SUPREME COURT OF QUEENSLAND

CITATION:	*Coelho v Todd & Anor* [2003] QSC 349
PARTIES:	**GONCALO FILIPE COELHO** (plaintiff) **v** **RONALD TODD** (first defendant) AND **YUSUFALI JANUWALA** (second defendant)
FILE NO:	878 of 1997
DIVISION:	Trial
PROCEEDING:	Trial
ORIGINATING COURT:	Supreme Court, Brisbane
DELIVERED ON:	20 October 2003
DELIVERED AT:	Brisbane
HEARING DATE:	6 October 2003 - 8 October 2003
JUDGE:	Chesterman J
ORDER:	**1. Judgment for the defendants**
CATCHWORDS:	TORTS - NEGLIGENCE – ESSENTIALS FOR ACTION FOR NEGLIGENCE – Professional negligence – Medical practitioners – whether doctors acted negligently in the performance of a hernia operation TORTS – NEGLIGENCE - Causation - *Res ipsa loquitur* - Drawing inference of negligence – Whether the plaintiff could reply upon *res ipsa loquitur* *Breen v. Larkin* [2002] QSC *Dwan v. Farquhar* [1988] 1 Qd R 234 *Rogers v. Whitaker* (1992) 175 CLR 479 *Schellenberg v. Tunnel Holding Pty Ltd* (1999) 2000 CLR 121
COUNSEL:	Plaintiff – litigant in person Ms J Rosengren for the defendants
SOLICITORS:	Plaintiff – litigant in person Blake Dawson Waldron for the defendants

[1] The plaintiff is a sixty-one year old plumber who claims damages for negligence giving rise to personal injury from the first defendant, a surgeon, and the second

defendant, a general medical practitioner. At all relevant times the second defendant was the plaintiff's doctor. During a consultation on 3 September 1990 he diagnosed bilateral inguinal hernias which he advised the plaintiff to have repaired by surgery. The plaintiff postponed the operation for some years but on 28 January 1994 he again consulted the second defendant about the condition and was referred to the first defendant for the purposes of undergoing surgery. The operation was performed on 11 February 1994 at the Ipswich General Hospital.

[2] The action was commenced almost three years later, on 30 January 1997. The statement of claim was not delivered until 26 July 2000, three and a half years later. Pleadings closed on 30 November 2000 after which no step was taken in the action until 4 April 2003 when the defendants applied for summary judgment. Thereafter the action proceeded speedily but along the way the plaintiff ceased to be legally represented and appeared for himself at the trial.

[3] Any litigant in person experiences difficulty in presenting his case. The plaintiff was no exception but it must be said that he is a very intelligent man who has researched the medical aspects of his complaint against the defendants in great detail and to good effect. The plaintiff was born in Portugal but came to Australia about 30 years ago. His command of English is very good though, very occasionally, his pronunciation caused difficulty which was quickly overcome. He readily understood the difference in role between witness and cross-examiner and conducted his questioning of the defendants' witnesses with a good understanding of the task. His closing address was delivered with some forensic skill. Unfortunately for the plaintiff his case lacked any support in the evidence but he still managed to put forward a coherent argument tinged with passion and some adroitly directed criticism of the defendants, which was, however, without foundation.

[4] The case as pleaded is that the second defendant:

> '… advised the plaintiff to undergo a hernia operation on both the left and right hand side … (but) did not inform the plaintiff as to the risk of injury or possible complications of the surgery'

and that the first defendant:

> '… performed (the operation) in a negligent manner and damage was suffered to the plaintiff's nerves and muscle tissue in the operation including … damage to the ilioinguinal nerve, cremasteric muscle and spermatic cord.'

[5] According to the statement of claim the plaintiff 'relies upon the doctrine of *res ipsa loquitur*.' Indeed that was the whole of the plaintiff's case as presented. He himself gave evidence but called no other witnesses. He tendered some documents relevant to quantum. He did not adduce any evidence from medical practitioners either by report or oral testimony. His case in brief was that he was well before the operation and ever since has suffered constant severe pain in his right lower abdominal region, disturbed sensation in the left groin and thigh and, of more consequence to him, he has become impotent.

[6] The plaintiff's evidence in chief was:

> 'I went to Dr Januwala … and … I asked him about my bulge that I had on the left hand side and he identified that as a hernia. … I went only for the left hand side but they convinced me to do the right hand side as well … Dr Januwala say that as a plumber and drainer … it's quite heavy work … It's not going to cost you much more and since we do one side I suggest that you do the other side as well. … Come the day of the operation I went to hospital and had the operation … When I woke up … a sister called Dr Todd. He came and he examined me. He … say "It looks good." … The doctor was touching me on the wounds and so on and I noticed that … the left hand side of my abdomen, right down to the groin and scrotum it felt … numb … and the right hand side … I felt pain right at that time. … Dr Todd … say to me … that's normal. You always have pain and you always have numbness where we do the incisions and I said to him "It's not the … incision. The whole … left hand side is all numb and on the right hand side I never had pain and … it's painful.
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> It so happened that when he came (the) second time I … had the time to reflect a bit on what he said and it … didn't actually make sense … I said … why don't you tell me what really happened … It's not logical that I have pain on the left hand side now I've got numbness … and the right hand side is painful. … He stayed quiet for a very brief moment and he stated to me … "I'm really sorry that something didn't go quite right and there was damage to nerves and muscle tissue".'

[7] Mr Coelho said that in hospital he experienced severe pain at the site of the operation but worse on the right hand side. He was given Pethidine but said that any movement caused sharp pain. He went home two days after the operation in great pain which did not subside. He contacted the first defendant who advised him to take the medication, presumably strong analgesics, which he had prescribed.

