SUPREME COURT OF QUEENSLAND

CITATION:	*Smit v Brisbane South Regional Health Authority* [2002] QSC 312
PARTIES:	**RONALD SMIT** (plaintiff) **v** **BRISBANE SOUTH REGIONAL HEALTH AUTHORITY** (sixth defendant)
FILE NO/S:	1233 of 1995
DIVISION:	Trial Division
PROCEEDING:	Trial
ORIGINATING COURT:	Supreme Court at Brisbane
DELIVERED ON:	9 October 2002
DELIVERED AT:	Brisbane
HEARING DATE:	5 – 12, 15 August 2002
JUDGE:	Muir J
ORDER:	**Judgment for the sixth defendant.**
CATCHWORDS:	NEGLIGENCE – MEDICAL NEGLIGENCE - BREACH OF DUTY – where alleged failure to diagnose and treat – where alleged that if treatment had commenced earlier, it would have been effective – whether correct treatment was administered – whether treatment would have prevented further deterioration MEDICINE – MEDICAL PRACTITIONERS – STANDARD OF CARE – where skill is that of medical registrar without any specialist qualifications – whether there should have been referral to a specialist *Albrighton v Royal Prince Alfred Hospital* (1980) 2 NSWLR 542 *Elliott v Beckerstaff* (1999) 48 NSWLR 214 *Ellis v Wallsend District Hospital* (1989) 17 NSWLR 553 *Hunter v Hanley* (1955) SLT 213 *Kondis v State Transport Authority* (1984) 154 CLR 672 *Maynard v West Midlands Regional Health Authority* [1984] 1 WLR 634 *The Board of Management of Royal Perth Hospital v Frost* (1997), unreported, Full Court of the Supreme Court of Western Australia

Roe v Minister of Health [1954] 2 QB 66
Rogers v Whitaker (1992) 175 CLR 479
Wilsher v Essex Area Health Authority [1987] 1 QB 730

COUNSEL: A J H Morris QC and E J Howard for the plaintiff
J Dalton for the sixth defendant

SOLICITORS: Trilby Misso & Company for the plaintiff
Minter Ellison for the sixth defendant

Introduction

[1] In August 1992, the plaintiff, then aged 33, contracted an illness which attacked his nervous system and caused him permanent severe sensory loss. Previously a fit and athletic young man, he is now unable to move appreciable distances without the aid of a wheelchair.

[2] Between 5 August 1992 when he first noticed his symptoms and 13 August 1992, he sought the advice and assistance of a number of medical practitioners and hospitals. On 13 August, after confirmation of a provisional diagnosis of Guillain-Barré Syndrome made the previous day, plasma transfer treatment was commenced at the Princess Alexandra Hospital. There is some controversy about whether he responded at all to the treatment but it is clear that if the treatment resulted in any improvement in the plaintiff's condition, it was minimal.

[3] The plaintiff's case is that a diagnosis of a variant of Guillain-Barré Syndrome (a rare acute disorder of the peripheral nervous system, often preceded by an infection which produces progressive weakness, sensory loss, autonomic dysfunction, or a combination of these, usually followed by gradual neurological recovery[1]) should have been made earlier, that treatment should have commenced earlier and that if the treatment had been administered earlier, it would have been effective. In particular, he contends that the sixth defendant, Brisbane South Regional Health Authority (a corporation which owns and operates the Redland Hospital and the Queen Elizabeth II Jubilee Hospital) was in breach of its duty of care for failing to cause a diagnosis of Guillain-Barré Syndrome to be made by 8 August 1992. Where convenient, I will refer to the disorder as "GBS".

[4] Whilst it is accepted by the plaintiff that the junior medical practitioners employed by the Authority who saw the plaintiff at relevant times may have lacked the knowledge, experience and skills necessary to make a definitive diagnosis of his condition, it is contended that such practitioners, acting appropriately, ought to have recognised the potential gravity of his condition and sought the assistance of a neurologist or specialist in a related discipline. Had this been done, the plaintiff argues, a diagnosis of Guillain-Barré Syndrome would have been made earlier and successful treatment administered.

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1 *Variants of Guillain-Barré Syndrome* by Z Simmonds MD, a paper presented at the 5th Annual Meeting of the American Academy of Neurology in April 2002.

[5] The Authority does not accept that the failure to make such a diagnosis before 12 or 13 August was the result of any breach of duty on the part of any of its employees. Its contention is that, having regard to the symptoms with which the plaintiff presented, the diagnoses made and courses of conduct adopted by its employees were appropriate. Furthermore, it asserts that the plaintiff suffered from acute idiopathic sensory neuropathy and not from sensory Guillain-Barré Syndrome. It is said that, that being the case, plasma exchange treatment would not have brought about any material improvement in the plaintiff's condition whenever administered.

[6] The plaintiff, in these proceedings, alleged breach of duty and claimed damages against four medical practitioners who practised at the Old Cleveland Road Medical Centre, the Manager of the Medical Centre and the Authority. Prior to the commencement of the trial the plaintiff's claims against the first to fifth defendants were settled and the plaintiff and the Authority agreed the quantum of the plaintiff's claim at $900,000.

The plaintiff's symptoms and treatment on and before 13 August 1992.

