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Judgment: approved by the Court for handing down | *Delivered:* **21/11/13**

*(subject to editorial corrections)**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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QUEEN'S BENCH DIVISION

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BETWEEN:

JOHN SELFRIDGE

Plaintiff;

-and-

THE NORTHERN HEALTH AND SOCIAL CARE TRUST

Defendant.

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GILLEN J

Introduction

[1] The plaintiff's claim in this case is against the defendant for personal injuries loss and damage sustained by reason of the negligence of the defendant in and about the failure to diagnose, repair and treat the symptoms of a bile leak until 14 November 2006.

[2] The plaintiff had symptomatic gallstones. On 16 October 2006 he was admitted for a planned day case laparoscopic cholecystectomy (hereinafter called "the laparoscopy"). The operation was performed under a general anaesthetic and the operation note recorded "5 ports direct access 2 x 10(mm), 3 x 5(mm) gallstones in gallbladder. … washed out with saline. "

[3] The events that occurred thereafter were the subject of close scrutiny by two distinguished consultants in this case namely on behalf of the plaintiff Mr McCloy FRCS consultant surgeon and endoscopist and on behalf of the defendant Mr Mackle FRCS consultant surgeon.

[4] Following the now accepted convention, the two experts met well in advance of the trial and produced a joint report of their meeting.

The Joint Report of the Experts' Meeting

[5] This meeting has allowed the court and the parties to narrow the issues very considerably in this case.

[6] A number of matters were agreed between the experts. First, pursuant to the laparoscopy on 16 October 2006, the plaintiff developed a bile leak. Mr Mackle considered that the bile leak was only small and that there was also blood leaking from a haematoma. Mr McCloy agreed that as well as bile there would be a small amount of blood after any laparoscopy cholecystectomy but there was no evidence of haematoma. The experts agreed that the leak of bile and blood had occurred within the first 24 hours after the operation, albeit the quantities were small.

[7] The experts further agreed that on the first post-operative day 17 October 2006 Mr Selfridge's blood profile revealed a grossly raised white cell count of 36.6 (normal up to 11.0) and a raised CRP (C-Reactive Protein) at 259 (normal up to 5). The experts discussed these grossly raised inflammatory markers and Mr Mackle expressed the opinion that this was evidence of an infected haematoma/blood clot which was further evidenced by the elevation of D-Dimer levels (which come from venous blood clots) on 19 October 2006. Mr McCloy opined that 24 hours was too early to get such gross infection so that the white cell count would be as high as 36.6 and that such levels would be expected from a more mature abscess. He felt that the associated grossly raised CRP supported a conclusion of inflammatory effect from leakage of bile which is very irritant to the abdominal cavity. However, both agreed that there was both blood and bile leaking.

[8] An ultrasound scan (USS) was carried out on 18 October 2006 which showed a tiny amount of fluid around the liver and small pleural effusions. Mr McCloy considered that these changes were sympathetic to irritation of bile in the abdominal cavity whilst Mr Mackle considered these findings were sympathetic to infection below the diaphragm and that a small haematoma would not have shown on the USS.

[9] In light of the findings from the previous blood tests and the ultrasound scan, on 18 October 2006, Mr McCloy would have performed a CT scan to define the extent and site of fluid collections within the abdomen. Mr Mackle agreed the CT scan was more sensitive in identifying fluid collections but felt that a USS was acceptable imaging at that stage and the plan would be to watch and treat with antibiotics.

[10] Both experts concurred that therapeutic intervention was indicated on 19/20 October 2006. Mr Mackle considered that percutaneous ultrasound-guided drainage should have been invoked on 19/20 October 2006 and if blood with or without bile was obtained by drainage then reoperation by open surgery was indicated on Thursday 19 October or by early morning Friday 20 October.

[11] Mr McCloy considered that following the findings from the consultant medical review on 19 October 2006 and the repeat USS that was performed that day, a laparoscopy should have been performed on Thursday evening or Friday morning 20 October at the latest. The preferred surgical intervention should have been laparoscopy and wash out and that this would have been performed by the majority of surgeons.

[12] In the event no such therapeutic intervention occurred on 19/20 October 2006. CRP remained raised throughout the following days although somewhat reduced and the liver function tests were still raised. He was discharged from the hospital on 25 October 2006 on oral antibiotics.