[8] The plaintiff's wife had left him not long before the operation. He was unable to perform housework or cook. For about two weeks he had meals delivered by a local charity. He spoke to Dr Todd by telephone and was advised to commence walking and exercising. He did so but 'was walking like an old man … curved forward because when I stretched with my body straight I would feel that sharp pain. The more I put myself straight the sharper pain came and … about two weeks after the operation … I was in the back yard trying to exercise … and I stretched up with my right hand … and something on the right hand side gave in like an elastic or rubber that broke …'

[9] The plaintiff described the sensation as occurring on the right hand side, internally, near the site of the right hernia. He contacted Dr Todd who told him not to worry, that it 'was something getting into place.' The plaintiff did not believe him because he could 'feel (his) body … could feel it really snapping … breaking up inside like a rubber band …' The plaintiff dates his impotence from this episode. He clearly believes that whatever caused the sensation is responsible for his impotence.

[10] This is the plaintiff's primary complaint. It is clearly a source of great concern and anxiety. He described with some precision and at some length the symptoms and effect of his condition. It is not necessary to set out his evidence in any detail. I

accept that his condition is genuine and that it causes him great distress and disappointment.

[11] The plaintiff described the site of the pain as being internal to the right hand buttock in the site of the inguinal canal. Exhibit 12 contains some extracts from Grant's Atlas of Anatomy. Diagram 5 (numbered by Dr O'Rourke) shows the canal to be below the abdomen, low in the area of the groin. The complaint concerning paraesthesia was that the plaintiff noticed an area of altered sensation extending from just below the navel on the left hand side extending to the base of the penis and down the left thigh.

[12] Counsel for the defendant tendered two medical reports which the plaintiff's former solicitors had obtained as part of their preparation of the plaintiff's case. The first was from Dr Sereda, a general surgeon. He did not interview or examine the plaintiff but was supplied with copies of the records from the Ipswich General Hospital, Princess Alexandra Hospital (which the plaintiff attended for examination into the causes of his impotence) as well as reports from radiologists and pathologists. Dr Sereda reported:

> 'The accepted treatment for patients with an inguinal hernia is for surgical repair to be performed. The reason for this is that inguinal herniae can strangulate, causing small bowel obstruction with subsequent gangrene of the bowel, perforation and generalised peritonitis, unless urgent surgery is performed … It is therefore advisable for patients to undergo a hernia repair as an elective procedure.
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> Post operative pain in the region of the inguinal canal is not an uncommon sequel following surgery and this is due to soft tissue scarring involving the ilio inguinal nerve despite careful dissection and preservation of the nerve. …
>
> Mr Coelho has subsequently developed impotence. However, there is no anatomical connection between the development of his impotence and the surgical repair. The development of his impotence is coincidental.'

[13] The second report was from Dr Preston, a urology registrar at Princess Alexandra Hospital. His report of 10 November 1997 was in these terms:

> 'Mr Coelho attended the Princess Alexandra Hospital initially on 24 February 1995 when he was seen in Dr Thompson's urology outpatients clinic. He was subsequently seen on 31 March 1995 and 1 February 1996 in the same clinic. He also attended Dr Boyle's urology clinic on 28 July 1995 and Dr Wall's general surgical clinic on 18 April 1995, 2 May 1995, 27 July 1995 and 8 August 1995.
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> Mr Coelho complained of some altered sensation in the left groin and erectile and ejaculatory dysfunction, which he alleges followed a bilateral hernia repair … in February 1994. Examinations by Dr Thompson, Dr Wall and Dr Boyle's registrar failed to demonstrate any testicular abnormality following the hernia repair. There was an

> ill defined area of paraesthesia in the left groin. The urology registrar commented that this area did not conform to a neurological distribution and concluded: "I can find no organic pathology to account for his symptoms." Dr Thompson noted that he felt there were significant psychological problems contributing to this presentation. He was seen on a number of occasions in the general surgical clinic and eventually had a magnetic resonance imaging scan of his pelvis … this was … normal … with no cause for the patient's symptoms being identified.
>
> In summary, the consensus … seemed to be that Mr Coelho's symptoms could not be explained as a complication of his previous hernia repair. The final note in the chart revealed he was using … injection therapy from an impotence clinic, the results to which were quite satisfactory.'

[14] The plaintiff is a plumber and drainer who conducts his own business. The work is physically demanding. It involves, though not continuously, lifting and digging. Mr Coelho has continued in his trade since the operation. That was his intention when he underwent surgery. Mr Coelho did not make it clear to what extent, if any, his ability to work or to conduct his business has been affected by his pain. Clearly enough his impotence is not relevant in this regard. The evidence on this point was brief and unclear. It may well be that the plaintiff deliberately sought to avoid the issue. It emerged that he has not submitted a tax return since 1991, three years before his surgery but he has continued in business and does so to this date. At a very late stage in the trial he produced some financial records but not in a form which would allow comparison between pre and post operation economic activity. The consequence is that it is impossible to know whether the plaintiff has suffered any diminution in earnings or earning capacity by reason of his complaints.

[15] The plaintiff alleged that he first complained to Dr Januwala about his symptoms of hernia in 1989. The complaint was of a left sided pain and bulging but 'there was nothing on the right hand side', which was not painful and did not bulge. His evidence was that Dr Januwala told him that he would develop a hernia in the future on the right side as well, but his wish was to have only the actual hernia on the left hand side repaired surgically.

[16] The plaintiff accepted that when he spoke to Dr Januwala about his herniatic condition in February 1994 he was having pain in his lower left abdomen whenever he lifted his toolbox or other heavy objects. He found it necessary to place his hand on the outside of his stomach wall when he lifted to prevent the hernia bulging out. He also experienced pain whenever he coughed.