[7] The plaintiff, a horticulturist, when taking a shower after finishing work on 5 August 1992, noticed lumps in his groin and neck. At that time he felt "slightly sore in the throat, and a little tired". He went to the Redland Hospital and, after waiting for about an hour and a half to be seen by a doctor, left before his name was called to go to a karate training session. After karate, he went to a general practitioner at the Medical Centre who prescribed amoxicillin, which he took.

[8] The plaintiff gave the following account of what then transpired. During the evening he experienced an intense burning sensation going down his legs and arms which he relieved by sitting in a bath of cold water. He returned to the medical centre next morning, and was advised that he was suffering from an allergic condition. His pain intensified during the day, he felt quite weak and short of breath and had a general aching of the lower back. He felt as if something was crawling underneath his skin, which sensation he found quite distressing. He was given a referral for a blood test and attended the medical centre with the results of the tests at around midday. He was examined again by a general practitioner. His pain continued to intensify as the day went on, the crawling sensations remained and at times he experienced sensations like wasp stings in the lower part of his limbs.

[9] At about 7 that evening, he was seen by Dr Grant at the Redland Hospital who recorded –

> "generalised aches and pains in fingers and lower limbs and feeling ill."

The plaintiff's evidence is that he was told that he had inflamed tonsils, to take Panadol or Panadeine and to go home and rest. The medical records indicate a diagnosis of a probable viral illness and the prescription of Panadol. Dr Grant retained no recollection of the consultation.

[10] The plaintiff went home to bed but during the night became concerned with his symptoms which he described as physical weakness and an irritating crawling sensation. He was driven by his father back to the Redland Hospital where he was seen by Dr Munster, a Principal House Officer, at about 2.30 am. She recorded his symptoms and her diagnosis as follows-

> "rolling all over the place and groaning … still getting burning and tingling all over !! … O/B abdo soft nodes as before no arthritis obvious red yes … [probable] viral illness/**low pain threshold**.
> Try valium 5 mg stat → no relief
> Try Indocid 25 mg tds/codeine 3gm stat." (emphasis added)

[11] In a statement tendered without objection, Dr Munster described the plaintiff's presentation during the consultation as "unusual and dramatic". She also remarked that the plaintiff "was not forthcoming with providing a useful history of the nature of his symptoms" and that his symptoms "were very non specific".

[12] The plaintiff said that he gave a history of his previous treatment and symptoms, that his reflexes were tested with a mallet, by means of pinprick and the passing of cotton wool over parts of his body. His recollection is that his throat was also inspected. Dr Munster does not recall making a neurological examination and there is no indication of one in her notes. She requested that the plaintiff return to the hospital on the afternoon of 7 August so that he could be reviewed.

[13] The plaintiff said that he was unable to sleep on returning home, that in the morning his burning sensations increased and that he was driven to the medical centre by his father where he saw a general practitioner who gave him a pethidine injection and referred him to the QEII Hospital.

[14] The letter of referral remarked that the plaintiff had been "unwell with severe arthralgia/myalgia and malaise for 3 days". Its author expressed uncertainty about the diagnosis but noted he had administered a 75 gram dose of pethidine. The plaintiff was seen at about 10.30am on 7 August at QEII by Dr Wilkinson who recorded his symptoms as a feeling of weakness, aches in the hand and ankle joints, swollen glands in the neck and an absence of fever.

[15] The plaintiff was seen again by Dr Wilkinson at about 4.15pm on 7 August. She noted that he was experiencing increased pain and that the pain was now throughout his body and not relieved by the medication he had taken. She referred him to Dr Rice, the principal house officer in internal medicine, who saw the plaintiff at about 5.30pm that day. He made a written record of the plaintiff's recent symtomology which included –

> "6.8.92 (Thursday)
> awoke with malaise, itch in hands & feet.
> Having 'cramps' of hands & feet suggestive of carpo-pedal spasm, not apparently assoc with hyperventilation
> Saw another cmo who changed A/B to doxycycline and ordered FBC, E/LFT, HIV serology.
> 7.8.92 (today)

> symptoms worsening, unrelieved by panadeine & ibuprofen
> denies fevers, night sweats, rashes
> **no myalgia or arthralgia.**
> No wt. loss." (emphasis added)

[16] Dr Rice diagnosed the plaintiff as suffering from a "viral illness with myalgia". As part of his assessment, he noted "**Narcissistic personality, (very) concerned (with) illness**" (emphasis added). He recommended that the plaintiff be admitted for observation and recorded – "If symptoms settle, may go home." Dr Rice was unable to explain the notation of "no myalgia" which was inconsistent with his diagnosis and the balance of the history provided by the plaintiff.

[17] Nursing notes made during the evening of 7 August include the following:

> "8.30pm C/e severe pain and spasms in groins tingling & pins & needles. Writing around in the bed. Dr Rice notified … dose Pethidine 100 mgs 1ml & Moxala 10 mgs 1ml given with very good effect. pt settled & sleeping by 8.45 pm. U/A p
> (22.30)
> patient buzzed. Pt complained 'pain coming back again' D/W Dr Rice said R/v pt … pt told this."

