SUPREME COURT OF QUEENSLAND

CITATION:	*Di Carlo v Dubois & Ors* [2004] QCA 150
PARTIES:	**SALVATORE DI CARLO** (plaintiff/appellant/applicant) v **DR PHILIP JAMES DUBOIS** (first defendant/first respondent) **PHILIP DUBOIS (MEDICAL) PTY LIMITED** ACN 010 673 864 (deregistered) (second defendant/second respondent) **DENNIS RICHARD OSBORNE, PHILIP JAMES DUBOIS, STEPHEN BENNETT KELLER, PIYOOSH KOTECHA, GARY EDWARD O'ROURKE, MARK JAMES READY, PETER STOREY, CHARLES BRUCE LEIBOWITZ, PETER CHARLES LUSH, NICHOLAS DAUNT, DAVID ALEXANDER NOBLE and PETER FERGUS LEGH, trading under the firm name or style of QUEENSLAND XRAY SERVICES** (third defendant/third respondent) **DR MICHAEL CORONEOS** (fifth defendant/fourth respondent)
FILE NO/S:	Appeal No 7132 of 2003 Appeal No 2504 of 2004 SC No 1281 of 1996
DIVISION:	Court of Appeal
PROCEEDING:	General Civil Appeal
ORIGINATING COURT:	Supreme Court at Brisbane
DELIVERED ON:	7 May 2004
DELIVERED AT:	Brisbane
HEARING DATE:	24 February 2004
JUDGES:	Davies and Williams JJA and McMurdo J Separate reasons for judgment of each member of the Court, each concurring as to the orders made
ORDER:	**1. Dismiss the appeal against the judgment of 16 July 2003** **2. Dismiss the application for an extension of time within which to appeal against the orders made on 18 December 2003** **3. Dismiss the appeal against the orders made on 10 March 2004**

4. Order that the appellant pay the first and third respondents' costs of each of the appeals and application

CATCHWORDS: TORTS - NEGLIGENCE - ESSENTIALS OF ACTION FOR NEGLIGENCE - DUTY OF CARE - SPECIAL RELATIONSHIPS AND DUTIES - OTHER CASES - where the appellant was concerned that he had a brain tumour - where the appellant was administered with a contrast agent prior to a CT scan and suffered an adverse reaction - where judgment was against the appellant at trial against three parties and where judgment was given for the appellant against the fourth - whether the respondents had a duty to warn of the risks of the procedure

TORTS - NEGLIGENCE - ESSENTIALS OF ACTION FOR NEGLIGENCE - DUTY OF CARE - SPECIAL RELATIONSHIPS AND DUTIES - OTHER CASES - whether the appellant if warned of the risks of treatment would not have undergone treatment - whether the learned trial judge erred in giving judgment against the appellant

PROCEDURE - COSTS - REVIEW - PRINCIPLES APPLICABLE - IN GENERAL - where the appellant sought to challenge costs orders made against him but was refused leave to appeal against costs by the learned trial judge - whether the trial judge erred in awarding costs

APPEAL AND NEW TRIAL - APPEAL - PRACTICE AND PROCEDURE - QUEENSLAND - POWERS OF COURT - ASSESSMENT OF DAMAGES - where the appellant had a prior existing injury and psychiatric problems - whether the learned trial judge erred in his assessment of damages

Canterbury v Spence (1972) 464 F.2d 772, distinguished
Chappel v Hart (1998) 195 CLR 232, cited
F v R (1983) 33 SASR 189, cited
Rogers v Whitaker (1992) 175 CLR 479, followed
Rosenberg v Percival (2001) 205 CLR 434, cited
Sidaway v Governors of Bethlem Royal Hospital [1985] AC 871, cited

COUNSEL: N M Cooke QC for the appellant/applicant
R V Hanson QC, with P L Feely, for the first, second and third respondents
No appearance on behalf of the fourth respondent

SOLICITORS: Baker Johnson Lawyers for the appellant/applicant
Flower & Hart for the first, second and third respondents
No appearance on behalf of the fourth respondent

DAVIES JA:

1. This appeal

[1] This is an appeal from a judgment given in the Trial Division of this Court on 16 July 2003 dismissing an action by the appellant against Dr Dubois, the first respondent, a company with which he was associated, the second respondent, and a partnership of which he was a partner, the third respondent and giving judgment for the appellant against the fourth respondent Dr Coroneos for $80,000. The principal questions which the learned trial judge had to decide in dismissing the appellant's action against the first, second and third respondents, and which the appellant contends his Honour decided wrongly, were:

1. whether the first respondent should have warned the appellant of the risks involved in the administration of a CT scan enhanced with a non-ionic contrast agent; and, if so
2. whether, if he had been so warned, the appellant would have gone ahead with the scan.

[2] It is common ground that, in order to have succeeded against the first, second and third respondents at trial, the appellant had to show both that the first respondent should have warned him of the risks associated with the scan and that, if he had been so warned, he would not have proceeded with it. The learned trial judge decided both of those questions adversely to the appellant.

[3] The learned trial judge then proceeded to assess damages in the sum of $80,000 and gave judgment for the appellant against the fourth respondent in that sum. The appellant in his notice of appeal also appealed against that assessment. However at the outset of his oral submissions Mr Cooke QC, for the appellant indicated that he did not intend to continue the appeal against the fourth respondent who was unrepresented and did not appear. That appeal was accordingly dismissed. The appeal against the amount of damages nevertheless continued against the other respondents.

2. Liability: the facts

[4] The undisputed or indisputable facts relevant to the appeal against the judgment dismissing the appellant's action against the first, second and third respondents may be shortly stated. By May 1993 the appellant had convinced himself that he had a brain tumour. Dr Coroneos, who is a neurosurgeon and was a friend of the appellant's, examined the appellant and told him that he had eliminated the possibility of a "mass lesion" and that clinical examination was normal. He said that he was 99.9 per cent sure that there was no underlying problem. He arranged for a CT scan to be done by the first respondent and went with the appellant to the respondents' premises when that was to be performed.

[5] There was a disputed question of fact, which depended on an assessment of the evidence of the appellant and Dr Coroneos, on the one hand, and a Dr Dubois and his radiographer, Mr Brown, on the other, as to whether Dr Coroneos had prescribed a CT scan without enhancement by a contrast agent or a CT scan so enhanced. However a leading independent expert Professor Palmer said that if the referring neurosurgeon was 99.9 per cent certain that there was no tumour (which was this case) an enhanced scan would be necessary to eliminate the residual possibility that there might be one. He went on to say that in such a case, if the referring doctor specifically asked for a non-contrast study, he would suspect a mistake in the request.

[6] On 29 May 1993 a CT scan was performed on the appellant, enhanced by a non-ionic contrast agent. It was preceded by a CT scan not so enhanced. The agent was administered by Mr Brown, a radiographer employed by the company which ran the first respondent's practice, presumably then the second respondent. The appellant had a severe allergic reaction to the administration of the contrast agent. Dr Dubois administered adrenalin to him and he was removed to the Mater Emergency Centre. After further treatment he recovered. The CT scan which had to be aborted because of the appellant's reaction, was completed later that day whilst the contrast agent remained in his system.

[7] The appellant's reaction involved swelling of the tongue, lips and airways and resulted in reduced blood pressure. It was described as an anaphylactic reaction involving respiratory difficulty associated with cardiovascular collapse. Had he not been treated quickly, as he was, it is possible he may have died or gone into cardiac arrest. The further treatment involved, first, injections of adrenalin, intravenous fluids and hydrocortisone and then Phenergan and oral dexamethasone.

[8] All relevant facts other than those which I have stated were disputed at the trial. Some of them were resolved against the appellant by his Honour's findings of credibility against both the appellant and Dr Coroneos. It is desirable to say something about these findings and their effect and the appellant's challenge to these findings, before considering the other questions involved in this appeal.

3. The credibility findings

[9] The learned trial judge concluded, in effect, that he was not prepared to accept the appellant's evidence except where it was independently supported. His Honour referred to a number of specific matters which led him to that conclusion.