[17] He testified that neither of the defendants advised him of any possible complications arising from the surgery. Dr Januwala told him that he himself had had a similar operation a few weeks earlier and he had been able to resume normal activities after about three weeks. In particular he complained that he had not been told that his condition could be treated by wearing a truss which would support the hernias and make surgery unnecessary. He denied that he was advised that if left untreated the hernias would increase in size and could give rise to serious and potentially life threatening complications.

The plaintiff denied that Dr Todd spoke to him about the possibility of complication from the operation. All he said, according to the plaintiff was '… everything should be alright … I'll ring the hospital right away.' The plaintiff said that if he had been given 'even a hint' that he would have post operative disability he would have bought a truss and not had the operation.

[18] The plaintiff consulted Dr Januwala on 15 March 1994, about a month after the operation. He was unsure whether he complained then of the pain that he now says is intractable and continuous and came when he was in hospital. He did say that he first complained of the pain to Dr Mohr, another general practitioner in the same practice as the second defendant. He said also that he had complained frequently to Dr Todd about his pain.

[19] The second defendant, Dr Januwala, qualified as a general medical practitioner in Glasgow in 1974. He was in a group practice in Ipswich between 1982 and 2000. He was the plaintiff's 'family doctor' for those years. Dr Januwala had a good recollection of the plaintiff and his consultations with him. His notes of those consultations which became Exhibit 10 were quite detailed. Although Dr Januwala did not describe the plaintiff in these terms I think it clear that he found him a demanding patient who was difficult to treat and who was rather obsessed with his own health and well being. The notes show that the plaintiff consulted Dr Januwala 17 times between 21 February 1983 and 3 September 1990 when there was the first mention of a diagnosis of hernia. On that day, 3 September 1990, the plaintiff complained of three separate ailments, the third of which was:

> 'Soreness in both groins as if something wants to pop out (on examination) bilateral ing hernia. Counselling re condition assurance ++ as anxiety. Explained re: anatomy (treatment) complication etc. Extremely tense, highly strung individual. Discussion re private vs public. Will let me know.'

[20] Dr Januwala's evidence was that the consultation lasted at least half an hour and that the examination revealed a hernia on both sides. He 'spent a fair bit of time explaining to him about this condition.' He said that a hernia was a common condition often related to lifting and that it was seen more commonly in men who engaged in manual labour. He explained that it was caused by a weakness in the stomach wall allowing a loop of bowel to protrude. He noticed the plaintiff was anxious and needed reassuring that the treatment was common and amenable to simple surgery and that surgery was the only available cure.

[21] The plaintiff consulted Dr Januwala on 14 September 1989 for a number of separate complaints. This is the occasion the plaintiff alleges he first complained about hernias. The consultation notes make no reference to it and Dr Januwala, in cross-examination, was adamant that if such a complaint were made he would have examined the plaintiff, discussed the symptoms with the plaintiff and made a note of the occurrence.

[22] I accept the evidence that it was on 3 September 1990 that the first diagnosis of hernia was made. I am satisfied that the plaintiff's memory is faulty. He did not complain to Dr Januwala of those symptoms in 1989.

[23] The second defendant said that the plaintiff complained of soreness in both groins. Dr Januwala explained to him the inevitable progress of his condition and that surgery was the only realistic prospect. At that or a subsequent consultation he told the plaintiff, who had mentioned that he had heard of a truss as a means of treating hernias, that that was a temporary option and would not 'resolve the issue and … the operation was the only way to go.'

[24] The plaintiff was not medically insured and Dr Januwala discussed with him the prospect of being admitted to hospital as an intermediate patient, i.e. being admitted to a public hospital though as a fee paying patient so that he could have the operation done at a time which suited him and with a surgeon of his choice. He explained that he would be in hospital for one or two days and that he would be off work for about six weeks.

[25] The next note of a consultation in which the plaintiff's hernia was mentioned occurred on 12 June 1992 when Dr Januwala 'again reminded him about hernias.' On 14 September 1992 the plaintiff sought treatment for back pain. On that occasion it appears that he inquired again about the cost of undergoing surgery to repair his hernias. On 28 January 1994 the complaint was again the subject of a consultation. The second defendant's note reads:

> 'Concerned about hernias again!! His wife Maria has left him again! … Again counselling ++ re private vs public etc. for referral to Dr R Todd'

[26] The plaintiff explained that his wife had left him on a few occasions in the previous year or so. On this occasion she had left him again and the indications were that the separation would be permanent. The plaintiff himself describes his decision to undergo surgery as being consequent upon his wife's desertion. It seems he wished to have his body repaired so as to 'get on with his life'. This is consistent with the terms of Dr Januwala's note. On this occasion Dr Januwala repeated his explanation of what surgery would involve: time off work, discomfort; the possibility that the wound would bleed or become infected. They also discussed whether the operation should be to repair both hernias or only the painful left one. Dr Januwala recommended strongly that both be done because inevitably the right sided hernia would increase and require treatment in the future. To have them both done together would involve minimal additional cost and avoid absence from work for a second time and reduce the risk associated with undergoing general anaesthetic. Dr Januwala himself had been operated on by Dr Todd. He told the plaintiff that. It was no doubt a factor in the plaintiff's choice of surgeon.

[27] Dr Januwala referred the plaintiff to Dr Todd on that day, 28 January 1984. His note to Dr Todd reads, in part:

> 'I've discussed fully costs involved etc. May be wise to discuss fully operative complications, possible costs, convalescence fully here.'

The request reflected Dr Januwala's concern that the plaintiff be fully informed of what the operation entailed and be reassured that he would be in good hands. The concern arose because of the plaintiff's preoccupation, which Dr Januwala recognised, with his bodily well being.