[18] It seems that the plaintiff's condition then settled. He was either not seen that evening after 22.30 by Dr Rice or he was asleep when seen. In any event, no further pethidine was administered. Dr Rice saw the plaintiff the following morning and recorded:

> "feels much better this morning
> pain settled
> Ass: prob. Infectious mononucleosis.
> home
> Repeat viral studies 2/52."

[19] In a typed discharge summary dictated on 13 August, Dr Rice observed –

> "A diagnosis of viral illness was made and the differential diagnosis of lymphoma and HIV was considered. Also noted was a possible Narcissistic personality with exaggerated concern over his minor illness despite reassurance from the number of doctors he had seen … He should be followed up with viral studies in about 2 weeks time and he has been given a request slip for this."

[20] The plaintiff said that in the course of 8 August his symptoms of crawling under the skin and burning started intensifying again. He visited the Medical Centre where he complained to a general practitioner about a burning throat and other symptoms. Late in the afternoon he was taken by his brother-in-law to the QEII Hospital with a view to seeking further medical attention. His evidence was that whilst waiting two and a half to three hours, he informed a person in administration that he had been there the night before, that he had waited a long time and was having difficulty sitting. That person is said to have responded that there were more pressing

emergencies requiring attention. The plaintiff said that he spoke to the administrative officer again and complained about not being seen before other persons who had come in after him with complaints which, on the face of it, were no more urgent than his. When he was told by that person that he could not help, he went home. He states that he was unable to sleep that night, experienced general soreness throughout his body, spasms in the legs, calf muscles, aching joints and a continuation of the crawling sensation. He said that he had difficulty in breathing and was unable to swallow.

[21] What then transpired, according to the plaintiff, was as follows. On Sunday, 9 August, his condition did not improve. By the morning of 10 August, the crawling sensations had settled but he was having trouble with his breathing and he felt sensations like "electric jolts" in his legs. He also continued to experience tingling and stinging in his arms and legs and a general weakness in his legs. The soreness in his throat had been replaced by a feeling of numbness. On Monday, 10 August, he went to the QEII Hospital to retrieve his wallet and possessions. There, he by-passed reception and went straight to a doctor with whom he spent about 15 minutes. After being told that the doctor could not do anything for him right then and that he would have to wait, he departed. There is no note of this visit in the medical records.

[22] On 11 August, he felt extremely tired with a sensation of protruding bones. His crawling sensation had receded, the electric jolting sensation continued at about the same level of intensity, his mobility was impeded and he had general aches. He returned to the Medical Centre at about midday on 11 August to seek further assistance, but obtained no alleviation of his symptoms.

[23] He experienced difficulty breathing on the evening of the 11th and was driven to the Redland Hospital in the early hours of the morning. He was seen at about 1.30am by Dr Craven who took his symptoms and past medical history. He noted – "Arthralgia, myalgia. No fevers etc. loss of appetite. Good fluid intake." (The plaintiff's evidence was that he was having difficulty swallowing.) He also recorded the onset of generalised numbness, loss of taste the previous evening and an increase in myalgia. He examined the plaintiff's throat, ears and trunk and then conducted a neurological examination. It involved strength tests, tests conducted by pricking with a pin to detect the presence of sensation and reflex tests. He noted that although the plaintiff's power was variable, it was at full strength in most respects. He recorded that the plaintiff "can get reaction to pin prick all areas" but that that also fluctuated and that his reflexes were "all dullish". He recorded his impression of "a generalised infective illness, presumably viral … strange 'reaction mechanisms'". He proposed that the plaintiff's pain be controlled with analgesics and that he return later that morning for a number of tests, including liver, kidney function and viral tests.

[24] Later that day the plaintiff was seen by another medical officer at the hospital who recorded "generalised aches and pains. No better".

[25] At around 7 pm the plaintiff was seen by Dr Wuth who, at the time, was the medical superintendent at the Mater Children's Hospital but was also working as a part-time senior medical officer at the Redland Hospital with a view to maintaining more clinical contact. The plaintiff complained to him of numbness of the whole body, inability to walk and breathe and excess salivation. Dr Wuth's examination failed to reveal any abnormality in the plaintiff's ear, nose, throat, chest or heart. He found a single node in the left groin, decreased reflexes and some muscular weaknesses to the face and limbs. The plaintiff complained also of decreased sensation but Dr Wuth established that he could distinguish between sharp and blunt in the peripheral parts of his body. After making a provisional diagnosis of Guillain-Barré Syndrome, he discussed the matter over the telephone with the registrar of the Princess Alexandra Hospital who agreed that the plaintiff should be admitted to that hospital.

[26] Dr Staples, then a neurological registrar at the hospital, confirmed the plaintiff's diagnosis of a GBS variant late in the afternoon of 13 August. On examination, the plaintiff was found to be unable to walk or control the direction of his limb movements. Dr Staples found other sensory defects which he described as "less impressive" than the plaintiff's proprioceptive loss (the loss occasioned by failure of the sensory nerve endings in muscles and tendons which transmit information used in the co-ordination of muscular activity). Dr Staples recommended plasma exchange therapy, which was administered in three stages on 14, 16 and 18 August.