[10] Two of these matters related to the appellant's evidence that the instruction which Dr Coroneos gave to Dr Dubois, based on the appellant's instruction to Dr Coroneos was for a plain CT scan, that is, one without enhancement by a contrast agent. The first of these was that at no time during the procedure which preceded the injection of the contrast agent - the application of a tourniquet, the finding of a vein, swabbing the area and the insertion of a butterfly clip - did the appellant say that his instruction to Dr Coroneos and the latter's instruction to Dr Dubois was that he was not to be injected. The second was that, when the appellant spoke to Dr Middleton, his psychiatrist, only a week after this incident, on 5 June 1993, he said, according to Dr Middleton's note, "The thing that pisses me off - non-ionic agent available". It may be inferred from this that the appellant's complaint at the time he spoke to Dr Middleton was based on his erroneous perception that an ionic contrast agent had been used in the injection, that this was contrary to the instruction to Dr Dubois and that this had caused his reaction. And it may be inferred from this, in turn, that, at that time, he was expressing no concern about the fact that he had been injected. The appellant was cross-examined about both of these matters.

[11] The third matter which led his Honour to the conclusion not to accept the appellant's evidence except where it was independently supported was the way in which he answered interrogatories in an action arising out of a motor vehicle accident in 1994 and the explanation which he gave for his answers in the course of his cross-examination in this action. In his judgment his Honour described the way in which the appellant answered these interrogatories as "suggestive of a carefully devised strategy to avoid a direct lie but not make disclosure with the explicitness and

frankness required". After reading the appellant's answers to those interrogatories and his cross-examination thereon in this case I agree with his Honour's conclusion.

[12] A fourth matter involved an untrue statement in his statement of loss and damage in that action and his explanation for that untrue statement when cross-examined in this action. His Honour said, correctly, that the appellant said "that it was not his document and that at the time, such documents were 'taken with very little value', as they were prepared by clerks in solicitors' offices, without consulting clients, by reference only to the documentary evidence".

[13] And the fifth matter upon which his Honour relied in reaching this conclusion was the totality of his explanations for differences between the opening of his case at the earlier trial and his evidence in that trial, between the opening of his case in this trial and his evidence in it and between the evidence given by him in the two trials.

[14] The appellant's counsel in this Court submitted that his Honour's conclusion as to the appellant's lack of credibility did not arise from any assessment of his demeanour, which led to a submission that this Court was in as good a position as his Honour to determine the appellant's credibility. The first and consequently the second of these propositions is not correct. Each of the above specific matters referred to by his Honour arose out of cross-examination of the appellant. It was the appellant's unsatisfactory answers in the course of this cross-examination which led his Honour to the conclusion which he did. I would have no doubt that, in assessing the appellant whilst giving those answers, his Honour relied on his demeanour. It was unnecessary for his Honour to specifically say so. It seems to me that that was self-evident.

[15] In this Court, Mr Hanson QC for the first, second and third respondents submitted that the appellant's answers as a whole on these matters demonstrated evasiveness, prevarication and lack of transparency. I agree with that submission. In my opinion his Honour was fully justified in declining to accept the appellant's evidence except where it was independently supported.

[16] His Honour's conclusion upon the appellant's credibility was relevant in three respects. The first was that which I have already mentioned; as to whether a plain CT scan was requested or whether the appellant believed that it was. His Honour found that a plain CT scan only had not been ordered and that the appellant did not believe that it had been.

[17] The second was that he did not accept that the appellant was not asked about relevant risk factors prior to administration of the contrast agent. Mr Brown, the radiologist could not recall specifically what was said to the appellant before he administered the contrast agent but said that he had a routine which he followed. This was to ask specifically if the patient was asthmatic and if he had had contrast agent given to him before. He would also ask whether the patient was allergic to shellfish. If he got a positive response to any of those questions he would refer the case to the radiologist on duty. Since he did not refer it on the day in question he assumed that he got a negative answer to each of those questions. The appellant's evidence in this respect, which was disbelieved by his Honour, was that Mr Brown said only "Are you an asthmatic" and when the appellant replied "No" and was about to say "but", Mr Brown said "You'll just feel a little prick" and the appellant

felt something go into his arm. His Honour accepted that Mr Brown followed his usual routine.

[18] The third, and most significant consequence of his Honour's finding in respect of the appellant's credibility was that he disbelieved the appellant's evidence that, had he received an appropriate warning about the danger of injection of the contrast agent, he would not have permitted the injection. For the reasons which I have already given, I think that his Honour was justified in reaching that conclusion.

[19] The learned trial judge also made an adverse finding with respect to Dr Coroneos' credibility on the only important issue on which he gave evidence; that he requested Dr Dubois to administer only a plain CT scan, that is, one without the prior injection of a contrast agent. There were, in my opinion, a number of matters which justified his Honour's conclusion in this respect.

[20] In the first place, as I have already mentioned, according to Professor Palmer the only way in which the presence of a tumour could be categorically eliminated in the circumstances of this case - the object of the exercise - was by administering a CT scan with a contrast agent. There was, as the learned trial judge accepted, no practical reason for administering only a plain scan.

[21] Secondly his Honour thought it probable that if Dr Coroneos had told Dr Dubois that a plain scan only was required, he would have raised with Dr Dubois the disregard by the latter of his instructions to give only a plain CT scan. It was not suggested that he did so.

[22] And thirdly there was Dr Coroneos' close financial relationship and friendship with the appellant. He was cross-examined on this and the learned trial judge refers to this cross-examination in a way in which, I infer, he had regard to it in arriving at his conclusion with respect to Dr Coroneos' credibility.

[23] Dr Coroneos was cross-examined on each of these matters as he was about other matters affecting his credibility including why his letter to Baker Johnson of 14 June 1996 was altered. It may be readily inferred that his Honour had regard to Dr Coroneos' demeanour in the course of that cross-examination in reaching his conclusion upon his credibility.

[24] Dr Dubois recalled that he and Dr Coroneos sat in an office before the administration of this procedure and discussed at some length that it was to involve a study of the brain and neck. He recalled that Dr Coroneos explained to him that the appellant was particularly concerned that he might have a brain tumour. And whilst Dr Dubois' recollection of the details of this conversation was limited he said that he had a high level of confidence that an unusual variation from the normal protocol in cases such as this, which involved a CT scan enhanced by a contrast agent, would have triggered a recollection because he would then have had an in-depth conversation about why there would be a departure from best practice.

[25] I can see no reason to conclude that the learned primary judge erred in his finding of credibility against Dr Coroneos. I turn now to what I described earlier as the principal questions.

4. Whether the first respondent should have warned the appellant of the risks involved in the administration of a CT scan enhanced with a non-ionic contrast agent

[26] That question depends on whether there was a foreseeable risk of harm inherent in the administration of such a scan and whether that risk was material. A risk is material if, in the circumstances of this case, a reasonable person in the appellant's position, if warned of the risk, would have been likely to attach significance to it or if the first respondent was or should reasonably have been aware that the appellant, if warned of the risk, would have been likely to attach significance to it: *Rogers v Whitaker*.[1]

[27] The court, in that case, did not deal further with the question of foreseeability except to describe it as foreseeability of a material risk inherent in the proposed treatment. However, as Gummow J pointed out in *Rosenberg v Percival*,[2] whether a risk is foreseeable and whether it is material must depend on the likelihood and the extent or severity of the potential injury. In considering whether a risk is material, likelihood of occurrence and severity of the potential injury then need to be considered in the circumstances of the plaintiff's case known or which ought to be known to the defendant; in this case the appellant's obsessional belief that he had a brain tumour and the fact that the only way of dispelling this belief, according to Professor Palmer, was by a CT scan enhanced by a contrast agent; his consequent nervousness about undergoing the procedure due to his fear that it would reveal a tumour; and the risk that a warning might increase his nervousness and thereby increase his risk of an adverse reaction.

