physician is under an obligation to communicate specific information to the patient when the exigencies of reasonable care call for it. Due care may require a physician perceiving symptoms of bodily abnormality to alert the patient to the condition. It may call upon the physician confronting an ailment which does not respond to his ministrations to inform the patient thereof. It may command the physician to instruct the patient as to any limitations to be presently observed for his own welfare, and as to any precautionary therapy he should seek in the future. It may oblige the physician to advise the patient of the need for or desirability of any alternative treatment promising greater benefit than that being pursued. Just as plainly, due care normally demands that the physician warn the patient of any risks to his well-being which contemplated therapy may involve.

The context in which the duty of risk-disclosure arises is invariably the occasion for decision as to whether a particular treatment procedure is to be undertaken. To the physician, whose training enables a self-satisfying evaluation, the answer may seem clear, but it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie. To enable the patient to chart his course understandably, some familiarity with the therapeutic alternatives and their hazards becomes essential.

A reasonable revelation in these respects is not only a necessity but, as we see it, is as much a matter of the physician's duty. It is a duty to warn of the dangers lurking in the proposed treatment, and that is surely a facet of due care. It is, too, a duty to impart information which the patient has every right to expect. The patient's reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arms length transactions. His dependence upon the physician for information affecting his well-being, in terms of contemplated treatment, is well-nigh abject. As earlier noted, long before the instant litigation arose, courts had recognized that the physician had the responsibility of satisfying the vital informational needs of the patient. More recently, we ourselves have found "in the fiducial qualities of [the physician-patient] relationship the physician's duty to reveal to the patient that which in his best interests it is important that he should know." We now find, as a part of the physician's overall obligation to the patient, a similar duty of reasonable disclosure of the choices with respect to proposed therapy and the dangers inherently and potentially involved.

This disclosure requirement, on analysis, reflects much more of a change in doctrinal emphasis than a substantive addition to malpractice law. It is well established that the physician must seek and secure his patient's consent before commencing an operation or other course of treatment. It is also clear that the consent, to be efficacious, must be free from imposition upon the patient. It is the settled rule that therapy not authorized by the patient may amount to a tort -- a common law battery -- by the physician. And it is evident that it is normally impossible to obtain a consent worthy of the name unless the physician first elucidates the options and the perils for the patient's edification. Thus the physician has long borne a duty, on pain of liability for unauthorized treatment, to make adequate disclosure to the patient. The evolution of the obligation to communicate for the patient's benefit as well as the physician's protection has hardly involved an extraordinary restructuring of the law."

36. In respect of the multiplicity of grounds of appeal, the respondent supplied a folder of relevant transcript references for the purpose of answering the factual assertions and allegations. These materials went far to establish the basis in evidence for the findings made by the trial judge.

37. The respondent submitted that the trial judge was entitled as a matter of fact on the evidence before the court to find that there was no negligence on the part of the respondents in any aspect of the treatment of the appellant with Sandostatin LAR. In light of *Hay v. O'Grady* [1992] I.L.R.M. 689 findings of fact in the High Court are not open to challenge unless they are unsupported by the evidence or the findings are not reasonably arrived at having regard to the evidence. Furthermore, the trial judge was also entitled to find as a matter of fact that the appellant's consent to the treatment was a valid informed consent and all findings made by the trial judge were supported by evidence.

38. In response to the submission that the judge failed to provide a reasoned decision the respondent submitted that the extensive judgment identified the issues arising, identified the relevant legal principles to be applied, summarised the evidence adduced and gave a reasoned decision for the findings made including the reasons as to why he preferred some evidence over other evidence. It was submitted that neither of the experts who gave evidence on behalf of the appellant were endocrinologists or had ever proscribed the drug Sandostatin LAR. The respondent submitted that it was made clear that the Sandostatin option was the most practical and feasible of the options available and the decision to prescribe Sandostatin was wholly justified on the basis of the evidence.