The expert medical witnesses

[27] Three medical specialists were called as experts. The plaintiff called Professor John Dwyer, Professor of Medicine and Head of the Department of Medicine at the University of New South Wales. Professor Dwyer, a clinical immunologist, has a consultancy practice based at the Prince of Wales Hospital, a teaching hospital adjacent to the University of New South Wales. He has particular interest in auto-immune diseases.

[28] Dr Peter Silburn and Dr John Cameron, consultant neurologists, were called on behalf of the Authority. Dr Silburn, who is in private practice, is a visiting neurologist at the Princess Alexandra Hospital and an honorary senior lecturer at the Department of Medicine, University of Queensland. He was the neurology registrar at the Princess Alexandra Hospital in 1993 and 1994. Dr Cameron has been in private practice as a neurological consultant and has been a visiting neurologist at the Princess Alexandra Hospital since 1980.

[29] Dr Christopher Staples, now a consultant neurologist in private practice, also gave evidence of an expert nature.

Professor Dwyer's evidence

[30] Professor Dwyer gave written opinions in which he concluded that, at relevant times, the plaintiff suffered from a sensory form of Guillain-Barré Syndrome. In his oral evidence in chief he disagreed with the opinions given by Dr Silburn and Dr

Staples in their respective reports and confirmed a diagnosis of an "atypical Guillain-Barré Syndrome". Professor Dwyer accepted that there was no evidence of demyelination (a process by which the myelin sheaths surrounding nerve fibres are damaged) but rejected the notion that demyelination was essential for a diagnosis of sensory Guillain-Barré Syndrome. He accepted that this was the traditional view of neurologists but said in his oral evidence –

> "I believe now the thinking has changed on that topic and that the mechanism associated with [GBS] may be an immune attack on other parts of the nervous system, namely the axon, not just the myelin."

[31] In cross-examination, Professor Dwyer conceded that the plaintiff's condition was not "a pure sensory Guillain-Barré Syndrome variant" adding that –

> "this is somewhere closer to that than it is to the classical Guillain-Barré Syndrome … on the balance of the evidence available I do think that this fits in with a variant of Guillain-Barré Syndrome closer to sensory Guillain-Barré … an immunological mechanism can affect nerves other than through attacking that myelin sheath and that's really the crux of our argument here …"

[32] He later added that "a medical judge and jury couldn't be terribly comfortable with a diagnosis of sensory neuropathy and couldn't be comfortable if they just limited it to a sensory form of guillain-barré syndrome".

[33] In a report dated 16 November 1998, he wrote of the plasma exchange treatment given the plaintiff –

> "I would think that the earlier the treatment was commenced the more likely it would be to help the patient recover. Indeed considerable benefit was obtained as soon as plasma exchange was introduced into Mr Smit's management. While the sensory form of the neuropathy tends to have a worse prognosis than the pure motor form, the pathology is thought to be very similar and both situations benefit from early treatment."

[34] In a report of 8 December 1999, he expressed these opinions –

> "Guillain-Barré Syndrome was significant symptomatology as a medical emergency … In a tertiary institute one would expect plasma exchange to be able to begin within 6 – 8 hours …
>
> Given that the amount of antibody in (sic) its affinity for bonding a nerve tissue will vary from case to case, it is not possible to be specific about the amount of benefit to be gained from the first (plasma) exchange. It would, however, be expected to be considerable and may well reverse pathological process though is leading to more damage to nervous tissue …
>
> Of course, by the time Mr Smit did have his first plasma exchange he had evidence of both sensory and motor nerve involvement. Nevertheless given that the pathology involved with both the sensory and motor form is identical it seems reasonable to extrapolate from our experience with plasma exchange in the motor form of the

> condition. Based on my experience I would suggest that **early exchange before damage to Mr Smit's nerves made it impossible for him to walk would have had a 70% chance of preventing that complication. In other words if Mr Smit was able to walk on the 9th and 10th of August 1992 plasma exchange prior to the 9th while not guaranteeing that he would not lose the capacity to walk, would have very significantly minimised that risk.** In my opinion the same line of argument might be applied to each of his other disabilities including that involving his mouth and throat." (emphasis supplied)

[35] In his oral evidence he confirmed his opinion that, as the relevant mechanism was "an active inflammatory process damaging nerves, it is reasonable to suppose that the earlier the treatment the better its prospects of success". He did not affirm his written opinion that there was a 70% chance that the plaintiff would not have lost his ability to walk saying instead –

> "… I think that there was obviously significant … damage, that occurred over the subsequent few days (i.e. after 9 August) and I think there's a 70% chance that damage would not have been extensive if he had been treated earlier."

[36] He had earlier been asked –

> "Had … that regime [of plasma exchange] started 72 hours or 96 hours earlier … from, say, the 8th of August rather than the 12th or the 13th August what difference would that have made ….?"

The response was –

> "I don't think anyone can say with certainty what difference that would have made. All one can do is say that current practice … is that a very active process is occurring in these syndromes in which your immune system is making a terrible mistake and actually attacking various components of the nervous system producing damage, damage which in some cases may be permanent. … We have a capacity to call off that attack, if you like, or to minimise that attack by removing those (chemicals) … literally binding to various components of nerve tissue and damaging them and the bodies from the blood by a technique known as plasma exchange. Conventional practice says that the sooner you can halt that active process the sooner you will stop damage to the nerves, the more likely you are, therefore, to minimise long-term damage and the quicker may be the recovery. In any particular case – one can't be certain, but best practice, best evidence based practice suggests that the minute the diagnosis is reasonably entertained, that plasma exchange should be commenced."