[13] Mr Selfridge's evidence before me was that subsequent to his discharge, he was still suffering pain but not as bad as it had been whilst he was on the antibiotics. However, once the antibiotics stopped, the pain returned and became very severe. He was readmitted as an emergency to Causeway hospital on 13 November 2006. A CT scan on 14 November 2006 showed a very large low attenuating fluid collection anterior to the right lobe of liver extending to the gallbladder fossa where there was a further large attenuating collection.

[14] Accordingly, on 14 November 2006 an emergency laparotomy and drainage of the abscess was carried out.

[15] In the period of his post-operative recovery, which was slow, the plaintiff had the appearance of bile draining from one of his drains which eventually dried up as did the drain discharge. He was discharged home on 13 December 2006.

[16] An outpatient review on 16 January 2007 noted that he was doing extremely well and was keen to go back to work.

The issue before me

[17] It is therefore common case between the experts that therapeutic intervention should have taken place on 19/20 October 2006. Accordingly, it was agreed that "the main loss as suffered by Mr Selfridge was due to the delay in treatment rather than a differential diagnosis as to whether there was blood or bile present in the peritoneal cavity". If intervention had happened then Mr Selfridge would have avoided the four weeks delay in receiving definitive therapeutic treatment – emergency laparotomy on 14 November 2006 and the prolonged recovery period after that of four weeks up until his discharge from hospital on 13 December 2006. The experts also agreed that if a laparoscopy/laparotomy had been performed by 20 October 2006 at the latest then he would have been discharged home within 5-7 days and on the balance of probabilities would not have suffered any further complications. After laparoscopy he would have made a three week recovery to full normal activities and after a laparotomy he would have had a six week recovery period until undertaking full normal activities.

[18] The issue before me is one of causation. It is agreed that there had been a breach of duty on the part of the defendant in that the plaintiff should have been offered treatment on 19/20 October 2006. The question for determination now before me is what should have occurred in the event that he was offered treatment of a proper nature on 19/20 October 2006. It is the plaintiff's case that the treatment of choice should have been the minimally invasive management by way of laparoscopy. In short, whilst a bile leak remains an unusual problem, laparoscopic surgery ought to have been invoked. It is the defendant's case that whilst *current* practice laparoscopy as a first choice treatment for bile leaks, in 2006 laparotomy was the conventional approach.

The evidence on behalf of the plaintiff

[19] On behalf of the plaintiff Mr McCloy FRCS gave evidence. He is a very distinguished consultant surgeon and endoscopist with a highly impressive curriculum vitae evincing an established national and international reputation in this area. He had co-established a unique multidisciplinary consultant led pancreato-biliary service at Manchester Royal Infirmary in 1990, had established one of the first six NHS laparoscopic general surgical units in the UK and had performed several "world-first" laparoscopic procedures including laparoscopic biliary bypass.

[20] In short compass, on this issue, Mr McCloy made the following points in the course of reports and letters prepared for this litigation and in evidence before me:

- The treatment of choice for imaging the abdomen for a suspected bile leak 3 or 4 days after surgery in 2006 was by way of laparoscopy, washout and drainage. By the time the plaintiff came back in November the majority of surgeons would have opted for a CT scan and a laparotomy which was indeed what happened but this was all too late.

- The plaintiff was not offered the choice of transfer to a specialist centre where techniques could have been available for advanced laparoscopic surgery.

- The advantage of laparoscopy is that it is much less invasive than laparotomy. The former involves insertion of tubes, telescopy, blowing up the abdomen with gas and sucking up the bile and blood. The latter involves a 10-15 cms incision using ligatures rather than clips in the abdomen through layers of muscle wall by way of open surgery,. The differences between the two procedures include much shorter periods of recovery and less risk of complications with laparoscopy. Laparotomy causes scars and a greater risk of adhesions. The advantages of the laparoscopy would have been obvious for this man. First, there is no risk of injury when drains are used. Secondly, the same technique had been used three days before. Thirdly, the wounds for the previous laparoscopy could have been used and fourthly, there would be no reason to create a new wound using laparotomy.

- Laparoscopy is the treatment of choice in 95% for patients with gallstones currently and for 85%-90% of patients in 2006. Not only was laparoscopy the treatment of choice but it was the standard practice for treatment of this kind throughout centres in the United Kingdom in 2006. This form of treatment for bile leak had spread rapidly from its introduction and was widespread by 1993/1994 in his opinion. It was routine practice in his centre albeit he had not travelled in the jurisdiction of Northern Ireland at that time.