[28] The undisputed evidence from both defendants and the expert medical witnesses called by them was that left untreated a hernia may allow a segment of bowel to protrude and strangulate leading to infection and gangrene. Should that happen the patient will die unless surgery is performed within hours. Apart from that possibility untreated hernias will grow in size causing increasing pain and discomfort and increasing the likelihood of strangulation of the bowel as I have just described.

[29] The second defendant assisted with the operation though he was a few minutes late. Dr Todd had actually made the first incision when the second defendant arrived in theatre. Dr Januwala's recollection is that the operation proceeded smoothly and uneventfully:

> 'There were no unnecessary bleeding points. There were no issues. The structures were identified correctly. The mesh was put in … and closure of the operation was uneventful …'

[30] The plaintiff next consulted Dr Januwala on 15 March 1994, about six weeks after the operation. The purpose of the visit appears to have been for marriage counselling. Dr Januwala made no note that the plaintiff had any complaint of pain or discomfort following the operation. The doctor's evidence was that he would 'certainly' have made a note of any complaint of pain or numbness, if one had been made.

[31] Dr Todd, the first defendant, qualified as a general surgeon in 1954. He retired in 1998 and now works three half days a week as a general practitioner visiting prisons. He had performed 'several thousands' of hernia operations when he operated on the plaintiff in February 1994.

[32] He examined the plaintiff first on 31 January 1994 following the referral from Dr Januwala. He confirmed the presence of bilateral inguinal hernias, the left larger than the right. The plaintiff told him that he was a plumber who 'had to dig drains and … lift heavy equipment.' Dr Todd explained that there was 'not really' any option for the plaintiff apart from surgery because, without surgical intervention the hernia 'would have been large enough for bowel to enter the hernia sac and become strangulated.' External support in the form of a truss was not appropriate because such implements do not cure the hernia. They strap to the body for the purpose of stopping the hernia protruding but 'they are cumbersome, uncomfortable and they become soiled. They are messy things (not recommended) except (for) a very old man with a heart condition who wouldn't be fit for an operation.' Left untreated a hernia will increase in size, become more painful and the surgical intervention to repair them becomes more difficult.

[33] Dr Todd advised the plaintiff to undergo the repair of both hernias at the one time because the right sided hernia 'would eventually become larger and more painful and it seemed advisable to have them both done at the same time.'

[34] Dr Todd did not have a particular recollection of his initial consultation with the plaintiff but was confident that he would have spoken to him as he did to all patients who attended for the same purpose. His practice was to ask his patients 'what their fears were, what their worries were, what complications they were worried about' so that he could explain things and address their fears. He is confident he would have treated the plaintiff according to his general manner and told him that 'there would

have been pain, as with any operation. There would have been haemorrhage as a possible complication. There could be infection.' The plaintiff's main concern was about the cost and how long he would be in hospital. He was also 'very upset because of his recent marital problems and a lot of our conversation was based around those facts'. The plaintiff, because he was uninsured, wanted to spend as little time as possible in hospital and Dr Todd agreed to discharge him 'as soon as possible.'

[35] Dr Todd did not tell the plaintiff that the operation may adversely affect his sexual function because he did not believe it would: he had never experienced such a consequence in all his years as a surgeon.

[36] The surgical technique was to sew a layer of Prolene mesh onto the innermost of the three layers of abdominal muscle, the weakness of which allowed the bowel to herniate. The mesh provides reinforcement for the muscle which is then able to restrain the bowel in its proper cavity. Dr Todd's recollection is that the operation was performed without difficulty or complication. Had there been any damage done to the cremastic muscle, the ilioinguinal nerve or the spermatic cord (as the statement of claim alleges), a note would have been made in the surgical records of the operation. There was no such note. Dr Todd denied that any of the three complaints would lead to sexual impotence. The only purpose of the cremastic muscle is to allow retraction of the testicles. The 'last time' Dr Todd examined the plaintiff 'he showed … how he could retract his testicle which means the cremastic muscle is functioning.'

[37] The spermatic cord does lie close to the site of the operation and care must be taken to avoid entrapping it in the repair. Dr Todd said that he had identified the cord and made sure that it had been retracted out of harm's way. Had the cord been entrapped and therefore constricted, the symptoms would have been 'swelling to the scrotum (and) the testicles … because the blood supply … would be compressed and … not allow good circulation but this did not happen.' Dr Todd accepted that 'patients frequently have pain due to the formation of scar tissue (which) can be painful for a while until mobility has been re-established.' The type and location of pain of which the plaintiff complains has never before been observed by Dr Todd as a sequel to a hernia repair.

[38] According to Dr Todd the ilioinguinal nerve is attached to and lies on top of the spermatic cord, both of which issue together out of the abdominal wall. The nerve provides sensation to the region below and adjacent to the incisions and about an inch and a half 'down into the thigh'. In retracting the spermatic cord to avoid damage the nerve is also retracted. That process may damage the nerve by stretching but the sensory disturbance of which the plaintiff complains, from the vicinity of his navel down the left hand side of his abdomen and down his left thigh is not consistent with damage to the ilioinguinal nerve which has a smaller and different area of distribution. The plaintiff did suffer some numbness following the operation because of the local anaesthetic injected to reduce post operative pain.