The evidence of Drs Cameron, Silburn and Staples

[37] As observed earlier, Drs Silburn, Cameron and Staples are all of the opinion that the plaintiff was not suffering from any variation of Guillain-Barré Syndrome but from

an acute sensory neuropathy. I will refer to this condition as "SGN" (an abbreviation for sensory ganglion neuropathy, there being consensus amongst these three neurologists that the plaintiff's condition damages the ganglion). In Dr Silburn's opinion the indicia of sensory Guillain-Barré Syndrome is demyelination, progressive weakness to the limbs and hyporeflexia which extends and peaks over a four week period. In his view, although the symptoms of the syndrome are predominantly sensory, there is always demyelination. Features which he identified as assisting in discriminating between the presence and absence of the syndrome included the predominance of sensory disturbance (for example, abnormalities of joint position and vibration sense), sensory involvement with alteration in pinprick sensation and intact motor responses and conduction. In his view, the existence of normal nerve function speed demonstrates the absence of demyelination.

[38] Dr Silburn disagreed with the view that a preceding viral illness is not commonly associated with the onset of SGN although commonly a feature of Guillain-Barré Syndrome. He disagreed also with Professor Dwyer's views that a feature of SGN was no elevation of protein in the cerebrospinal fluid and that there had been a "marked elevation" of protein in the plaintiff's case. He denied that .53, which was the plaintiff's recorded level, was a marked elevation, observing that people with migraine headaches often have a reading of .7 and that a reading beyond .53 is not uncommon after exercise. Dr Cameron and Dr Staples also rejected the suggestion that the plaintiff's protein level was "markedly elevated".

[39] In Dr Silburn's opinion, the Princess Alexandra Hospital medical records in respect of the period at and shortly after the plaintiff's admission, revealed an absence of sensory response and a normal motor response. He concluded that if the plaintiff had sustained severe damage to his motor axons, pronounced muscle wasting would have been apparent but that, in fact, it is noticeably absent. He said that in determining whether there had been a favourable reaction to the treatment, little weight could be given to patients' observations for a variety of reasons and noted that the clinical records in the plaintiff's case showed no improvement in proprioception, vibration or in terms of power or strength of the muscles. He pointed to the results of the nerve conduction studies which, to his mind, offered clear evidence of lack of demyelination. Dr Cameron and Dr Staples also did not accept that the hospital records showed a material positive response to treatment. I will refer to this evidence in a little more detail later.

[40] In Dr Silburn's opinion, the medical literature established that treatment for sensory Guillain-Barré Syndrome, to be effective, needed to be administered within two weeks of the onset of symptoms. Such treatment, in his opinion, hastens the speed of recovery but does not affect the long-term outcome of the condition. There was no evidence, in his view, to support the opinion that the earlier the treatment was administered the more efficacious it would be. Dr Cameron's oral opinion was that a better response to the treatment could be achieved if it was administered in the first week to week and a half of the onset of symptoms but that a response to the treatment could be expected if administered within three weeks. In his report of 28 September 1998 he referred to a North American study in 1985 which found that such treatment (in the case of GBS) was effective if administered within two weeks of the onset of symptoms. That study showed that after six months the treated

patients had similar outcomes to the untreated patients. The report also discussed French studies which showed improvement in the condition of patients where the treatment was commenced within 17 days of the onset of symptoms. These studies, however, suggested "a long term benefit from the plasma exchange … in the treated patients compared with the control group". Dr Silburn, in his report of 30 November 1998, cited the French studies in support of his opinion that plasma exchange "does not necessarily decrease the incidence of severe motor sequelae".

[41] Dr Silburn pointed out that in many cases plasma exchange treatment was not given because of the risk factors attaching to it and that patients often made a full recovery without treatment. In his view, treatment in the normal course would be administered only when a patient reached the stage of not being able to walk. Dr Staples and Dr Cameron were in general agreement with this viewpoint. Dr Cameron said that he saw about eight or so patients a year suffering from a Guillain-Barré Syndrome and that about two or three of these on average would receive plasma transfer treatment. Of the treatment he said – "It is only used for those who are rapidly evolving, who have gone off their legs, who are going into respiratory compromise." These three witnesses agreed that there was no known treatment for acute sensory neuropathy and studies referred to in the literature showed that treatment such as plasma exchange was of no benefit. Dr Staples stated that the inability to walk would need to have resulted from motor rather than sensory loss.