[28] If the evidence upon the likelihood of the risk of injury to the appellant from the administration of an enhanced CT scan was only that of the independent experts who gave evidence or whose writings were tendered, Professor Palmer, Professor Thomson and Dr Katayama, it would appear to have been very slight indeed. Two research papers were in evidence, one by Professor Palmer the other by Dr Katayama and others.

[29] According to Professor Palmer's paper, which was derived from a survey which he did, and his evidence, the overall risk of both high and low risk patients suffering a severe reaction to non-ionic contrast media was one in a little over 6,000. Dr Katayama's calculation of the same risk, from a survey which he did, was one in 4,000. Professor Thomson said that the risk of a severe reaction from non-ionic contrast media in the general population, that is, presumably, both high risk and low risk patients was one in 10,000. It was common ground in this case that the appellant's reaction was a severe one.

[30] The difficulty with these calculations, from the appellant's point of view, is that they include both high risk and low risk patients. If high risk patients were eliminated from them, according to Professor Palmer, the risk of a severe reaction in patients would be nil or virtually nil. It is necessary therefore to identify the characteristics by which these doctors identified high risk patients and to determine whether the appellant was one.

[31] In his published paper which was admitted in evidence, Professor Palmer refers to a 1986 report of the Royal Australasian College of Radiologists which suggested

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1 (1992) 175 CLR 479 at 490.

2 (2001) 205 CLR 434 at 455 - 458.

guidelines to identify high risk groups, who should receive non-ionic media. These were patients with previous reactions to contrast media or who had asthma, a significant allergic history (not to drugs), renal or cardiac impairment, poor hydration, diabetes mellitus, myelomatosis or sickle-cell anaemia; or infants or small children. In his statement Professor Palmer said that his staff ask questions concerning risk factors, for example, whether the patient had had contrast media before and, if so whether he had had any reaction to it; whether he was allergic to anything or had a history of allergy to anything; whether he had asthma or a history of asthma; whether he was a diabetic; or whether he suffered from heart disease. It was thus these factors which, in his view, identified a high risk patient.

[32] Similarly Professor Thomson said that patients at Royal Melbourne Hospital in 1993 who were receiving such treatment were questioned prior to injection about previous iodinated contrast injections, poor reaction to iodinated contrast, allergy history, asthma, hay fever and medication history. It was apparently these questions which, to him, identified high risk patients. He went on to explain this by saying:

> "Factors indicating increased risk of reaction to iodinated contrast media in the caucasian Australian population are prior reaction to contrast (10 times), allergy to iodine or sea food (2 - 3 times), asthma (5 times), hayfever and other drug allergies (2 times). Risk of adverse reaction is also increased with drug interactions, (notably phenformins) and in patients with renal or hepatic dysfunction."

[33] Here, on the evidence which the learned trial judge accepted, the appellant gave negative answers to the questions whether he was asthmatic, if he had had contrast agent given to him before and whether he was allergic to shellfish. There was no evidence that the appellant had any of the other conditions referred to above which would have put him into a high risk category.

[34] There were some who thought at the time that anxiety might increase the severity of the reaction or might even precipitate it. It was, at that time, one of the risk factors identified by the Royal Australasian College of Radiologists although it seems no longer to be so. Professor Palmer described this view as dubious.

[35] Upon the evidence of Professor Palmer and, implicitly, Professor Thomson, it seems to me, the appellant failed to prove that he was other than a low risk patient and that, consequently, the chances of his suffering the severe reaction which he did to the injection of the contrast agent were infinitesimally small. This conclusion from the evidence of Professor Palmer and, implicitly, Professor Thomson does not seem to have been adverted to by his Honour. I turn, then to the evidence of Dr Dubois.

[36] Dr Dubois claimed equal or superior experience and, presumably knowledge to Professor Palmer. He accepted that Dr Coroneos had told him, before the appellant was given his injection, that the latter was extremely anxious. And he knew that extreme anxiety was one of the risk factors which the Royal Australasian College of Radiologists regarded as significant in its guidelines. Then followed this question and answer:

> "So, if it is one of those risk factors, potentially, he has a higher risk than normal of a severe reaction? -- Three times the normal risk, that is, 1 in 2,000."

[37] Dr Dubois did not explain what he meant by "the normal risk" or how he arrived at the view that extreme anxiety increased it three times. However one in 6,000, it will be recalled, was Professor Palmer's assessment of the risk for all patients, high and low risk, of a severe reaction from an injection such as this.

[38] If Dr Dubois was starting from the figure of one in 6,000 on the basis of Professor Palmer's report, he failed to appreciate, as it seems his Honour also did, that that was not the normal risk if normal risk means the risk incurred by normal, that is, low risk patients. That was infinitesimally small. Nevertheless his opinion was that of an expert radiologist and a defendant in the action. His evidence in this respect was set out by the learned trial judge in his judgment.

[39] It is not entirely clear whether his Honour accepted this evidence though it seems likely that he did. His conclusion that there was no breach of a duty of care by Dr Dubois appears to have been based on his view that, accepting that the risk factor in this case was of one in 2,000, Dr Dubois nevertheless appropriately balanced the need to warn of material risks and the risk of increasing the chance of an adverse reaction by heightening the patient's anxiety, by implementing a procedure of not giving a direct warning but asking questions designed to ascertain whether the particular patient fell within a known category.

[40] If that was, as I think, the basis of his Honour's conclusion, then in my opinion a risk of one in 2,000 that the appellant would suffer a reaction as severe as this, with the possibility of death, was one which was reasonably foreseeable and one to which a reasonable person in the appellant's position, if warned of the risk, would have been likely to attach significance. It follows, in my opinion, that Dr Dubois should have warned the appellant of this risk, of which he was aware, before the appellant was injected.

[41] It is true that there were some who thought that to warn a highly anxious person such as the appellant of the risks involved in such an injection would be likely to make his reaction worse or possibly even precipitate an adverse reaction. It is also true that Professor Palmer, having obtained satisfactory answers to questions of the kind asked by Mr Brown, was not in the practice of giving any such warning because of the possibility that anxiety thereby produced in the patient might cause an adverse reaction; and that Professor Thomson, after obtaining satisfactory answers to similar questions would simply say to his patients, in general terms, that there was a risk of reaction to it but, for the same reason, not mention how serious that might be. But this is explicable by Professor Palmer's view, and presumably also Professor Thomson's, contrary, it seems, to that of Dr Dubois, that, having obtained satisfactory answers to the questions to which I have referred, the risk of severe reaction, even in a nervous, but otherwise not high risk, patient, was negligible.

5. Whether, if the appellant had been warned of the risk of a severe reaction, he would have gone ahead with the procedure

[42] His Honour's adverse finding with respect to the appellant's credit meant that he disbelieved his evidence that, had he been warned of this risk, he would not have gone ahead with the injection of a contrast agent.

[43] Mr Cooke QC submitted that, the appellant having proved the respondent's breach of duty to warn of the risk and that the risk eventuated and caused harm to him, had

made out a prima facie case of causal connection; and that an evidentiary onus then rested on the respondents to point to other evidence suggesting that no causal connection existed. He relied for that proposition on the dissenting judgment of McHugh J in *Chappel v Hart*[3] where his Honour stated a proposition in those terms.

[44] In *Chappel v Hart* the plaintiff's statement that, if she had received an appropriate warning, she would have delayed the surgery and had it performed by the most experienced surgeon in the field, was accepted by the court. The majority thought that this would have reduced the risk of the injury which occurred. McHugh J, however, thought that, even accepting her evidence, the plaintiff failed to prove that taking that course would have avoided her injury.

[45] The statement by McHugh J relied on by the appellant is no doubt correct but that evidentiary burden is a light one. And when a plaintiff's statement that had he been warned of the risk he would not have gone ahead with the procedure, is disbelieved, there is a heavy evidentiary onus on him to prove causation by other means. As McHugh J said in *Rosenberg v Percival*:[4]

> "Australian law is committed to a subjective test in determining whether a patient would have refused to undergo a medical procedure if that person had been warned of the risk of relevant injury. If the patient is believed, he or she succeeds even though the objective facts point the other way. If the evidence of the patient is rejected, he or she carries the heavy evidentiary burden of persuading the court to make a favourable finding on the causation issue solely by reference to the objective facts and probabilities…
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> …
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> When the direct testimony of that person on the causation issue has been rejected, it is unlikely, as a matter of fact, that the patient will succeed on that issue unless the objective evidence in favour of the patient is very strong."