[39] The plaintiff consulted Dr Todd 11 times between 18 February 1984 and 27 October 1995. Dr Todd's notes show that the sutures were removed on 18 February 1994 when the plaintiff was given a certificate for his private insurer stating that he could not work for six weeks. The wounds were inspected on 25 February and 11 March 1994 and were seen to be recovering well. On

24 March 1994 the plaintiff returned to work and complained of 'mild discomfort'. He was told to return in a month's time if the discomfort continued. The plaintiff saw Dr Todd on 20 April and 5 May but appears not to have complained of pain. His concern rather was a loss of libido. On 8 August 1994 the notes show that he complained of pain in the right groin 'above and lateral' to the end of the scar. He was injected with cortisone. On 22 August 1994 he reported that his pain was 'less frequent and less intense'. On 25 October 1995 there was a complaint that he was concerned about pain 'from right hernia repair …'

[40] The plaintiff was examined by Dr Stening, a urologist, for the purposes of giving evidence for the defendants. His report of 18 September 2003 recites:

> 'Mr Coelho states that he underwent the operation of bilateral inguinal hernia repair on 11th February 1994. The operative report confirms that the operation was carried out on the stated date. There were bilateral direct inguinal herniae demonstrated with a Prolene mesh inserted on both sides.
>
> Mr Coelho was discharged on 13th February 1994. Nursing notes from the clinical records of the Ipswich General hospital indicate that there was pain requiring Pethidine during the previous night shift. Wound healing was proceeding as anticipated.
>
> Mr Coelho states that immediately following the operation he noted the left side was "very numb". The right hernia repair was very painful and it was at this stage that Dr Todd first saw him in the post-operative period.
>
> Mr Coelho states on the second post-operative visit that it was "still very painful on the right side".
>
> He stated "that nerve and muscle tissue was damaged on the right hand side". He claims he was told this by Dr Todd. The advice was that this discomfort should resolve without any specific measures. Mr Coelho states that he perceived at that time that "something had gone wrong".
>
> At the time of his discharge after two days, he stated that there was severe pain in the right side when he left to return home. He states that two weeks after the operation, he was reaching above his head with his right arm and "felt something snap in the right side".
>
> **Progress following the immediate post-operative period**
>
> Approximately three months following the operation, Mr Coelho complained of problems with erectile function and at about this time there was a marital breakdown which has become permanent with his wife leaving him.
>
> He was referred to Dr Les Thompson, who assessed him urologically and the clinical conclusion was that there was no organic cause for

his erectile dysfunction. It was noted that the prostate specific antigen was elevated to 7.3ng/ml, which led to transrectal ultrasound guided needle biopsy of the prostate gland, which was negative for carcinoma of the prostate.

Present Clinical State:

Mr Coelho states that he has pain that was described as originating in the right gluteal region and radiating to the right inguinal area and to the anteromedial proximal right lower limb. He described this pain as stabbing and exacerbated by digging, lifting or sexual intercourse. Resting by lying down and relaxing relieved the pain.

His demeanour could be described as intense and somewhat agitated, with a significant degree of fixed ideation as to the cause of his erectile dysfunction, which he related to the operative procedure of bilateral hernia repair.

I could not detect any abnormality in either inguinoscrotal regions, in the form of tenderness or palpable findings, either when lying or standing. There was perhaps a slight diffuse cough impulse over the right inguinal area, however nothing to suggest any recurrent hernia formation.

There were no abdominal signs and on digital rectal examination the prostate was palpably normal.

Opinion:

The patient's present symptoms related to the genitourinary system consist of partial erectile dysfunction which is responsive to treatment by standard treatment, that is oral PED5 inhibitors. At present he is taking the drug Cialis.

The erectile function also has responded to direct intracavernosal injection of Alprostadil.

The main complaint is of diminished sensation of orgasm or climax at the time of ejaculation. Ejaculatory volume is claimed to be less than normal and even under the influence of the treatment for erectile function, he states that the glans penis is never as distended or firm as it should be or was prior to the time of the operation.

On clinical evidence, there is no evidence of any entrapment of the spermatic cord. There is no local tenderness over the inguinoscrotal region, nor swelling to indicate that the spermatic cord is entrapped as alleged.

In my opinion there is no direct causal relationship between either the right or left inguinal repair and the complaint of erectile dysfunction. It is not appropriate for a man undergoing bilateral

> inguinal repair to be informed of any effect on erective function. There is no physiological or anatomical basis for erectile dysfunction following this type of operation.
>
> It is possible that the presently prescribed anti-depressant drug that is an SSRI inhibitor, namely Luvox, could be playing a part in this man's erectile dysfunction, as this drug has been causally related to impotence.
>
> Mr Coelho has undergone considerable emotional and psychological upheaval prior to and immediately following the hernial operation, in relation to his marital situation. This could have a significant indirect behavioural effect on his erectile function.
>
> Mr Coelho is agitated, aggrieved and in my opinion exhibiting behaviour indicating considerable disturbance and anxiety concerning his complaint of erectile failure. He has a fixed idea that the operation of inguinal hernia repair caused is problem and does not respond to the rationale that such a procedure could not physiologically alter his erectile function.
>
> I do consider that he would benefit from further counselling as to the cause of his complaint.'

[41] In oral evidence Dr Stening summarised his conclusion that the bilateral hernia repair undergone by the plaintiff could not have caused his impotence in these terms:

> '… Erectile function is a complex physiological function … related to an intact blood supply to the erectile bodies in the phallus and … an intact neurological pathway between the spinal cord, brain and the erectile part of the penis. The structures that are encountered in an inguinal hernia repair are not in any way directly related to erectile function.'

[42] Dr Stening examined the plaintiff to see whether he exhibited any signs of spermatic cord entrapment. He looked for:

> '… any sign of local tenderness … in the inguinal area. Any swelling or induration or other change within the scrotal contents … I couldn't detect any features … that would indicate it was entrapped.'

[43] The location of the pain described by the plaintiff to Dr Stening was that it was:

> '… just posterior (to) the hip … and perhaps a little further behind … radiating down to the inguinal region and also to the right lower limb … on the medial surface.'

Dr Stening explained that 'any pain originating from where the hernia repair was carried out … would not cause pain … posteriorly, further behind … not above it anatomically, that is.'

