SUPREME COURT OF QUEENSLAND

CITATION:	*McIntosh v Hazel* [2003] QSC 076
PARTIES:	**KEVIN McINTOSH** (plaintiff) **v** **IAN HAZEL** (defendant)
FILE NO/S:	S9205/02
DIVISION:	Trial Division
PROCEEDING:	
ORIGINATING COURT:	Supreme Court
DELIVERED ON:	25 March 2003
DELIVERED AT:	Brisbane
HEARING DATE:	26 February 2003 – 28 February 2003
JUDGE:	Byrne J
ORDER:	
CATCHWORDS:	TORTS – NEGLIGENCE – Medical Negligence – General Practitioner – where Plaintiff alleged misdiagnosis of tumour by General Practitioner – where lower leg amputated as a result of complications related to removal of tumour
COUNSEL:	M Grant-Taylor SC with D.J. Kelly for the Plaintiff S Williams QC with M Burns for the Defendant
SOLICITORS:	Erich Monahan & Tisdall for the Plaintiff Tress Cocks & Maddox for the Defendant

[1] In late September 1999, the plaintiff underwent surgery for the removal of a large myxoid liposarcoma from his inner left thigh. This malignant tumour had grown to encase the femoral artery and vein. To obtain what the surgeon, Dr Dickinson, calls "a safe surgical margin around the tumour", the femoral vessels were resected and reconstructed prosthetically. In late July 2000, following complications relating to the operation, including an infected graft, the plaintiff's left lower leg was amputated. On his case, in February 1998, the defendant, a general practitioner to whom the plaintiff presented the tumour for examination, misdiagnosed it as unconcerning "fatty tissue". This mistake is said to have deprived the plaintiff of the chance that the amputation and other adverse consequences of the surgical intervention could have been avoided through much earlier excision of a smaller tumour.

[2] The first issue is whether the plaintiff has proved that, in February 1998, he drew the defendant's attention to the lump that constituted the growing tumour. If not, as the plaintiff accepts (Ex 39A, para 1), his case fails.

[3] The plaintiff was born in 1947. He was not in good health when he began to consult the defendant in late 1996: the main ailments were type 2 diabetes, suffered since age 40, and rheumatoid arthritis, for which the plaintiff was placed on a disability support pension in 1993. To alleviate these conditions, he regularly took prescribed medications.

[4] According to the plaintiff, on a day in 1998, while standing in the shower, he detected a lump on the inside of his left thigh, shaped like a football, about 2 ½ inches long and about 1½ inches wide. About a week later, in "early February", he consulted the defendant. He did not attend to ask about the lump, which was not causing discomfort. Rather, he said in his evidence-in-chief, he was there "about my rheumatoid arthritis because sometimes I get scrips off" the defendant for that ailment. Generally, he got his prescriptions for his rheumatoid arthritis and diabetes at the Princess Alexandra Hospital; occasionally the defendant was the prescribing doctor.

[5] While there for the prescription, he happened, he said, to ask the defendant, "Can you have a look at this? What is it?", indicating the lump. On his account, the defendant asked him to "stand up" and, after feeling the inside of the leg, said: "It's only fatty tissue: nothing to worry about".

[6] The plaintiff maintains that the lump had doubled in size by "late" October 1998, when he saw the defendant for the primary purpose of having it further investigated. The plaintiff says that he told the defendant that the lump was "getting a lot bigger", that the defendant felt it and said, "Don't worry about it. It's only fatty tissue", and that he again "accepted" that diagnosis and assurance.

[7] It was not until 9 August 1999 that a medical practitioner attributed significance to the lump. On that day, the plaintiff mentioned it to Dr Devereaux, a rheumatologist, who promptly put in train investigations which lead to the excision of the tumour six weeks later.

[8] Is the plaintiff's account of the February 1998 incident reliable?

[9] The defendant has no notes of consultations before mid-February 1998, when his records were destroyed by fire. Nor does he recall having seen the plaintiff that month. Records of the Health Insurance Commission, however, show that the plaintiff consulted the defendant in February 1998: on the 3rd and the 12th. But the consultations concerned an assessment of the heart, not a prescription.

[10] On 3 February, the defendant referred the plaintiff for an "exercise ECG" (Ex 31) that took place eight days later. The consultation on the 12th very likely concerned the test results. So the notion that either February consultation was to obtain a scrip

seems mistaken. And this is not the only indication that the plaintiff's recollection of events in 1998 is not accurate.

[11] Dr Devereaux once used to treat the plaintiff at the Princess Alexandra Hospital Rheumatology Clinic. On 6 April 1998, on the defendant's referral, Dr Devereaux first saw him as a private patient. Treating him as a new patient, Dr Devereaux re-took medical and social histories. And he performed a "complete examination".

[12] The plaintiff stripped to his underpants for the assessment. Dr Devereaux weighed him. He assessed the extent of loss of shoulder rotation. He detected a loss of extension to both elbows, synovitis at both wrists, irritable hips, quadriceps wasting, effusions and crepitus affecting both knees, and synovitis of joints of the feet. The examination involved the plaintiff's lying on his back as each leg was rotated, Dr Devereaux holding the lower part. Wasting in the thigh muscle above the knees was visible. An abdominal examination involved palpation to detect "reasonable masses": none was found.