[46] Here the objective evidence in favour of the appellant was far from very strong. Mr Cooke QC sought to rely on the appellant's psychiatric condition at the time as indicating that it would have been unlikely that he would have consented to the procedure had he been told of its risks. He had consulted Dr Middleton, a specialist psychiatrist, less than a week before this incident, complaining about dizziness, soreness in the neck, lack of concentration and difficulty in sleeping. There had been some traumatic events in his life sometime beforehand and Dr Middleton thought that his symptoms were consistent with a post-traumatic stress disorder. In particular, Dr Middleton said, the appellant was particularly focussed on there being something wrong with him. The appellant actually used the words "carcinoma phobia" to Dr Middleton. This is, of course, consistent with what Dr Coroneos told Dr Dubois.

[47] Contrary to the submission, in this respect, by Mr Cooke QC, it seems to me that the appellant's obsessive fear that he had a brain tumour meant that it was unlikely that he would have rejected the procedure had he been warned of its risks. In other words his irrational fear that he had a brain tumour was, it seems to me, much greater than any fear he would have had of an adverse reaction after being warned

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3 (1998) 195 CLR 232 at 247.

4 (2001) 205 CLR 434 at 449.

of its possibility. He would have been told, it seems from Professor Palmer's evidence, had he asked, that the only way in which a brain tumour could be excluded was by a CT scan of the kind which he had.

[48] It follows, in my opinion, that the learned trial judge was correct in concluding that the appellant had not discharged the onus of proof of showing that, had a warning been given, he would not have proceeded with an enhanced CT scan. For those reasons this appeal must fail.

6. Damages

[49] I agree, for the reasons given by McMurdo J that the appeal against the judgment, to the extent that it appealed against the amount of damages awarded by the learned trial judge would also have been dismissed.

7. Costs

[50] I agree with the reasons given by McMurdo J for dismissing the appellant's application for an extension of time within which to appeal against the orders for costs made by the learned primary judge on 18 December 2003 and for dismissing his appeal against the orders made by the learned primary judge on 10 March 2004. The appellant is obliged to pay the first and third respondents' costs of the principal appeal, the application for an extension of time and the appeal against the orders made on 10 March 2004.

Orders

1. Dismiss the appeal against the judgment of 16 July 2003.
2. Dismiss the application for an extension of time within which to appeal against the orders made on 18 December 2003.
3. Dismiss the appeal against the orders made on 10 March 2004.
4. Order that the appellant pay the first and third respondents' costs of each of the appeals and application.

[51] **WILLIAMS JA:** In the end result I agree with Davies JA and McMurdo J that the appeal must be dismissed on the ground that the finding by the learned trial judge that the appellant would have gone ahead with the procedure, even if warned of the risk of a severe reaction, was supported by the evidence and could not be overturned on appeal. I also agree with all that has been said by McMurdo J on the issues of quantum and costs.

[52] However, I am not persuaded that this Court should overturn the finding made by the learned trial judge that the duty of care owed to a patient, defined here as a duty to warn of a material risk inherent in the proposed treatment because if warned of the risk the patient would be likely to attach significance to it, was not breached. As I differ from other members of the court on that issue it is necessary for me to state briefly my reasons for so concluding. My reasoning is based on findings of fact made by the learned trial judge. I will not repeat non-controversial facts mentioned in other judgments.

[53] On 14 May 1993, some two weeks before the procedure in question was carried out, the appellant consulted Dr Middleton, a psychiatrist. Amongst other things that doctor noted that the plaintiff had a preoccupation with a fear of illness described as “carcinoma phobia”. The appellant indicated that he was frightened he might have a brain tumour and had convinced himself that he had one. The respondent, Dr

Coroneos, examined the plaintiff on 25 May 1993. The findings made by the learned trial judge with respect to that consultation can be summarised as follows:

> "The plaintiff was concerned with the continuing symptoms and anxious as to the likelihood of pathology in his central nervous system. Dr Coroneos said he eliminated the possibility of a 'mass lesion' and told the plaintiff that despite an essentially normal clinical examination one could not exclude such pathology. On that basis he advised that a CT examination of the brain and cervical spine could be performed. He said that the plaintiff was extremely anxious at the prospect of undergoing those examinations and told him that he had a strange feeling that they would find pathology. . . . Dr Coroneos offered to come to the procedure with him so that he could take immediate steps in the event any pathology was identified. . . . His account of what he told Dr Coroneos is consistent with considerable concern on his part that he may have a tumour."

[54] The procedure in question was carried out on 29 May 1993. The learned trial judge expressly found that "there was no direct warning of possible risks given." He noted in making findings with respect to the appellant's pre-incident medical history that there was "evidence that the plaintiff had asthma as a child but it did not persist into adulthood."

[55] The evidence of Dr Coroneos at the trial was that he ordered a plain CT scan, but that evidence was justifiably rejected by the learned trial judge. I will not repeat evidence relating to that issue which is set out in other reasons for judgment. However it should be noted that the learned trial judge did find that Dr Coroneos told the appellant that "there were no risks".

[56] The learned trial judge accepted the evidence of Brown, the radiographer who performed the procedure. He was found to be "very experienced". Though Brown could not recall precisely the conversation he had with the appellant he said asked specifically "if the patient was asthmatic or had other allergies". Given the practice which he routinely followed "he assumed that he got a negative answer to each question". Importantly the learned trial judge accepted, as he was clearly entitled to, that the appellant gave negative answers to Brown's questions about asthma and other allergies.

[57] It was against the background of those findings of fact that the learned trial judge made his assessment of the medical evidence and considered the legal issues made relevant by *Rogers v Whitaker* (1992) 175 CLR 479 and *Rosenberg v Percival* (2001) 205 CLR 434. After citing relevant passages from *Rogers v Whitaker* the learned trial judge said:

> "The evidence suggests that there is no dispute that there is a known risk of an adverse reaction to contrast, which is greater when certain known predisposing factors exist. There is no dispute that the risks relevant to the present case were known at the relevant time. However, in the absence of pre-disposing factors the likelihood of the occurrence of an adverse reaction was, according to the evidence, not high. In the present case, I have not accepted the account given by the plaintiff and Dr Coroneos of the events leading up to and surrounding the performance of the procedure. It is also plain that the plaintiff remained very concerned that he may suffer from a

> serious condition notwithstanding what he had been told as to the unlikelihood of it by Dr Coroneos. Looking at the matter objectively in light of the findings of fact and the lack of any reaction to what must obviously have been preparation to administer an injection, I am satisfied that the plaintiff has not discharged the onus of proving that he would not have undergone the procedure had he been directly warned. In addition, the case is one which involved, to an extent, medical judgments of competing potential risks and drawing of a balance as to the best approach in the circumstances to informing the patient, for reasons enlarged on in the next section."

[58] Leaving aside the last sentence in that quote the reasoning of the learned trial judge is unobjectionable and provides the basis for the conclusion that the appeal must be dismissed. It was primarily because of what was said in that last sentence that the learned trial judge concluded that there was no breach of a duty to warn. It is the correctness of what is said in the last sentence which gives rise to the issue now under consideration.

[59] The learned trial judge then went on to analyse in some detail the evidence given by experts as to the "medical evidence concerning warnings"; that is the "next section" in the sentence referred to above.

[60] On the whole of the evidence Professor Palmer would seem to be the leading authority and that proposition appears to have been inferentially accepted by the learned trial judge. Professor Palmer's study appears to be the benchmark, and is relied on by all the other experts. He concluded that the "rate of an adverse reaction for non-ionic contrast agent was 1 in 6000." As Davies JA correctly points out the basis for determining that ratio included both high and low risk patients. If the high risk patients were eliminated the risk of a severe reaction becomes almost negligible. Professor Palmer placed in the high risk category patients with previous reactions to contrast medium, asthma sufferers and those with a significant allergic history. Professor Palmer's evidence, as found by the learned trial judge, was that "the desirability of giving warnings of an adverse reaction was in 1993 subject to different views. . . .at that time there was no 'usual practice'."