39. The evidence supported a finding that Dr. Buckley advised the appellant of the benefits of the drug prior to the commencement of treatment. She was cautioned about gastro intestinal problems and the potential diarrhoea associated with the drug. Dr. Buckley had never encountered the side effect of thyroid hormone dysfunction with a patient with whom he had prescribed Sandostatin LAR. His evidence was that he did not know at the time that the drug could cause hypothyroidism. Furthermore the data sheet in 2000/2001 did not mention in the "undesirable effects" any adverse effect of thyroid function. The respondent argued that the side effect was a desired side effect in the circumstances in that it controlled the over production of thyroid stimulating hormone. All in all, the finding that there was no failure on the part of Dr. Buckley to give advice and warning to the plaintiff concerning the side effects of the treatment such to vitiate the consent given by the plaintiff was wholly supported by the evidence.

40. In his presentation on behalf of Dr. Buckley, Mr. Eugene Gleeson S.C. argued that the clinical findings present at the time justified the recommendation and prescription of Sandostatin LAR. The plaintiff was secreting excessive growth hormone, which represented a condition of biochemical acromegaly. In regard to the evidence in the case, it was significant he suggested that the plaintiff had not called a specialist endocrinologist to testify.

41. Counsel pointed out that the context of the phone call made by Dr. Buckley to Ms. Healy was that she had been calling to know about her test results. The doctor saw the availability of this form of the drug as an opportunity to effect a significant improvement of the serious conditions from which the patient was suffering. Referring to the case of *Bolton v. Blackrock Clinic* (unreported Supreme Court 23rd January 1997) he submitted that the clinician had some latitude in regard to a particular patient as to the manner in which he communicated information and that it was important that a patient should not be confused by being inundated with information about small risks. He was critical of what he called the shopping list, namely, the extensive catalogue of information to be supplied to a patient that he suggested was the basis of Dr. White's argument.

42. Fundamentally, the respondent's position was that the findings made by the trial judge were grounded in the evidence given at

the trial, that the judge had carefully considered all the elements of fact and law in the case and that his conclusions were unimpeachable.

Discussion
43. In regard to the approach that this Court takes to the appeal, in *Hay v. O'Grady* [1992] I.L.R.M. 689, the Supreme Court declared that an appeal court is bound by findings of fact made by the trial judge which are supported by credible evidence, even if there appears to be a preponderance of testimony against them. This is because the trial judge has the advantage of hearing the evidence and observing the manner in which it is given and the demeanour of the witnesses. Where inferences of fact are derived from oral evidence the appeal court should be slow to differ. However, the appellate tribunal is in as good a position as the trial judge in drawing inferences from circumstantial evidence.

Treatment: Prescription of Sandostatin LAR
44. There is no basis for criticising the findings of the trial judge on this aspect of the case dealing with the prescription by Dr. Buckley of Sandostatin LAR for the plaintiff. The judge found that the clinical indications were present; that the doctor complied with the instruction sheet as issued by the manufacturer and that his practice was in accord in prescribing the drug and in the particular form that he directed with that of a body of medical opinion of appropriate expertise. In fact, the evidence of the defendant's expert endocrinologists was that his treatment was entirely appropriate. In other words, it was not simply that there was a body of opinion that held a view supportive of the course taken by Dr. Buckley, but rather that the expert evidence that the judge accepted was that the clinical practice adopted by Dr. Buckley was entirely appropriate in the circumstances, having regard to the symptoms displayed by Ms. Healy and her test results.

45. It was open to the trial judge to reach the conclusions that he did on the evidence that he heard. His preference of the defendant's experts is rationally grounded and the judge's rejection of the criticisms made on behalf of the plaintiff in respect of Dr. Buckley's treatment is based on careful consideration of the evidence.

46. It is not open to an appeal Court to overturn findings of primary fact made by a trial judge if they are based on the evidence heard in the course of the trial. Most cases involve inferences of fact derived from the evidence. It is open to a party on an appeal to invite the Court to depart from the inferences drawn by the judge at trial but the Court will be slow to interfere when the inferences are legitimately drawn and based on the evidence and are not impeachable as a matter of logic or reasoning. This Court must accordingly afford weight to the inferences drawn by the trial judge. In respect of other matters, such as documentary evidence, where the appeal Court is in as good a position as the trial judge, no such inhibitions apply.

47. In the judgment of the Court, it is unnecessary in this case to invoke any of these precepts to buttress the trial judge's conclusions on this part of the case. The judge's findings are obviously based on the evidence; they are justified by reference to the expert testimony and by rational analysis and his conclusions are, in the circumstances, unimpeachable.