[13] The plaintiff recounted his medical history, which included: gastritis, treated with antibiotics; iron deficiency associated with diarrhoea; diabetes, controlled by medication; sleep apnoea, controlled with a positive pressure mask; impotence, reviewed by a urologist; and atypical chest pain, the subject of a "recent normal stress test" (Ex 37 – no doubt a reference to the 11 February assessment). But although Dr Devereaux had asked the plaintiff to reveal "exactly what problems and what difficulties … he was having", no mention was made of a lump near the thigh. Nor did Dr Devereaux see such a thing.

[14] The plaintiff can recall nothing of this thorough examination.

[15] Accepting that he did see Dr Devereaux for that examination within two months or so of the occasion on which he says he disclosed the lump to the defendant, the plaintiff explains the omission to mention the lump on the basis that he had recently been assured by the defendant that it was of no concern.

[16] Not for another 16 months did the plaintiff tell Dr Devereaux of the lump. In the meantime, he saw Dr Devereaux at least another five times: on 16 July, 7 September and 7 December 1998, and 8 February and 10 May 1999.

[17] The plaintiff's account of his "late" October 1998 consultation with Dr Hazel – which he says related specifically to the growing lump – is not accurate either.

[18] The defendant's concise, contemporaneous notes disclose that he saw the plaintiff on 6 April 1998 about blood sugar level monitoring. On 2 May, the plaintiff presented with an upper respiratory tract infection. An attendance on 3 October concerned a bunion on the foot; the plaintiff sought an exemption from wearing safety boots at work. These things are disclosed in the defendant's records (Ex 36). Those notes also reveal that the defendant saw the plaintiff on three occasions

towards the end of October 1998. But the notes do not accord with the plaintiff's memory of the claimed "late" October inquiry about the lump.

[19] The notes reveal the following encounters towards the end of 1998. A long consultation on 24 October concerned an ingrown nail in the right little toe. A section of the nail was removed, a dressing supplied, and antibiotics prescribed. Two days later, the plaintiff was complaining of soreness in the toe. Under local anaesthetic, an incision resulted in removal of ungual fold. Next day, the wound was cleaned, an oral antibiotic prescribed, and the plaintiff asked to come back in a week. When he did return – on 21 December – he complained of a small cyst near the inner aspect of the right testicle. A left knee effusion associated with the rheumatoid arthritis was also observed.

[20] In short, contrary to his testimony, the plaintiff did not see the defendant to discuss the lump. He was at the surgery in October, and in December, for other reasons.

[21] The defendant's notes of the 1998 consultations contain no reference to a complaint about, or an observation of, the lump that was the tumour. And if that lump – which the plaintiff says was by late October large and still growing – had been mentioned, or seen by the defendant, it would, I am persuaded, have been recorded, as was the testicular cyst mentioned in December. Two things in particular point to that conclusion. First, the kind of notes kept suggest as much. Secondly, the defendant is sure that he would not have dismissed as mere "fatty tissue" a lump of the size, firm consistency and intra-muscular location of that which the plaintiff says was disclosed. Having seen and heard him explain why, his confidence in that respect does not strike me as very likely to be misplaced.

[22] The plaintiff is, the defendant agreed, the kind of man to have complained of a lump with the characteristics he thinks he disclosed in early February 1998. And in the witness box, he presented as a disingenuous, easy-going, man, generally given to candour. He now believes that he twice told the defendant of the lump, to be assured that it was benign tissue. But his ability to recall events in 1998 is poor – witness the forgotten examination by Dr Devereaux; and, in important respects, his recollection is inconsistent with established facts, especially concerning the February and October consultations.

[23] In all the circumstances, I am not satisfied that, more probably than not, his recollection of the critical February 1998 consultation is reliable.

[24] Two other points – neither of which matters to my conclusion – may as well be mentioned for completeness.

[25] For the defendant, considerations additional to those that impress me as decisive were said to support the view that the plaintiff has not proved the February 1998 disclosure: for example, (i) the variety of allegations in the (amended) statement of claim about the dates of the February and October consultations; (ii) the plaintiff's testimonial denial that the second disclosure happened on any of the three days

alternatively pleaded; (iii) he and members of his immediate family returned to the defendant for treatment many times after the tumour was diagnosed. But I have not attached significance to those considerations. Problems with the pleading and the dates are probably explained by poor memory – which is clear enough in any event. And that the family continued to consult the defendant in circumstances where, if the plaintiff's account were true, a loss of confidence might well have been expected could be explained by his deferential disposition and relaxed temperament and an absence of family discussion of the relatively late diagnosis of the tumour.

[26] Finally, the plaintiff associates the initial disclosure of the lump with an attendance to get a scrip. In 1998, he was commonly obtaining his prescriptions at the Princess Alexandra Hospital. There is, I suppose, a chance that a disclosure of the kind he has come to consider he made to the defendant may, at some stage, have been communicated to one of the several other doctors who prescribed his medication throughout 1998. However that may be, as he has failed to prove that he made such a disclosure to the defendant in February 1998, his claim fails.