[61] The learned trial judge then referred to the evidence of Professor Thomson, another expert in the field. He noted that Professor Thomson's evidence was that the "rate of severe reaction in people with no known risk factors was about 1 in 10,000." The learned trial judge then referred to the evidence of Mr Winningham, a radiographer of some experience. That witness said he would "also be on alert for anxious patients who had fears about the examination and the injection and take that into account".

[62] Guidelines dated 27 July 1990 and March 1993 issued by the Royal Australasian College of Radiologists were in evidence and were then analysed by the learned trial judge. Those documents established that the risk of an adverse drug reaction would be reduced by a factor of six if non-ionic contrast medium was used; that of course was the medium used in the present case. The risk factors listed in those documents included "excessive anxiousness", but as Davies JA has noted that appears to be no longer the case.

[63] The respondent, Dr Dubois, was also a very experienced radiologist. His evidence was that his practice in 1993 only used non-ionic contrast since it was significantly safer than ionic. In his view severe reactions were about six times less frequent with non-ionic contrast. His evidence was that the critical risk factors were a history of allergies or asthma. The learned trial judge then set out the following summary of the evidence of Dr Dubois and what is said therein can be taken to be relevant findings made by him. The learned trial judge said:

> "He said that no warning of the possibility of a reaction was given at that time. In the practice, the risk of mortality was estimated as less than 1 in 250,000 and the risk of any adverse reaction at all at much less than 1 in 1,000. He said that the view that a warning ought not be given as to the possibility of a reaction was within the range of informed opinion within the College of Radiologists.
>
> In 1993 almost 100% of cervical spine CT's were done with contrast. It was a policy of the practice. In the case of brain CT's for the purpose of reassuring a patient by ruling out a tumour, the same would be the case. Because of conferences and interactions with high level referrers such as Dr Coroneos both of those facts would be well known. He agreed that medical responsibility for administration of the contrast lies with the radiologist. He said that he knew, from talking to Dr Coroneos, that the plaintiff was anxious. The risk factor of any reaction in such a case would be in 1 in 2,000 approximately. He did not recall telling Mr Brown about the patient's anxiety."

[64] Because the reasonableness of the findings made by the learned trial judge are in issue it becomes necessary to quote relevant passages from the evidence of Professor Palmer, Professor Thomson and the respondent Dr Dubois in order to evaluate the correctness of the conclusions reached by the learned trial judge.

[65] The following extracts from the evidence of Professor Palmer are relevant:

> "Q. Now, with any patient coming in for a brain scan with contrast, do you give the patient any explanation or warning before the injection of the contrast medium takes place? – A. Well, usually the radiologist or, certainly in my case, the radiologist would ask about risk factors, tell the patient that they may get a feeling of warmth when it is injected, but it was not my practice to indicate that there was even a small possibility of death on the grounds that there was some evidence, which is not entirely agreed, but there's some evidence that anxiety produced in the patient by the procedure may, itself, be a factor in causing an adverse reaction.
> Q. Well, would it be the invariable practice to warn about the risks of non-ionic contrast medium before injection? – A. No, it wouldn't – it certainly would not have been in 1993 – not to the extent of producing severe reactions and death, no.
> Q. And why not? – A. For the reason I just mentioned – that there was some evidence that you, by producing anxiety in the patient, actually increased the chances of having an adverse reaction.
>
> …

Q. Is it your practice to tell the patient that there is a risk of a severe reaction that might cause breathing difficulties? – A. It is not my usual practice to do so. . . .
Q. And you think that's the better practice because it might provoke anxiety? – A. Yes. There is some evidence that anxiety itself either makes a reaction worse or, in fact, is the prime reason for the reaction. I must say, the evidence is dubious, but there is some evidence.
Q. Would that be the better practice in 1993, not to tell the patient of these risks? – A. I don't know whether it would be the better practice. Around about the time of the early 1990s, because there was a change in attitude towards disclosure of things to patients, and in this context in some cases in the profession, in the use of the non-ionic medium, there was a variety of views being expressed at that time as to what one should do in terms of disclosing to patients all the possible adverse reactions and with contrast medium the incidents are so low that I think a lot of people thought that you would probably do more harm by telling patients of that possibility than good.
Q. So a practice which chose not to warn patients of the possibility of death or severe reaction could not be accused of standing outside the usual practice? Would that be the case, professor? – A. Yes. What I was trying to imply was that there wasn't a usual practice at that time. Some people told everything and some people said very little, but the responsibility for the investigation was with the radiologist and so a radiologist who didn't tell patients of this were open to criticism, but I could understand why people didn't.

…

Q. So, are you saying there is no need to get informed consent before you inject contrast? – A. No. What I'm saying is I can't remember in 1993 precisely what we did about informed consent. Informed consent sort of works both ways. One of the problems with inducing anxiety during questioning with patients is there is some evidence, for what it is worth, an anxiety increases the risk of a contrast reaction. I'm not sure that I believe it but there is a view in the profession that that may be so.

…

Q. You said that you wouldn't advise the patient of any risks including breathing difficulties or death? – A. No, but I would tell the patient that if they felt at all uncomfortable, any difficulties they had, to raise their hand when they were in the scanner, and we would come in and see to them.

…

Q. So, you wouldn't warn of any material risks of the procedure? – A. No, I wouldn't have raised the possibility of death orally. …

> Q. You told Mr Cooke that you wouldn't have warned in 1993. … – A. No, I wouldn't have verbally warned him. No, I wouldn't, I agree.
>
> …
>
> Q. Mr Cooke said to you, "Would it be the invariable practice to warn about the risks of non-ionic contrast medium before the injection?" And you said, "No, it wouldn't."? – A. It wouldn't have been universal, no. . . .
>
> …
>
> I can say at that time I would not personally, when speaking to the patient, indicate that there was a possibility of a severe reaction."

[66] Early in the evidence of Professor Thomson he said it was standard practice for radiologists to warn a patient of the risks involved in the administration of contrast dye. That answer was expanded on in later evidence as follows:

> "Q. Assuming that you were going to have a change in plan from a plain CT to a CT with contrast, what would be the standard practice of a radiologist? Would you then discuss that with the patient? – A. Normally we would then go into the room from the console and say to the patient, "We want to give you contrast because we want to see if we can see blood vessels.", or some statement such as that, and then we would ask them, you know, 'Have you had contrast before? Do you have any' – and we would try and elicit risk factors from the patient to give us an idea of whether it was going to be safe to give the contrast or not.
> Q. At the point in time would you also tell the patient about the risks involved in the contrast? – A. Yeah, normally we are fairly minimal with what we say in terms of the risk. We don't normally tell a patient he might die. We say there is a risk of a reaction to it, and most patients at that stage are happy to accept some unspecified risk on the basis that they know that most of the people that have a CT have the contrast anyway.
>
> …
>
> Q. Do you subscribe to the view that telling the patient these sort of morbid possibilities enhances their anxiety and perhaps the chance of a reaction? – A. I believe if you have got a nervous patient, you can make them more nervous by giving them information that you think at the time is not really necessary.
> Q. Can that, perhaps, enhance the prospect of an adverse reaction? – A. It is my personal belief that's so, but there is no real data to prove it."

[67] Finally there is evidence of Dr Dubois; the following extracts from his evidence are the most relevant for present purposes:

> "Q. And was there a procedure in place for warning patients that there may be some reaction to the contrast medium? – A. No, there

are various reasons why, after very careful consideration, that was not our practice. . . . because the risk of mortality is estimated to be less than 1 in a quarter million, we – it was our judgment that we would not warn of that.
Q. Did you not warn of an unspecified life threatening risk – reaction? – A. That was not our practice and for good reason. There was a view – and this has been expressed in literature, particularly primarily by Lalli, an author in north America, but as with all the literature on the subject, our primary references are often requoted. There is another article by Wolff which supports the hypothesis, and both of those produce evidence that if you interrogate patients or express in too many words the possibility of some adverse effect of the drug you are likely in fact to provoke an adverse reaction, and since the risk of adverse reaction is much less than one in a thousand we choose not to do that.
Q. That was your practice in 1993? – A. It was indeed.