- By the time the plaintiff was re-admitted, laparotomy was necessary because fibrous tissue would have gathered within 7-10 days and clearance would have been difficult. This was entirely different from what the situation would have been in 19/20 October 2006 with a fresh surgical site and a low density area with a collection of fluid to deal with. Hence it could have been washed out more easily than the situation one month later. He would have been discharged within 5-7 days.

[21] A paper had emanated from the Royal College of Surgeons in January 2007 under the heading *"An Algorithm for the Management of Bile Leak following Laparoscopic Cholecystectomy" (the McCloy paper)* and was introduced into this case by Mr McCloy. He drew attention to the following points in the course of that paper.

- The management of bile leaks following laparoscopic cholecystectomy has evolved with increased experienced of laparoscopy.

- Prior to 1998 laparoscopy was not used routinely.

- The introduction of a minimally invasive protocol utilising ERC and re-laparoscopy offers an effective modern algorithm for the management of bile leaks after laparoscopic cholecystectomy.

- In 1998, the Hepatobiliary Unit at Leicester Royal Infirmary (LRI) introduced a protocol for the minimally invasive management of bile leaks. The study compared patient outcomes before and after introduction of the protocol.

- A total of 24 patients with bile leak following laparoscopic cholecystectomy for symptomatic gallstones were managed at LRI between 1993 and 2003. Ten of these were between 1993 and 1998 before the introduction of the minimally invasive protocol. Fourteen individuals had a bile leak following this and were managed according to the protocol. Such was the success of the laparoscopic procedure that it is currently the procedure of choice for symptomatic gallstones. "It has evolved from an innovative, but time consuming novelty to a routine day-case procedure over the last 20 years".

- The paper concludes:

> "In our experience a structured step wise approach to the management of uncommon complications such as bile leaks is advantageous. In order to run such a protocol there must be the resources and skills available to provide ERC and advanced laparoscopic surgery seven days a week."

[22] It was Mr McCloy's evidence that notwithstanding that this paper, which had been presented orally in Japan in 2004, was not delivered until 2007 i.e. after the plaintiff's operation, and the various case histories had not been written up, the paucity of reference in the literature to it was not significant and did not reflect the fact that this procedure had been carried out in 85/90% of such cases in England and Wales in 2006.

The evidence of the defendant

[23] Another distinguished consultant in this field Mr Mackle FRCS (Ireland) gave evidence on behalf of the defendant. Mr Mackle FRCS (Ireland) has been a consultant since February 1992 at the Craigavon Area Hospital, the Ulster Independent Clinic and Hillsborough Private Clinic.

[24] He provided four reports between 21 March 2010 and 5 August 2013. He had attended the meeting of experts with Mr McCloy on 18 June 2012.

[25] In the course of those reports and in oral evidence before me Mr Mackle made the following points:

- Whilst he agreed that today laparoscopy would be the treatment of choice for the plaintiff, on 19/20 October 2006 it would not have been the main technique used. Indeed at that time he was not aware of any definitive move towards the use of laparoscopy rather than laparotomy for treatment of bile leaks.

- He observed that the paper invoked by Mr McCloy was published after the plaintiff's treatment.

- Dealing with the paper itself, he drew attention to the paucity of case histories depicted therein. It was clear that at least up until 1998 laparotomy had been invoked as a technique for dealing with bile leakage and that essentially the report was relying on 14 individuals with a bile leak who were thereafter managed according to the protocol.

- In any event laparoscopic surgery was a developing technique, and it was not standard practice to convert from the conventional laparotomy technique in Northern Ireland by 2006. Bile leakage was not a common complaint.

- He noted that in the McCloy paper re-laparoscopy was necessary in only five out of the fourteen instances between 1998 and 2003. Whilst he accepted that Mr McCloy's evidence was that 85-90% of gall bladder removals were by laparoscopy by 2006 he did not accept that Mr McCloy was asserting that 85/90% cases of *bile leak* were being dealt with by this procedure.

- In short, in 2006 very many surgeons in Northern Ireland would have carried out open surgery in this instance and this was a perfectly reasonable approach to have taken. It was definitely not standard practice to have converted to laparoscopy in 2006 and the likelihood was that laparotomy would have been invoked in October 2006 had the plaintiff been treated then.