[44] In cross-examination Dr Stening agreed that some tests undergone by the plaintiff in Princess Alexandra Hospital suggested that the cause of the plaintiff's impotence were physiological not psychological. The doctor's evidence was that there was no obvious physiological explanation for the condition. The plaintiff 'is not diabetic and there is no history of any skeletal injury to the pelvic area. He hasn't got any sign of major vascular deficiency … there is no history of any spinal cord lesion.' He noted that the plaintiff has been prescribed an anti-depressant drug which can produce impotence. He thought that the Princess Alexandra Hospital study did not 'clearly define the cause' of the problem. It was, however, his clear opinion that the hernia repair was not responsible.

[45] The plaintiff was also examined by Dr O'Rourke, a most experienced and highly qualified surgeon, for the purposes of providing a report and giving evidence. His report of 15 September 2003 relevantly says:

> '***3. Is it likely that the injuries about which the plaintiff complains are connected with the bilateral inguina hernia repair?***
> I will take his injuries one by one in this regard.
>
> ***(a) Impotency:*** There is no anatomical or physiological way that this could be related to his surgical repair. He has been investigated extensively by four urologists, namely Dr's Heathcote, Thompson and Cartmill and G. Malone, none of whom agree that there is any association whatsoever.
>
> The elevation of his PSA was associated with his benign prostatic hypertrophy, which is related to the aging process. Impotency is often associated with anxiety and stress and I notice he had a marital separation about the time of the surgery, or it may be a secondary consequence of antidepressant drugs. I believe the patient was taking an antidepressant drug at some stage.
>
> ***(c) Right inguinodynia:*** What this means is pain in the right groin. The pain in the lateral aspect of the wound developed late in the piece. I note in Dr. Todd's notes, his first record of post operative pain in the groin was on the 8th August, some 6 months after surgery. This was treated with the standard procedure of injection of local steroids, in case there was mesh irritation. Mesh irritation pain usually comes on early after the operation. I notice also in Dr. Todd's notes that in the previous May, the patient related that his marriage had completely broken down.
>
> ***(d) Right sacro iliac joint pain:*** The right sacro iliac joint is the posterior aspect of the trunk, i.e. it is at the back near the midline. Again this could not be related anatomically or physiologically to a hernia repair. One

could even say lying on a table can cause some pain, but never in the long-term sacro iliac joint pain. I notice that there has been as assessment by an orthopaedic surgeon, who could again find no problems.

(e) Dysaesthesia in the right groin & (f) dysaesthesia in the left groin: Operation of an inguinal hernia is associated with a nerve which runs across the inguinal canal, namely the ilioinguinal nerve. Most surgeons preserve this nerve, but some prefer to divide it electively. Post operatively if the nerve is divided or a traction injury has occurred, there may be an area of hyperaesthesia in the region of the pubis or on the anterior scrotal wall. This is usually self-limiting and normally has gone away in 6 months and rarely lasts longer than 12 months.

I note in regard to this, this patient was examined by Dr. Christopher Staples, a neurologist and he found the altered area of sensation was not consistent with any nerve or dermatome abnormality and felt that the pain may well be psychosomatic. He stated he could find lo local pathology and no evidence of organic pathology to account for his symptoms. I note he offered the patient Amitripyline, but he refused to accept any advice in this regard.

(g) Anxiety about spermatic cord entrapment: This is a most unusual concern for a patient. I don't know the genesis of this symptom, but I must say in the may *[sic]* years I have practiced surgery and the thousands of hernias which I have performed and reviewed myself and those that I have reviewed on behalf of others and on WorkCover Tribunals over the last 20 years, I have never actually ever seen spermatic cord entrapment in a patient having an open operation. This indeed is a new symptom for the record books.'

[46] Dr O'Rourke summarised his views in oral testimony. He repeated that the plaintiff's operation could not be the cause of his impotence. He said:

> '… Impotence is caused either centrally, in the brain, or else in the prostatic area … The hernia is in front … then there is symphysis pubis, which is bone, and behind that is the prostate. So the prostate is nowhere in the same zone … You would have to smash bone to get at the prostate.'

[47] Dr O'Rourke explained that the surgical technique used in repairing a hernia is most unlikely to lead to spermatic cord entrapment. He explained:

> '… The whole principle of inserting mesh is that there is no tension … The mesh is laid and … sewn … with a series of interrupted

> sutures without any tension. There is no entrapment. You may go around the cord but there is no tension, and tension is what causes pain and … constriction … With any normal surgeon … spermatic cord entrapment is not even considered. It is not something you ever see …'

[48] Significantly Dr O'Rourke described the symptoms that would be experienced from spermatic cord entrapment. He said:

> 'Well initially they get a very firm swollen testis, probably about four times its normal size. The whole thing would become red. They'd get a high fever. They'd find it difficult to walk. They usually have to be hospitalised, have intravenous antibiotics and they'd get … acute inflammation … and for three months they would find it difficult to get around … they wouldn't be able to work, they wouldn't be able to do anything.'

As a further consequence the testicle would 'shrivel and you would have an atrophic tiny testis as a … permanent memento of that event.'

[49] The obvious point is that a consequence of cord entrapment would be apparent on any examination of the plaintiff, apart from the severity of the symptoms.

[50] The plaintiff does not have an atrophic testicle. He has never complained of the symptoms which Dr O'Rourke described which cannot have been overlooked. It is obvious, therefore, that the plaintiff's spermatic cord was not constricted in the operation performed by Dr Todd.

[51] According to Dr O'Rourke the function of the ilioinguinal nerve is sensory only. It has no motor function. It serves an area of the upper thigh and the front of the scrotal wall as well as a little part of the groin very close to the base of the scrotum. Sometimes during the retraction of the nerve to insert the mesh the nerve suffers a transient injury 'whereby between six weeks and three months afterwards you have a numbness in the area … described … and which always goes away'. The numbness or paraesthesia which the plaintiff described 'from just underneath the navel all the way down to the base of the penis on the left hand side' is not consistent with damage to the ilioinguinal nerve.