…

Q. Your side has admitted that there was no warning given. Do you want to resile at all? – A. Not at all. That may be a legal matter. I'm just telling you, as I said, I did not myself warn the patient of any risk. . . .

…

At the opposite end of the spectrum you will have a large body of Fellows of the College of Radiologists, and their equivalent overseas, who will say that the risk is not material and, therefore, you should not engage in any discussion warning of risk that you provoke anxiety and, therefore, according to some studies, you increase the risk of having a reaction. So, on balance of those opinions and the inability to resolve the different opinions, our practice has made the decision to perform the studies without detailed explanation of any risk. We consider there is not a material risk. In our hands the risk is much less than 1 in 6,000.

…

Q. Who told you that he was extremely anxious? – A. Dr Coroneos did.
Q. You knew before the CAT scan began that the patient was extremely anxious about it? – A. Indeed, I did.
Q. That is one of the risk factors which the Royal Australian College of Radiologists regards as significant in its guidelines, isn't it? – A. It is.
Q. So, if it is one of those risk factors, potentially, he has a higher risk than normal of a severe reaction? – A. Three times the normal risk, that is, 1 in 2,000."

[68] Those extracts from the evidence of the medical experts support the findings of fact made by the learned trial judge quoted above. Against the background of those findings the learned trial judge then reasoned as follows:

> "The evidence concerning the practice in 1993 with regard to giving a warning of possible reaction to contrast medium is to the effect that a direct warning was not given by any of the witnesses. The rationale for that approach was that there was a perception that there was evidence that a heightened anxiety level in the patient may be a factor increasing the risk of an adverse reaction. A balance was drawn between the need to warn of material risks and the risk of increasing the chance of an adverse reaction, by heightening the patient's anxiety, by implementing a procedure of not giving a direct warning but asking questions designed to ascertain whether the particular patient fell within a known risk category. If an answer given indicated that a patient had a risk factor, the decision whether to proceed or not was made by a radiologist. As a matter of practicality, asking a patient if he was anxious would seem to have a distinct downside. If he was already anxious, or not anxious, but in either case asked why the question was asked and was told that anxiousness was a risk factor, it would seem counter-productive.
>
> Dr Dubois' evidence, which was not seriously challenged, was that, in his practice, the decision to follow the procedure adopted was arrived at after consideration. I am satisfied that it is not a case where there was no identifiable reason for adopting the procedure in operation in the practice. The particular case is not one where there was a specific inquiry by the patient as to risk, let alone one that eventuated. The judgment to implement the procedure which involved not giving a direct warning of risk factors was made after considering what were essentially medical issues. The procedure implemented was not inconsistent with mainstream medical opinion at the time.
>
> The case is one where there was a system in place, the purpose of which was to minimise one risk while providing a means for identifying other known risk factors, which, if discovered, would be further considered by a radiologist. To the extent that ultimate responsibility is said to rest upon the radiologist, the system followed was designed to accommodate it. In my view, the standard of care inherent in that system was reasonable and, on the facts found, there was no breach of the duty of care owed to the plaintiff by the first, second and third defendants."

[69] If there be any weakness in that approach it is identified in the reasons of McMurdo J where reference is made to the passages in *Rogers v Whitaker* at 486 and *Rosenberg* at 439 quoting from Lord Scarman in *Sidaway v Governors of Bethlem Royal Hospital* [1985] AC 871 at 876. The matter is however complicated because of the considerations referred to by the learned trial judge in the passage last quoted. If anxiety is the only relevant risk factor then a warning would only heighten the anxiety and therefore heighten the risk factor with respect to a procedure which, on the evidence, it was necessary to carry out in order to allay the appellant's fear that

he had a malignant brain lesion and was not statistically likely to cause an adverse reaction. The interests represented by Dr Dubois in these proceedings were in a difficult medical situation. As the learned trial judge has pointed out they were faced with a situation involving "medical judgments of competing potential risks and drawing of a balance as to the best approach in the circumstances to informing the patient". Given the evidence accepted by the learned trial judge, that the procedure implemented by Dr Dubois was not inconsistent with mainstream medical opinion at the time, I am not persuaded that the failure to give a positive warning of the risks involved constituted a breach of the duty of care owed by doctor in the circumstances.

[70] Further, as Davies JA has pointed out in his reasons: "Upon the evidence of Professor Palmer and, implicitly, Professor Thomson, it seems to me, that the appellant failed to prove that he was other than a low risk patient and that, consequently, the chances of his suffering the severe reaction which he did to the injection of the contrast agent were infinitesimally small." That, to my mind, is the critical conclusion which should be drawn from the whole of the evidence and accords with the conclusions of the learned trial judge.

[71] For all of those reasons I am not persuaded that the learned trial judge was wrong in finding that the failure to warn did not evidence a breach of duty.

[72] As already noted I agree with the orders proposed.

[73] **McMURDO J:** I agree with the conclusions of Davies JA that the first respondent should have warned the appellant of the risk but that the appeal should be dismissed because the appellant has failed to prove that, if warned, he would not have gone ahead.

[74] The first respondent's duty was to warn the appellant of any material risk inherent in the proposed treatment. The risk was material if a reasonable person in the appellant's position, if warned of the risk, would be likely to have attached significance to it or if the first respondent was or should reasonably have been aware that the appellant, if warned of the risk, would have been likely to attach significance to it: *Rogers v Whitaker* (1992) 175 CLR 479.

Material Risk

[75] The appellant submits that his Honour failed to consider at all whether the risk was material, or at least whether it was material according to the alternative tests from *Rogers v Whitaker*. The respondents submit that the trial judge determined this question of materiality in this part of the judgment:

> "[113] The evidence suggests that there is no dispute that there is a known risk of an adverse reaction to contrast, which is greater when certain known predisposing factors exist. There is no dispute that the risks relevant to the present case were known at the relevant time. However, in the absence of pre-disposing factors the likelihood of the occurrence of an adverse reaction was, according to the evidence, not high. In the present case, I have not accepted the account given by the plaintiff and Dr Coroneos of the events leading up to and surrounding the performance of the procedure. It is also

> plain that the plaintiff remained very concerned that he may suffer a serious condition notwithstanding what he had been told as to the unlikelihood of it by Dr Coroneos. Looking at the matter objectively in light of the findings of fact and the lack of any reaction to what must obviously have been preparation to administer an injection, I am satisfied that the plaintiff has not discharged the onus of proving that he would not have undergone the procedure had he been directly warned. In addition, the case is one which involved, to an extent, medical judgments of competing potential risks and drawing of a balance as to the best approach in the circumstances to informing the patient, for reasons enlarged on in the next section."

[76] As Gummow J said in *Rosenberg v Percival* (2001) 205 CLR 434 at 458, the phrase "likely to attach significance to" forms part of each of the alternative tests of materiality expressed in *Rogers v Whitaker*, and that phrase requires a consideration of the extent or severity of the potential injury, and the likelihood of it occurring. Those factors are to be considered together because "a slight risk of a serious harm might satisfy the test, while a greater risk of a small harm might not". Other relevant factors in the consideration of materiality include the circumstances of the patient, and particularly the patient's need for the treatment as well as the existence of reasonably available and satisfactory alternative treatments, so that "A patient may be more likely to attach significance to a risk if the procedure is elective rather than life saving".[5]

[77] The evidence as to the likelihood of an adverse reaction is summarised in the judgment of Davies JA. An important matter in assessing that likelihood was that, as the first respondent said he was told by Dr Coroneos, the appellant was "particularly anxious that he had various symptoms" and he was "extremely anxious about (the CAT scan)". On the first respondent's own evidence, this made the appellant several times more likely to have the allergic reaction which eventuated. This was one of the risk factors which the Royal Australian College of Radiologists regarded as significant in its Guidelines published in 1990 and 1993, as the first respondent acknowledged. The first respondent described his own practice in these terms:

> "The standard procedure for people injecting contrast in our practice, such as Mr Brown, would be to make an inquiry of risk factors. And then, if there were no significant risk factors, to proceed with the injection. If at any time Mr Brown felt that as a result of his interrogation of the patient, or for any other reason, that there were risk factors, then he would come to the radiologist and the radiologist would then further interview the patient and inject the contrast agent, if appropriate, or advise the patient of alternatives that might be available."