Consent
48. The leading judgments on the issue of consent are those of Kearns J in the High Court in *Geoghegan v. Harris* [2000] 3 I.R. 536 and the Supreme Court decision in *Fitzpatrick v. White* [2008] 3 I.R. 551.

49. In *Geoghegan* Kearns J. held that the defendant was obliged to give a warning to the plaintiff of any material risk which was a known or a 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. 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. When deciding whether or not a warning would cause a patient to forego an operation, the court was to first adopt an objective test. The test was to yield to a subjective test where there was clear evidence in existence from which a court could reliably infer what a particular patient would have decided. It was further held that 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.

50. The Supreme Court in *Fitzpatrick* approved the judgment in *Geoghegan* and stated that the consent must be voluntary, must involve the requisite mental capacity and must be informed. The material risks must be disclosed and, when considering what a material risk is, the doctor must consider the statistical frequency of the risk and the severity of the consequences. The 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. The court will then apply a subjective test and consider whether, if the appropriate warnings were given, the patient would have proceeded with the treatment.

51. In his judgment, O'Neill J. cited passages from *Geoghegan v Harris* [2000] I.R. 536 commencing with the head note summarising the conclusions of the court:

> *"Held by the High Court (Kearns J.)*
>
> *1. That 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 this case was extremely remote it was a known complication and a warning of the risk was required. (Walsh v. Family Planning Services Ltd [1992] 1 I.R. 496 applied.*
>
> *2. 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. Walsh v. Family Law Planning Services [1992] 1 I.R. 496 considered.*
>
> *3. That, when deciding whether or not a warning would cause a patient to forego an operation, the court was first to 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 reliably infer what a particular patient would have decided.*
>
> *4. That no category of inquisitive patient existed in Irish law because of the onerous obligations imposed on the medical provision to warn patients of all risks with severe consequences regardless of their infrequency."*

At p. 549 of the report Kearns J. said the following:

"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 a right to know and the practitioner a duty to advise of all material risks associated with the proposed form of treatment. The court must ultimately decide what is material. 'Materiality' includes considerations 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 be to be regarded as insignificant 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 risk, 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.

The decision in Walsh v. Family Planning Services Ltd [1992] 1 I.R. 496 effectively confines the test of materiality to severity of consequences only. This approach is best encapsulated in the memorable passage of McCarthy J. when he stated at p. 521:

> *'…those concerned…if they knew of such a risk, however remote, had a duty to inform those who are critically concerned with that risk. Remote percentages of risk lose their significance to those unfortunate enough to be 100% involved.'*

However, the attractiveness of the observation should not occlude the possibility that at times a risk may become so remote, in relation at any rate to the less and most serious consequences, that a reasonable man may not regard it as material or significant. While such cases may be few in number, they do suggest that an absolute requirement for disclosure in every case is unduly onerous, and perhaps in the end counter productive if it needlessly deters patients from undergoing operations which are in their best interests to have.

As pointed out by Mr. John Healy in his book "Medical Negligence Common Law Perspectives" at p. 99:

> *'Materiality is not a static concept.'*
>
> *If the assessment of materiality is to "abide a rule of reason" any absolute requirement which ignores frequency seems at variance with any such rule.*
>
> *Each case it seems to me should be considered in the light of its own particular facts, evidence and circumstances to see if the reasonable patient in the plaintiff's position would have required a warning of the particular risk."*

Further, on in his judgment at p. 559 Kearns J. says the following:

> *"A reasonable patient would then place in the balance of making any decision the benefits associated with the procedure....*
>
> *Commencing with the objective test, it seems to me that had a proper warning been given by the defendant to a reasonable patient in the plaintiff's position such a reasonable patient was more likely, for the reasons stated, to have proceeded with the operation. However, as a credible and reliable picture emerges overall and analysing the evidence particular to this case, the issue can and must be resolved by reference to the subjective test of what the plaintiff himself can as a matter of probability would have done…"*

Earlier in the judgment at p. 550 under the heading 'Causation' Kearns J. said the following:

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

Discussion: Informed Consent

52. The trial judge held that the impression the plaintiff took from the telephone conversation with Dr. Buckley on 5th September 2000 was that her condition had deteriorated alarmingly and that her heath was in grave peril. However, he did not think that the first named defendant could be blamed for that impression because he simply did his duty to the patient to convey full and accurate information to her concerning her condition. The plaintiff's belief that she would be in big trouble as to her health was not the result of misinformation or wrong advice given by the doctor. The judge found that Dr Buckley was not aware of the plaintiff's state of knowledge concerning her tumour and could not be blamed for the deficiencies in her knowledge of the condition.