- The Coleraine Hospital was a small hospital and did not have a 24/7 interventional radiology service. The main hepatobiliary service for Northern Ireland in 2006 was provided by the Mater Hospital. This hospital was likewise a small hospital and it too did not have an interventional radiology service. Thus in 2006 a 24/7 interventional radiology service was not available in any site in Northern Ireland and in particular not at the main hepatobiliary service for Northern Ireland. There was therefore no question of transfer to a specialised centre.

Conclusions

[26] To recover in negligence a plaintiff must show on the balance of probabilities that the breach of duty caused the damage which he has suffered. The test is strictly a matter of fact and not of foreseeability.

[27] I am not satisfied that the plaintiff has proved on the balance of probabilities that the delay in offering him treatment on 19/20 October 2006 caused him to have a laparotomy whereas if the operation had been carried out at the appropriate time the treatment would have been a laparoscopy.

[28] Whilst I recognise the distinguished credentials of Mr McCloy, I consider that greater weight should be given to the local knowledge and experience of Mr Mackle in outlining what would have been a reasonable and likely choice of treatment in Northern Ireland in October 2006. He is a consultant well versed in the techniques adopted by surgeons in Northern Ireland at that time and his evidence convinced me that the overwhelming likelihood is that the plaintiff would have been treated by a laparotomy if treated in October 2006.

[29] Advances in medical science or medical knowledge between the date of alleged malpractice and the date of trial have to be ignored when determining whether a defendant has adopted a proper technique (see Roe v NOH (1954) 2 QB 66).

[30] A question in this case which arises is as to when the published material put before me and the practice contained therein became part of the current knowledge. There is no doubt that I must assume that doctors do not fall behind the development of accepted medical practice because they have an obligation to keep themselves informed albeit professional persons cannot be expected to read every relevant publication or to remember everything that is read (Gascoine v Ian Sheridan and Co (1994) 5 Med LR 437).

[31] Had the techniques and treatment of choice outlined in the McCloy paper entered the general corpus of knowledge of what all experts in this field could be expected to be aware in Northern Ireland in 2006? Despite Mr McCloy's evidence that his experience was that surgeons in England were so aware, I place greater weight on the local knowledge and experience of Mr Mackle that this was not the case in Northern Ireland. Self-evidently this was a developing technique and the rarity of the condition is well illustrated in the paper relied on by Mr McCloy. I accept the evidence of Mr Mackle that the laparoscopic approach is not likely to have been invoked in 2006 for this plaintiff albeit developments have occurred in the ensuing years which leads it to be the treatment of choice in this relatively rare condition nowadays. Evidence of the current state of knowledge and standard practice in other jurisdictions is not necessarily relevant to the standard of care applicable to doctors in this jurisdiction. Thus in Whiteford v Hunter (1950) WN 552, HL the defendant's mistake in diagnosis of prostate cancer was not negligent on account of his failure to use an instrument which was routinely used in such circumstances in the USA. I am satisfied that the likelihood of treatment in this case needs to be measured by reference to the prevailing Northern Ireland standards and practice.

[32] I have therefore come to the conclusion that the general damages in this case must be confined to the delay in treatment between 19/20 October 2006 and November 2006 ie. a period of approximately four weeks. During that time the plaintiff suffered unnecessary pain and suffering with feelings of weakness, loss of appetite, loss of weight, pain in his right-hand side and left-hand side. The antibiotics given to him on his discharge from hospital reduced the pain but once they had finished, the pain became very severe and he described it as "the severest pain I had". He suffered an abscess and therefore a prolonged period in hospital as a result of this. In addition, there was a prolonged recovery period of up to four weeks until his discharge from hospital on 13 December 2006. If a laparoscopy/laparotomy had been performed by 20 October 2006 at the latest, then he would have been discharged home within 5-7 days and on the balance of probabilities would not have suffered any further complications. After a laparotomy he would have had a six week recovery period until undertaking full normal activities. This has to be compared with the prolonged debility and pain which he suffered instead.

[33] I consider that the general damages in this case merit an award of £8,000 to which will be added the conventional interest on general damages.

[34] So far as special damages are concerned, I shall invite counsel to address me on the arithmetical calculation for the relevant period. To that figure will be added the conventional interest of 6%.