Yet although the first respondent did know of a significant risk factor, which was the appellant's extreme anxiety, he did not interview the appellant at all, nor did he inform the appellant that he belonged to a class of patients for whom there was a

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5 At 459.

likelihood of an adverse reaction which was several times higher than for the average person.

[78] The evidence of Dr Thomson was that he would usually give all patients some warning, albeit a general one without the specific reference to the prospect of a life threatening reaction. It was his practice not to inform a patient that the reaction could be that serious because, he said, "if you have got a nervous patient, you can make them more nervous by giving them information that you think at the time is not really necessary" and that this could "enhance the prospect of an adverse reaction … but there is no real data to prove it". Professor Palmer's practice was not to warn of the possibility of a severe reaction because that might provoke anxiety, and "There is some evidence that anxiety itself either makes a reaction worse or, in fact, is the prime reason for the reaction" although he added that "the evidence is dubious, but there is some evidence".

[79] The first respondent was in no doubt that a very anxious patient, such as the appellant, was much more likely to have a severe reaction. And the opinions of Dr Thomson and Professor Palmer, whilst expressing some reservations as to the effect of a patient's anxiety, were consistent with the first respondent's (more definite) opinion. On all the evidence then, the first respondent should have characterised the appellant as having a relatively higher risk of an adverse reaction. In my view, it should have been found that the risk was material: an allergic reaction was potentially life threatening, the patient had an unusually high risk of the reaction and the procedure was elective.

Breach of duty

[80] The trial judge held that the first respondent was not negligent, not because of any express finding that the risk was immaterial, but upon the basis that the duty to warn had to be balanced against the prospect that the appellant would have become yet more anxious had he been warned. He identified a practice or approach, common to all relevant witnesses, of not giving a warning of a possible life threatening reaction because of the possibility of increasing the anxiety of a patient and perhaps thereby increasing the risk of an adverse reaction. In his Honour's view, the "standard of care inherent in that system was reasonable". However, the acceptance of that practice would seem to have the consequence of denying "the right of the patient to make up (his) own mind in the light of the relevant information whether or not (he) will accept the treatment", as Lord Scarman described it in *Sidaway v Governors of Bethlem Royal Hospital* [1985] AC 871 at 876, in a passage cited with approval in *Rogers v Whitaker* at 486 and in *Rosenberg* at 439. The appropriate standard of care gives weight to "the paramount consideration that a person is entitled to make his own decisions about his life": *F v R* (1983) 33 SASR 189 at 193 cited with approval in *Rogers v Whitaker* at 487. It is the patient's choice as to whether to undergo the proposed treatment and "the choice is, in reality, meaningless unless it is made on the basis of relevant information and advice".[6] The effect of this practice was to leave the real choice to the medical practitioner.

[81] The duty to disclose or advise of material risk is subject to the therapeutic privilege which is "an opportunity afforded to the doctor to prove that he or she reasonably believed that disclosure of a risk would prove damaging to a patient".[7] That

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6 *Rogers v Whitaker* at 489.

7 *Rogers v Whitaker* at 486.

privilege was described by Lord Scarman in *Sidaway* at 889-890, in this way: "Even if the risk be material, the doctor will not be liable if on a reasonable assessment of his patient's condition he takes the view that a warning would be detrimental to his patient's health". In *F v R* at 193 King CJ said that: "Even where all other considerations indicate full disclosure of risks, a doctor is justified in withholding information, and in particular refraining from volunteering information, when he judges on reasonable grounds that the patient's health, physical or mental, might be seriously harmed by the information". In *Canterbury v Spence* (1972) 464 F.2d 772, in a passage at page 789 cited with approval in *Rogers v Whitaker* at 486, the privilege was described as follows:

> "The second exception obtains when risk-disclosure poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view.
>
> …
>
> The critical inquiry is whether the physician responded to a sound medical judgment that communication of the risk information would present a threat to the patient's well-being.
>
> The physician's privilege to withhold information for therapeutic reasons must be carefully circumscribed, however, for otherwise it might devour the disclosure rule itself."

The respondents apparently do not seek to rely upon this exception and nor could they, upon the evidence. The practice which they and others followed in not disclosing this risk was a general one, applied to all patients. It did not involve a consideration of a particular patient's physical or mental health and the likelihood that his or her health would be seriously harmed by the warning. Nor could it be suggested that in the appellant's case the warning itself would have seriously harmed his health. And this was not a case where the proposed scan was clearly necessary for the appellant's health, such that the immediate necessity for the scan could have reasonably justified the withholding of the information; instead, the first respondent followed a practice that required no consideration of whether for a particular patient, the scan was necessary. In my view, this was not an example of the therapeutic privilege and, accordingly, the practice was not in accordance with the duty as defined in *Rogers v Whitaker*. In my respectful view, the trial judge ought to have concluded that the first respondent was obliged to inform of this material risk.

Causation

[82] The fact that the appellant was "likely to attach significance to" the risk does not mean that he would have refused the treatment if informed of it, but only that he "would have been likely seriously to consider and weigh up the risk before reaching a decision on whether to proceed with the treatment": *Rosenberg* at 459 per Gummow J. Accordingly, the appellant had to prove also that he would have decided not to have this scan had he been properly informed.

[83] The trial judge's reasoning on this question is within the passage I have set out above. Plainly, the trial judge rejected the appellant's evidence that he would have refused the scan had he been informed of the risk. That was a finding affected by his Honour's conclusions as to the appellant's credibility. Much of the trial

involved evidence and argument as to the appellant's credibility, and unfavourable findings were made at least in relation to certain factual issues. His Honour summarised his conclusions as to the appellant's credibility in these terms:

> "[68] Having regard to the combination of the plaintiff's imperfect recollection of events surrounding administration of the contrast and other matters that affect confidence in the reliability or transparency of his evidence, I do not accept that he was not asked about relevant risk factors prior to administration of the contrast. Even though I do not accept the accuracy of the plaintiff's recollection of what was said to him before the contrast was administered, he did not suggest that no question was asked of him. The conclusion that he was asked relevant questions is supported by the fact that Mr Brown did not refer any concerns over risk factors to Dr Dubois. Nor do I accept that there was a request for a plain scan only, or the plaintiff believed that there was one. The general approach to his evidence otherwise will be to look for supporting evidence and to decide, in conjunction with evidence to the contrary, whether to act on it or not."

[84] Although the trial judge stopped short of a finding that the whole of the appellant's evidence, when unsupported by other evidence, was incredible, the rejection of the appellant's evidence on this causation question must have been affected by an assessment of credibility. It is a finding which should not be reversed unless the trial judge's advantage by having seen and heard the appellant could not be sufficient to explain or justify that finding.[8] For the appellant, it was submitted that the objective facts demonstrate a likelihood that the appellant would not have proceeded. In this context, where the appellant's direct testimony on the issue of causation has been rejected, "it is unlikely, as a matter of fact, that the patient will succeed on that issue unless the objective evidence in favour of the patient is very strong": McHugh J in *Rosenberg v Percival* at 449.