53. The appellant submits that the trial judge erred in finding that Dr. Buckley was not aware of the plaintiff's misunderstanding and argues that the doctor actually acknowledged in cross-examination that that was probably the case. On this factual point, there appear to be different passages in the evidence and that the High Court was entitled to reach the conclusion it did. In direct examination and in cross-examination, Dr. Buckley referred to what he knew at the time and what he now believed was the case in light of the evidence of Ms. Healy and of his study of the documents in the case in preparation for the trial. In the fullest answer that he gave on this question, he said in cross-examination:

> "I told her that her tumour was large and that we had the opportunity to treat it. However, judge, I'm not clear at this remove as to my understanding up to then of what Mrs Healy thought her tumour was or how big it was. I suppose my recollection now is conditioned to some extent by minute examination of the papers leading up to this case. So my understanding of Mrs. Healey's understanding of her tumour size at the time I'm just not very clear on. But certainly in retrospect it is now evident to me that she thought her tumour was then small, a residue, and I told her that it was large enough to require exercise of the opportunity to treat it."

54. The judgment says that the plaintiff's lack of awareness of the true state of her tumour was "surprising if not extraordinary".

55. This conclusion was made by the trial judge with the benefit of observing the witnesses, considering not just their words as recorded in the transcript but the manner in which they gave the evidence in direct questioning and cross-examination. Having regard to the transcript references on this point, it seems to the court at the least that the appellant is not correct in asserting that this was a clear error which it is open to this court to rectify.

56. If the trial judge's finding that Dr. Buckley did not know of the misunderstanding is correct or protected from review by *Hay v. O'Grady* considerations there is no basis for criticising the doctor because Ms. Healy became alarmed at his accurate information about the tumour and hormone discharge.

57. It is clear on the evidence that whatever Dr. Buckley knew about Ms. Healy's view of her tumour, he would still have recommended Sandostatin LAR treatment because he was dealing with objective symptoms. There is ample evidence to justify the concern the doctor had about the tumour and the hormone discharge. On the findings of the trial judge, Ms. Healy needed the drug irrespective of what she believed. If she had been informed of the correct situation as proposed, namely, that the doctor was indeed worried about the tumour and the discharge but that the situation had not changed since her operation biopsy in 1982, she would not or may not have been alarmed but might have been concerned and upset about the misunderstanding that she had.

58. In the circumstances, as found by the trial judge, Dr. Buckley's behaviour in regard to consent does not fall foul of the general test of medical negligence in *Dunne v. National Maternity Hospital* and the decision on consent in *Geoghegan v. Harris*.

59. The law on consent to medical treatment has been developing in other jurisdictions, as the case that counsel cited from the United States District Court, *Canterbury v. Spence*, demonstrates. In the neighbouring jurisdiction the latest decisions in the UK Supreme Court, including *Montgomery v Lanarkshire Health Board (General Medical Council intervening)* [2015] UKSC 11 reflect enhanced status of the patient as the chooser of treatment. However, Counsel correctly did not seek to rely on that particular decision which was given only in March 2015. Any such changed standard cannot be imposed on Dr. Buckley in Cork in 2000. The law on consent in this jurisdiction may require to be re-considered in the light of developments, especially in regard to the patient's capacity to choose between treatment and no treatment. However any expansion of patient power will require careful delineation. Having said that, it would be quite unjust to apply a new standard to Dr. Buckley's treatment 15 years ago.

60. The judge found that the doctor discussed the principal known side effect from this drug, namely, gastrointestinal upset involving vomiting and diarrhoea during the phone call and subsequently in the consultation which occurred on 18th September 2000 that came about because of the plaintiff's experience of gastric upset.