[42] On 25 August 1992, Dr Reid, a visiting neurologist at the Princess Alexandra Hospital, performed nerve conduction studies on the plaintiff and reported that there was evidence of a sensory neuropathy "with motor studies being normal". Dr Staples also conducted a nerve conduction study of the patient on 5 August 1994 and concluded that there was evidence of a "severe sensory neuropathy consistent with a sensory ganglion neuropathy". He said that the tests, conducted by himself and Dr Reid revealed normal motor conduction and that this was inconsistent with Guillain-Barré Syndrome. He concluded from these tests and from the worsening of the plaintiff's clinical state since he had seen him in 1992, that the plaintiff's condition could not have been a sensory variant of Guillain-Barré Syndrome. He said that, after seeing the plaintiff, noting the progression of the condition despite plasmapheresis and, the lack of spontaneous improvement, the plaintiff's condition had all the hallmarks of a ganglion neuropathy. After reaching that conclusion, he did nerve conduction studies on the plaintiff which confirmed his opinion. He said that at the time of this initial diagnosis in 1992, although there was some perceived weakness in the plaintiff's motor involvement, that could be explained by an erroneous deduction which failed to have proper regard to the degree of the plaintiff's proprioceptive impairment.

Further findings of fact in relation to the plaintiff's symptoms

[43] In the course of the trial there was controversy over the accuracy of the symptoms recalled by the plaintiff and the reporting of those symptoms to employees of the Authority.

[44] I accept that the plaintiff attempted to give his evidence honestly and accurately. So too did his father who gave much more limited evidence. I am unable to conclude, however, that the recollection of either of them is reasonably reliable. In August 1992, as the plaintiff himself states, he was in pain and on drugs. He was also distracted. He gave a four page statement to solicitors in 1994 which suggests that his recollection at that time of his dealings with the Authority's hospitals and staff was of a general nature only. Even then his recollection of the medically qualified employees of the Authority did not extend, generally, to a recollection of the sex of the person with whom he had dealt.

[45] It is of relevance also that the plaintiff and his father harbour a strong sense of grievance against the Authority. That is understandable. The plaintiff, sensing that something was seriously wrong, consulted or attempted to consult a great many medical practitioners between 5 and 12 August 1992. He became increasingly frustrated at the lack of any clear diagnosis and treatment. His fears for his health were subsequently vindicated and the treatment administered to him proved ineffective. He was later advised that the failure of the treatment probably resulted from its delayed commencement.

[46] As a result of these matters the plaintiff is likely over the years to have dwelt more on those symptoms or matters which, in his view, should have alerted medical practitioners to the gravity of his complaints than on the way in which he may have explained those symptoms or any changes in them from time to time. I suspect that this has caused some distortion of his recollections.

[47] The plaintiff's recollection is also inconsistent, in many significant respects, with the medical records. I accept the submission of Mr Morris QC, who appeared for the plaintiff, that the records will tend to contain the recipient medical practitioner's interpretation of what he was told rather than a direct expression of what was actually said. That notwithstanding, many of the notes appear to have been made with care and can be expected in most cases to record the maker's appreciation of the symptoms most relevant to the making of a diagnosis.

[48] For these reasons, and having regard also to the evidence of the medical practitioners concerned, I find that the medical records are a far more reliable guide to the events and matters in question than the recollections of the plaintiff and his father.

[49] Mr Morris submitted further that the "subjective interpretations" of members of the medical staff were made even less reliable as a result of an "assumption" or "mindset" that the plaintiff had "a low pain threshold" or a "narcissistic personality". The former words appear in Dr Munster's Redland Hospital notes of 7 August and the latter in Dr Rice's QEII Hospital notes of 8 August and in his later discharge summary.

[50] It was asserted that there was little in the notes or evidence to support these assessments, that the evidence revealed that the plaintiff had complained about pain and other symptoms which appeared to the doctors to be worse that any detectable

organic cause and that the complaints had been discounted in consequence. The fact that two different doctors at separate hospitals had arrived at a similar conclusion, it was argued, supported these conclusions.

[51] It is likely that these appreciations by Dr Munster and Dr Rice did have a bearing on how they viewed the extent of the pain experienced by the plaintiff. But it is plain that they both considered the plaintiff to be suffering from an illness causing significant pain and treated him accordingly.

[52] It was not suggested that a medical practitioner in making a diagnosis is not entitled to evaluate a patient's accounts of symptoms, including complaints of pain and discomfort, by reference to personality traits or behavioural patterns, such as hypochondria or stoicism. Nor was it suggested that Dr Munster and Dr Rice should not have engaged in such a process.

[53] As for the alleged absence of evidence in the records to support the assessments under consideration, one would not normally expect to find in hospital records made by treating doctors a reasoned justification of an impression of the subject kind involving as it does, the exercise of a judgment which is peripheral to any diagnosis and treatment. Nor is it at all remarkable that Dr Rice's and Dr Munster's respective recollections of their treatment of the plaintiff are limited. They can hardly be expected now to recall all the matters which lead to them to form the views under discussion.

[54] There was no evidence that Dr Munster failed to approach her task with appropriate care and there is clear evidence that Dr Rice was quite painstaking. Dr Cameron described his assessment as "thorough". He exercised further caution in admitting the plaintiff to hospital for overnight observation. That course was unexceptionable. If the assessments under consideration were erroneous when made they were nevertheless arrived at in each case upon due consideration and after the exercise of due care and skill.

The expert evidence on the issue of failure to refer to or consult with a specialist

[55] The plaintiff's primary case is that he should have been referred to a neurologist on 7 August or on the morning of 8 August 1992, at the latest.