[85] Two factors were identified by the trial judge as the objective evidence on this issue. One of those was the lack of any protest to the administration of an injection. That was certainly an important consideration in assessing the appellant's evidence that he did not wish to undertake any invasive procedure. It was less relevant as objective evidence of his likely reaction to a proper warning. The other matter identified by his Honour was, in my view, critical. It was that the appellant "remained very concerned that he may suffer from a serious condition notwithstanding what he had been told as to the unlikelihood of it by Dr Coroneos". On an objective view, a highly anxious patient might be likely to refuse a treatment if appropriately warned of a material risk, but this patient was also very concerned that he had a brain tumour. Such was that concern that he was not prepared to accept the strong advice from Dr Coroneos that he was 99 per cent sure that it was not the case. The only means of providing the appellant with a complete assurance was to have him undergo this scan, and had he declined it, he would have remained in his highly anxious state as to the likelihood of an untreated tumour. In these circumstances, the objective facts do not demonstrate that he would have refused the scan, by preferring to accept the risk of the tumour to the risk of a reaction to the

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[8] *Rosenberg v Percival* at 444.

scan. Accordingly, the trial judge correctly concluded that the appellant failed to prove the necessary causal connection.

Assessment of damages

[86] Although this appeal will be dismissed, it is appropriate to consider the appellant's challenge to the assessment of damages. The trial judge was satisfied that the appellant's experience of reacting to the contrast medium in the course of this scan procedure heightened the level of an existing post-traumatic stress disorder. He assessed damages at $80,000, comprising $25,000 for general damages, $40,000 for lost earning capacity (past and future), and $15,000 for special damages (including interest).

[87] Whilst his Honour accepted that the relevant incident affected the appellant's post-traumatic stress disorder, he was not satisfied that the effect was as substantial and long lasting as the appellant had argued. Clearly, the appellant was psychiatrically unwell before this incident. He had sought advice from a psychiatrist, Dr Middleton, only a fortnight before the incident and he had earlier sought medical advice and treatment for lack of concentration, memory disturbance and stress after commencing practice at the Bar in May 1991. He had complained to Dr Middleton of considerable anxiety, difficulty in working, and a fear of "losing it" in court.

[88] Further complications in the identification of the effect of this incident upon that existing condition came from a number of circumstances as follows. First, the appellant was involved in a car accident in 1994 in which he successfully sued for damages for personal injuries, including a component of economic loss. They were physical injuries, but in those proceedings he claimed that they made him unable to work for remuneration for about three hours per day and intermittently during the day. This was sworn by the appellant in answers to interrogatories in those proceedings, which implied that the effects of these physical injuries were likely to continue. Second, the appellant undertook the conduct of a brief, leading another junior counsel, for the unsuccessful plaintiff in what has been referred to as the *Naomi Marble* case, which was tried in this court over 126 sitting days during 1996. The case was an unhappy and stressful one for the appellant, who conceded that the brief was beyond his then experience and expertise. His junior counsel gave evidence in the present matter describing the appellant during that trial as disorganised and extremely emotional, and as reacting disproportionately to rulings by the trial judge or the conduct of his opponents. The appellant's conduct in that case was the subject of a complaint by the trial judge to the Bar Association of Queensland, which resulted in disciplinary proceedings against him. In those proceedings, his membership of the Association was suspended for a period. In short, the *Naomi Marble* case must have been a major setback to the development of his practice. Thirdly, to the extent that he sought to show the extent of his alleged disability by reference to the accounts for his practice, there was the difficulty from the loss of many relevant records. Still, some records were available, but they showed no obvious impact of the incident the subject of this case upon his earnings as a barrister. The appellant's case here and at trial was not argued by a comparison of his earnings prior to this incident with those subsequent to it. Instead, it was argued that his diminished earning capacity could be measured by the loss from an alleged disability to undertake, on average, another brief per week throughout the balance of a career at the Bar ending upon retirement at age 70.

[89] The trial judge saw the appellant's unhappy experiences from the *Naomi Marble* case as having had a potential to aggravate the post traumatic stress disorder which pre-existed the incident the subject of the present claim. The appellant argues that there is no medical evidence for such a view, and that the appellant's behaviour in the course of that case was a manifestation of his illness. Even assuming that to be so, the appellant's difficulty was in demonstrating an impact of this incident, distinct from the impact of other matters such as the motor vehicle accident in 1994, upon his health and in particular his earning capacity to the extent which he alleged. As that was not demonstrated by, for example, a decrease in his income compared with that prior to this incident, or by any other objective facts, the appellant's case had to heavily rely upon the opinion of Dr Middleton. His Honour did not completely accept Dr Middleton's evidence. In particular, his Honour said that his evidence did not "address the role that subsequent events may have played in causing or in perpetuation of any lessening in the plaintiff's incapacity to practice". His Honour was not bound to accept everything which Dr Middleton said, even if it was uncontradicted by other opinion evidence.

[90] The appellant's case was a difficult one because the distinct effects of this incident had to be proved against the circumstances of his prior illness and the sworn impact of his car accident. Added to those complications were the variables which could affect the success of a barrister's practice. In the result, it was open to his Honour to reject the substance of the appellant's case, which was that he suffered from this incident a permanent disability which could be measured by the loss of a brief per week. If that case was not accepted, then it was open to his Honour to assess damages as he did, and in particular in relation to economic loss, to conclude that there was some loss for a limited period which could be assessed only by "estimating it as a lump sum in the absence of any more reliable basis". In my view there is no demonstrated error in the assessment of damages and nor is it shown to be manifestly inadequate.

Appeal as to costs

[91] The judgment under appeal was delivered on 16 July 2003. Orders for costs of the proceedings were made on 18 December 2003. Prior to the trial conducted by Mackenzie J, an earlier trial before another judge and a jury had commenced before the jury was discharged and that trial was adjourned. On 18 December, Mackenzie J ordered that there be no order as to costs thrown away by that adjournment. He further ordered the present appellant to pay the present respondents their costs of the proceedings, and the fifth defendant, Dr Coroneos, to pay to the appellant his costs of the proceedings between them. His Honour rejected a submission for the appellant that there should be a Bullock order against Dr Coroneos.

[92] Upon the hearing of this appeal, the appellant indicated that he wished to challenge at least some of those costs orders in the event that he was otherwise unsuccessful. At that point in time, however, he had neither lodged a notice of appeal against the costs orders made on 18 December last, nor had he obtained the leave of Mackenzie J to lodge such an appeal, as apparently required by s 254 of the *Supreme Court Act* 1995 (Qld). The appellant then sought that leave, which Mackenzie J refused on 10 March 2004. Leave was refused for two reasons. The first was that, in his Honour's view, leave to appeal could not be given outside the time of 28 days allowed by the rules for an appeal, absent an order extending that time for appeal made by the Court of Appeal. As more than 28 days had expired from 18 December 2003 and no extension of time to appeal had been granted, his Honour

was of the view that he had no power to give leave. Secondly, his Honour was not persuaded that the proposed appeal on costs had reasonable prospects of success. However, his Honour did give leave to appeal against his own refusal of leave. By this course the merits of the costs orders made on 18 December became the subject of written submissions in this appeal. As the appellant's submissions make clear, the change to those orders which he would seek in the event that he was otherwise unsuccessful in this appeal is that there be a Bullock order against Dr Coroneos.

[93] In my view it is unnecessary to consider whether there is a power to give leave under s 254 outside the time for an appeal as prescribed by the rules or as extended by the Court of Appeal. Nor is it necessary to consider whether, as the appellant submits, there is a power to make the order which he seeks without the need for a distinct appeal against the decision of 18 December, but simply pursuant to the court's powers within the appeal against the principal judgment to "make any order the nature of the case requires": r 766(1)(b). This is because the exercise of the trial judge's discretion as to costs, in my view, is not shown to have been affected by any error. As his Honour said, this is not a case where it was alleged that one or other defendant was responsible for any particular breach of duty and it was necessary to take action against all of them to ensure that the appropriate defendant was made liable. Ultimately the appellant's case has failed because he has not proved the necessary causal link between any negligence and loss. He has failed on that issue because the trial judge rejected his evidence on that issue and because his case was not otherwise proved by the objective facts. In these circumstances the responsibility for his unsuccessful suit against the respondents should not be that of Dr Coroneos. His application for an extension of time in which to appeal the orders of 18 December 2003, and his appeal from the orders made on 10 March 2004, should be dismissed with costs.

[94] I agree with the other orders proposed by Davies JA.