61. Dr. Buckley spoke to Ms. Healy on three occasions in relation to the treatment: the phone call to her home, in his rooms with her husband and at the Cork Clinic again with Mr. Healy present. He did not tell Ms. Healy that the tumour was stable and that it was the same as it had been since 1982 i.e. for 17 years. Dr. Buckley denied that he told the patient that the tumour was growing. It could be, as he acknowledged, that the patient held her mistaken belief and concluded from his statement that she had a large tumour and that the situation had therefore deteriorated. Any such deduction that she made did not come from him, Dr. Buckley insisted.

62. Dr. Buckley thought that this large tumour was dangerous and that here was an opportunity to treat it with a drug that was effective to stop the secretions and to reduce the size. Ms. Healy was not suitable or would not tolerate surgery or any more radiotherapy, so the drug was an attractive, effective option. The doctor told her as much. She agreed to the treatment. That is his case.

63. The doctor was of opinion that the patient had a serious condition that needed to be treated; that other options were not available and that this effective drug therapy was available. He told her about it and warned her as to unpleasant side effects. On the evidence, it was reasonably open to him to hold that view.

64. The option of doing nothing is always available to a patient. Counsel for the appellant, Dr. White S.C. places much emphasis on this point. He submits that it was Dr. Buckley's duty to lay this before Ms. Healy as an option to be considered against the drug therapy he was prescribing for her. Indeed, that should not have been the situation, according to Counsel. The relationship should not have been as it was, with Dr. Buckley as the professional prescribing what treatment the patient was going to get. She should have been exercising a choice between different options that the doctor laid out before her, with the pros and cons of each being described by the doctor.

65. It seems to us that this is somewhat unreal. It is true that there is an option to do nothing, but when a person visits a specialist doctor on referral from her General Practitioner, it may reasonably be assumed that she wishes to receive medical treatment for her condition. There is a sense in which she has chosen to do something about her condition and to have excluded the "do nothing" option.

66. When the plaintiff has a serious medical condition and has presented herself to the doctor through the agency of her general practitioner in quest of treatment to alleviate her condition, it is difficult to see how he ought to be considered negligent for not debating the merits of doing nothing as compared with treatment that is effective, minimally invasive and safe i.e. not known to pose a grave danger to her life or health. The evidence here is that the doctor had become aware of the availability of this depot form of the drug and he strongly recommended it but warned about side effects that actually came about.

67. It is possible that there is confusion here. If the choice was between performing a difficult and dangerous operation to remove or reduce the tumour surgically, it seems obvious that the surgeon would and should discuss in detail the various options. They would include, in particular, doing nothing. A surgeon would very likely be held negligent if he failed, without strong reason, to inform the patient of the pros and cons of not intervening as compared with the potential benefits of operating, and also the percentages of failure and success if known and applicable. But the situation in this case was very different. The doctor recommended what he reasonably believed to be good, effective drug treatment. The nature of the risk was unpleasant consequences and the potential benefit from the treatment was substantial. A doctor cannot be held negligent for not knowing or discovering that plaintiff has a mistaken belief about her condition, when there is nothing to indicate that to him. As said above, the fact that a patient is going to this specialist is already in some sense an implicit rejection of that do "nothing option" in these particular circumstances.

68. It is not indisputably accurate to say that the plaintiff's tumour was stable. Dr. Buckley did not accept that it was stable. True, it had not increased in size over the period of years but he was of opinion that the tumour was a major health risk to Ms. Healy and that this drug was an effective therapy, which was minimally invasive. He told her about the known material risks. Any other known possible consequences were not material and did not happen. The then unknown effect of hypothyroidism did affect Ms. Healy and

was the reason for her acute admission to hospital.

69. The doctor was not obliged to discover that Ms Healy was under a misapprehension about her condition and then to persuade her of the true situation. The advice he gave her was in fact correct insofar as he described the treatment and the potential side effect which actually eventuated. As to other side effects, either they did not happen and therefore no case can be based on them, or – as in the case of hypothyroidism – it was not known to occur in relatively short-term treatment.

70. In our view, the trial judge was entitled to find and was correct in finding that the doctor was not negligent in regard to consent.

71. In light of our conclusions on the issues raised, the appeal is dismissed.