[56] Professor Dwyer expressed the oral opinion that, based solely on the contents of the medical and nursing notes, the Authority should have appreciated on 7 or 8 August that the plaintiff's condition could not be explained by any of the mechanisms previously suggested by treating doctors and that the plaintiff had "a prognosis and rapidly worsening problem clearly involving a sensory neuropathy necessitating a neurological consultation with a neurologist within 24 hours of presentation, if not sooner".

[57] Dr Cameron and Dr Silburn both disagreed with Professor Dwyer's opinions on this point. Referring to the symptoms recorded by Dr Rice, Dr Cameron said that "they are sensory symptoms which can be caused by a huge number" of things. Dr Silburn, referring to the circumstances of the plaintiff's discharge from hospital on the morning of 8 August, said – "there is no evidence that this man has a permanent neurological problem…" and that there was "an alternative explanation" for the plaintiff's symptoms. Asked in cross-examination whether, if he had seen the plaintiff on 8 August 1992, he would have diagnosed a "potential neurological problem" he replied "no"; and that "he would be waiting to see if there were any definite objective signs".

Findings on the issue of failure to refer to or to consult with a specialist

[58] It is plain that the authority owed the plaintiff a duty of care and the contrary was not argued. In addresses it was accepted by counsel for both parties that the standard of care imposed on the Authority's medical staff, for whom it is vicariously liable, is that of an "ordinary skilled person exercising and professing to have that special skill".[2] On that basis, the relevant skill, when considering vicarious liability, would appear to be that of a medical registrar without any specialist qualifications or training in neurology. Dr Rice and a number of the other doctors who saw the plaintiff at the Redland and QEII Hospitals lacked neurological qualifications and were therefore not obliged to exercise the skill of a neurologist.[3]

[59] Dr Rice was a principal house officer which, as he explained, is a position held by a medical practitioner who generally has at least four years experience. Medical registrars and principal house officers fulfil similar roles but the former are normally in the process of attempting to acquire specialist qualifications. Dr Wilkinson was a house officer and thus in her second or third year after qualifying. Dr Munster was a principal house officer.

[60] There was no exploration in the course of the trial of the separate and non-delegable duty the Authority owed as a result of holding out its hospitals as providers of emergency services[4] or of the consequent standard of care.[5]

[61] In the United Kingdom there is some authority for the proposition that, in considering a hospital authority's vicarious liability for its employees, the standard of care may vary from employee to employee, depending on their respective qualifications and experience[6] or upon the nature of the post held.[7]

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2 *Rogers v Whitaker* (1992) 175 CLR 479 at 487.

3 Cf *Maynard v West Midlands Regional Health Authority* [1984] 1 WLR 634 at 638-9 per Lord Scarman with whose reasons the other members of the Court agreed.

4 *Ellis v Wallsend District Hospital* (1989) 17 NSWLR 553; *Wilsher v Essex Area Health Authority* [1987] 1QB 730; *Elliott v Beckerstaff* (1999) 48 NSWLR 214; *Kondis v State Transport Authority* (1984) 154 CLR 672; and *The Board of Management of Royal Perth Hospital v Frost* (1997), unreported, Full Court of the Supreme Court of Western Australia.

5 See *Ellis v Wallsend District Hospital (supra)* at 605.

6 *Junor v McNicol*, The Times, March 26, 1959 and *Wilsher v Essex Area Health Authority (supra)*.

7 *Wilsher (supra)*.

[62] In *Wilsher v Essex Area Health Authority*[8] there was a divergence of views as to the standard of care imposed on doctors in a special baby care unit in a hospital. Glidewell LJ rejected the notion that the standard of care was dependent on training and experience, saying –

> "In my view, the law requires the trainee or learner to be judged by the same standard as his more experienced colleagues. If it did not, inexperience would frequently be urged as a defence to an action for professional negligence."[9]

[63] Mustill LJ linked the standard of care to the post occupied by the doctor. He said in that regard - [10]

> "In such a case as the present, the standard is not just that of the averagely competent and well-informed junior houseman (or whatever the position of the doctor) but of such a person who fills a post in a unit offering a highly specialised service. But, even so, it must be recognised that different posts make different demands. If it is borne in mind that the structure of hospital medicine envisages that the lower ranks will be occupied by those of whom it would be wrong to expect too much, the risk of abuse by litigious patients can be mitigated, if not entirely eliminated."

[64] Sir Nicholas Browne-Wilkinson VC formulated a different test, stating - [11]

> "Of course, such a doctor would be negligent if he undertook treatment for which he knows he lacks the necessary experience and skill. But one of the chief hazards of inexperience is that one does not always know the risks which exist. In my judgment, so long as the English law rests liability on personal fault, a doctor who has properly accepted a post in a hospital in order to gain necessary experience should only be held liable for acts or omissions which a careful doctor with his qualifications and experience would not have done or omitted."

[65] The tests applied by Mustill LJ and Sir Nicholas Browne-Wilkinson VC have been subjected to academic criticism[12] and do not seem to me to be consistent with Australian authority.

[66] I do not intend to suggest by the above discussion that the plaintiff would have benefited from the application of a standard of care fixed by reference to the Authority's non-delegable duty. I raise these matters principally to record the manner in which the case was argued. On the facts as found by me, I think it plain enough that the application of a lesser or greater standard of care would not have affected my determination of liability.