[52] In relation to the complaint of pain internal to the right hip extending down to the outer side of the upper thigh is in an area 'not related to the hernia repair'.

[53] Dr O'Rourke corroborated Dr Todd's evidence that unless the plaintiff's hernias were repaired surgically they would inevitably have progressed with increasing pain and disability. Given the plaintiff's occupation it was 'very sensible advice to have them repaired. … repaired reasonably early is a much easier surgical procedure, and if it's easier for the surgeon it's much easier for the patient afterwards.' He also confirmed that wearing a truss was not a viable alternative mode of treatment. It 'was a device devised in Europe for people who didn't want to or were too sick to have a hernia … they don't have the humidity we have in Queensland … wearing a truss in Queensland is horrendous because they sweat … and they smell and … if one is doing physical labour they slip and … press on the wrong area and they will make the hernia worse.'

[54] Dr O'Rourke denied that any damage to the cremastic muscle caused during surgery could be the cause of the plaintiff's complaints. He said:

> 'The cremastor is a muscle … an embryological remnant … the testis when you are a little embryo is up near your kidneys and it descends during embryonic life, pulled down by the cremastor … When you are an adult the cremastor is just an embryonic remnant which surrounds the (spermatic) cord. It is said its function is to cause retraction of the testis but if you remove the cremastor – which most of us do during a hernia operation – you can still retract your testis by simply breathing in and retracting your abdominal muscles … In adult life the cremastor really has minimum significance … I have never heard of anybody who has ever had symptoms in relation to the cremastor …'

The answer was given in answer to a proposition put by the plaintiff in cross-examination that in the operation his spermatic cord might have become entangled in the cremasteric muscle. Apart from Dr O'Rourke's explanation his earlier evidence concerning the symptoms that would be evident from spermatic cord entrapment means that it cannot have happened.

[55] Dr Mohr is a general practitioner. She saw the plaintiff on six occasions between 20 April 1994 and 20 July 1995 at the second defendant's Riverview surgery. From August 1995 until 1999 Dr Mohr practiced from a surgery in Goodna where she saw the plaintiff from time to time. On none of those six occasions did Dr Mohr note a complaint of pain or numbness such as the plaintiff now describes. Dr Mohr said that she would have made a note of complaints or pain or numbness had the plaintiff mentioned them. He did complain on 28 April 1994 of impaired sexual performance and repeated the complaint on 21 June. The plaintiff consulted Dr Mohr when he discovered he had become impotent. He 'was … panicking because after … about … two weeks from that thing breaking up my hair started falling off … in chunks.'

[56] In cross-examination it emerged that the first time the plaintiff complained to Dr Mohr about pain was on 1 August 1995 at Goodna. The doctor said that she made a note of the complaint and has no reason to believe she would not have made a note of pain had it been mentioned to her at an earlier consultation. The complaint was of pain in the right testicle, not the pain which the plaintiff described at trial. Dr Mohr made a full note of what the plaintiff said to her on 1 August 1995. Relevantly she recorded the plaintiff as saying:

> 'Pain in right testicle after operation for bilateral hernias. Right testicle does not sit the way it used to … When he has intercourse he says that there is discomfort in "inguinal canal where the vas and the vessels cross". That is where the discomfort is, and then he loses erection and is wondering if something is "broken in there". …'

[57] I accept the evidence of the defendants, Dr Todd and Dr Januwala, and the opinions of Dr Stening, Dr O'Rourke and Dr Sereda. In my opinion the best evidence of the plaintiff's complaints is what Dr Januwala and Dr Mohr recorded in their notes of their consultations with the plaintiff. I think it most unlikely that a complaint of

severe and constant pain would have gone unrecorded, especially over the course of many consultations which the plaintiff had clearly had with the doctors.

[58] It is to be noted that the first complaint of pain made to Dr Mohr was in August 1995 but is clearly not the same complaint which the plaintiff now advances. It is also significant that the plaintiff did not mention to the doctors his dramatic account of 'something breaking' internally when he stretched a few weeks after his operation. It is also noteworthy that the complaint of pain to Dr Todd made in August 1994 was localised in the area of the scar and responded to injections of cortisone. I am satisfied that the plaintiff did not complain to either of the defendants or to Dr Mohr about right sided pain or left sided paraesthesia until after August 1995, 18 months after the operation and about the same length of time after the occasion from which the plaintiff now dates the onset of his symptoms. I do not accept the plaintiff's account of his conversation with Dr Todd on the day following the operation. I do not believe the plaintiff had tried to mislead the court but in my opinion his memory has become clouded and distorted by his preoccupation with his symptoms and his conviction that they have blighted his life. There is no doubt he feels the loss of his potency very keenly. I accept that he is genuine in his complaints and that he experiences the symptoms he described in evidence. I am not satisfied they occurred when or how he described.

[59] The plaintiff's real concern is his impotence. I have no doubt the complaint is genuine and of great seriousness for the plaintiff. His concern is not compensation but a desire that his function be restored. The latter is beyond the power of the court which can only provide the balm of monetary recompense.

[60] On the evidence it is not possible to conclude that the plaintiff's complaints of pain, sensory disturbance or impotence have any causal connection with the surgery performed by Dr Todd. The case as presented is a simplistic one of a connection in time between operation and symptoms and an assertion that the event earlier in time must have caused the subsequent symptoms. The findings I have made show that there is no close temporal connection, certainly between the operation and symptoms of pain and paraesthesia. His observation of impotence occurred earlier but on the evidence cannot be causally related to his surgery.

[61] The defendants accept that they owed the plaintiff a duty to take reasonable care not to harm him.

> '… The standard of care to be observed by a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that special skill. But, that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in a relevant profession … The courts have adopted the principle that, while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care …' Per Mason CJ, Brennan, Dawson Toohey and McHugh JJ in Rogers v Whitaker (1992) 175 CLR 479 at 487.

At 489 their Honours made the point:

> 'Whether a medical practitioner carries out a particular form of treatment in accordance with the appropriate standard of care is a question in the resolution of which responsible professional opinion will have an influential, often a decisive, role to play …'

Thomas J said in *Dwan v. Farquhar* [1988] 1 Qd R 234 at 241:

> 'To make out a case of negligence … against a medical practitioner, it is necessary to show a departure by the defendant from the standards of the ordinary skilled practitioner. The test whether a surgeon has been negligent is whether he has failed to measure up in any respect, whether in clinical judgment or otherwise, to the standard of the ordinary skilled surgeon exercising and professing to have the special skill of the surgeon … It is significant in the present case that there is no evidence from any expert source suggesting a failure on the part of the surgeon to act in the way he would then have been expected to act.'

[62] The operation of the principle expressed in the Latin, *res ipsa loquitur*, has been substantially curtailed by the High Court's exposition of it in *Schellenberg v. Tunnel Holdings Pty Ltd* (1999) 200 CLR 121 in which the point is made that before the principle can apply the accident which is said to have been caused by negligence must be of a kind which in the ordinary experience of human affairs indicates a lack of care. The inference of negligence 'is merely a conclusion that is derived by the trier of fact from all the circumstances of the occurrence.' Per Gleeson CJ and McHugh J para 24. Kirby J pointed out (para 118) that the implements at issue in that case, an air pressure hose with specially designed couplings and clamps, were 'not within the ordinary knowledge of tribunals of fact'. His Honour said:

> 'They do not constitute simple implements with which the ordinary decision-maker (judge or jury) is familiar in daily life or which are so rudimentary that they may be readily understood.'

[63] The same is obviously true of complicated physiological functions. In *Breen v Larkin* [2002] QSC I drew attention to the difficulty of utilising the principle in the case of medical negligence involving assisted childbirth. The approach is equally valid in this case involving the malfunctioning of organs anatomically remote from the site of the surgery and involving structures unconnected physiologically with it.

[64] Thomas J took the same approach in a case involving blood, contaminated with AIDS, transfused during an operation at a time prior to the existence of a test to screen blood for AIDS. His Honour said (in *Dwan* at 242):

> 'In the present case the material is of a sufficiently complex nature as to go beyond any situation where the principle of *res ipsa loquitar* could assist the applicant. The circumstances do not suggest that the surgeon did other than observe the usual procedures or that he should have done anything differently. Without such evidence he could not be held liable in negligence.'

[65] The claim against the second defendant is that he failed to advise the plaintiff about the possible complications from undergoing a surgical repair of his hernias and failed to advise him that he could treat his condition by wearing a truss. The evidence is overwhelmingly against the plaintiff. The unanimous medical opinion is that the only responsible professional advice which Dr Januwala could have given the plaintiff was that he should undergo surgery for both hernias. Given his age, occupation and state of health the only viable option was surgical repair. To leave the hernias untreated would have led to increasing pain and disability to the point where the plaintiff could not have worked. In addition there was a discernible risk of a life threatening strangulation of the bowel. Treatment by external support would have been unsatisfactory.

[66] The complaint therefore comes down to a failure to warn that the plaintiff might suffer his present symptoms: impotence, pain and sensory disturbance. Again the evidence destroys the case. None of the doctors who gave evidence had ever encountered or heard of these symptoms arising from the surgical repair of hernias. Dr O'Rourke put the matter bluntly. He said that the plaintiff's complaints were 'one for the record books'. It was not unreasonable not to warn the plaintiff that he might experience symptoms which none of the doctors, who between them had experience of thousands of identical operations, had never encountered and had never read about.

[67] I am satisfied that Dr Januwala did speak at some length to the plaintiff about his herniatic condition, the need for surgery, the consequences of not having the operation and the foreseeable consequences of the procedure. I am satisfied that he gave advice in the conventional terms which Dr Todd, Dr O'Rourke and Dr Turnbull all said should have been given. I prefer Dr Januwala's account of his consultations and discussions to the plaintiff's recollection. Dr Januwala was not affected by extreme emotion and had the support of his contemporaneous notes.

[68] The plaintiff faintly tried to criticise Dr Januwala for recommending Dr Todd who, it was insinuated, was too old to perform the operation. There is no basis for the complaint in the evidence.

[69] The case against Dr Todd is of the negligent performance of the operation. The evidence does not support this case either. According to Dr Todd's account, which I accept, the operation was performed in the normal manner and without mishap. The spermatic cord and ilioinguinal nerve were located and retracted, i.e. moved out of harm's way. Mesh was inserted and sewn into the wall of abdominal muscle to prevent future herniation. It is possible that the nerve was damaged in the operation because retraction may cause it to stretch. This can occur without negligence. The consequence is of temporary disturbance to the sensoral distribution of the nerve. It would not explain the numbness and paraesthesia of which the plaintiff complains. The spermatic cord cannot have become entrapped in the mesh or in the aperture through which it exits the abdomen. Dr Todd said he took care not to trap the cord. It is clear from Dr O'Rourke's evidence that the plaintiff had not suffered the symptoms that would follow constriction of the cord.

[70] On the evidence the plaintiff's impotence was not a foreseeable consequence of the surgery undertaken by Dr Todd. Indeed it is not a consequence in fact of the operation. Its cause was not identified and is coincidental to the operation.

[71] The plaintiff has failed to prove that either of the defendants was negligent and failed to prove that his pain and impotence were caused by the hernia repair. Accordingly there must be judgment for the defendants.