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8 *(supra)*.
9 At 831.
10 At 813.
11 At 777.
12 Michael Jones, *Medical Negligence* (2nd ed) at 130-134.

[67] The opinions of Dr Silburn and Dr Cameron both offer strong support for the view that none of the treating doctors fell short of his or her standard of care in failing to refer the plaintiff to a specialist prior to 12 August. The fact that there is a body of competent medical opinion which supports their conduct, however, is not sufficient in itself to resolve the question in favour of the Authority.[13] Those opinions, and that of Professor Dwyer, are evidence to which regard must be had in determining whether the appropriate skill was exercised.[14] But just as the opinions of Drs Silburn and Cameron cannot, without more, establish that the standard of care was not breached, the contrary opinions of Professor Dwyer do not establish the opposite.

[68] The following observations of Lord President Clyde in *Hunter v Hanley*,[15] quoted with approval by Lord Scarman in *Maynard v West Midlands Regional Health Authority*[16] are of general relevance to the issue now under consideration –

> "In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men … The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care …".

[69] Lord Scarman later said - [17]

> "I would only add that a doctor who professes to exercise a special skill must exercise the ordinary skill of his speciality. Differences of opinion and practice exist, and will always exist, in the medical as in other professions. There is seldom any one answer exclusive of all others to problems of professional judgment. A court may prefer one body of opinion to the other: but that is no basis for a conclusion of negligence.
>
> … For in the realm of diagnosis and treatment negligence is not established by preferring one respectable body of a professional opinion to another. Failure to exercise the ordinary skill of a doctor (in the appropriate speciality, if he be a specialist) is necessary."

[70] It is significant in my view that the symptoms reported to Drs Munster, Wilkinson and Rice could have been associated with a wide range of complaints and were not necessarily associated with a neurological problem. In those circumstances, Dr Rice cannot be criticised for the approach he took of admitting the plaintiff for observation, making proper observations and then adopting a wait and see attitude. He had no good reason to suspect, when discharging the plaintiff, that his condition was grave or that urgent treatment may be required (assuming, contrary to my finding, that treatment would then have been administered and that it would have assisted). Furthermore, he had no reason to suppose that if the plaintiff's condition

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13 *Rogers v Whitaker (supra)* at 487.

14 See the observations of Reynolds JA in *Albrighton v Royal Prince Alfred Hospital* (1980) 2 NSWLR 542 at 562.

15 (1955) SLT 213, 217.

16 *(supra)* at 638.

17 At 639.

worsened he would not return to the hospital or otherwise seek appropriate assistance.

[71] Dr Wilkinson took the precaution of referring the plaintiff to Dr Rice thus ensuring that his puzzling symptoms could be considered by a more senior person. She thus discharged her duty of care. Dr Munster, who requested the plaintiff to return to the Redland Hospital for review later on 7 August, also acted appropriately. All three of these doctors were concerned that any progress of the plaintiff's symptoms be monitored carefully.

[72] The above condensed account of the evidence suggests a clear divergence of opinion between Professor Dwyer on the one hand and Drs Cameron and Silburn on the other. Professor Dwyer's views, however, were based, at least in part, on a perception that "there was a rapidly progressing syndrome developing here with quite marked changes, sensory problems with all this pain…". He conceded, in effect, that if Dr Rice had been told on the morning of 8 August "that the patient was feeling better and that the pain had settled", that would have had an important bearing on his criticism of Dr Rice's conduct. Dr Cameron also attached considerable significance to the settling or abatement of the plaintiff's symptoms. So too did Dr Silburn. He said in cross-examination with reference to the plaintiff's discharge on the 8th that "… at this point … there is no evidence that (the plaintiff) has a permanent neurological problem".

[73] The fact is that the plaintiff's symptoms, as reported to employees of the Authority by him, were fluctuating and at times, improving markedly. Dr Silburn described the phenomenon as "Fluctuation in severity from nothing to severe". For example, the plaintiff, to quote from Dr Munster's notes, was "rolling all over the place and groaning" at 2:30am on 7 August. His pain was sufficiently severe at 8:30 that evening to warrant the prescription of pethidine but his condition settled at around 10:30 pm. By the time Dr Rice saw him on the morning of the 8th he was able to record "feels much better this morning" and "pain settled". I find that these notes accurately state what was conveyed to Dr Rice by the plaintiff.

[74] It is of some significance that the first notes which describe a symptom which is "distinctly neurological" are those made on 12 August referring to "last night onset of generalised numbness". Professor Dwyer's opinion was that the proper course to be followed at that stage was for the plaintiff to be admitted for observation. Acceptance of that criticism would not be of assistance to the plaintiff as admission to the Redland Hospital would have accelerated the plaintiff's diagnosis and transfer to the Princess Alexandra Hospital by no more than a few hours.

[75] The diagnosis of GBS made by Dr Wuth on 12 August and the evidence of Dr Grant are invoked by Mr Morris to support the argument that the plaintiff should have been referred to a neurologist at an earlier date.

[76] Dr Wuth, it will be recalled, made a provisional diagnosis of Guillain-Barré Syndrome on 12 August 2002. It is reasonable to infer that Dr Wuth's involvement in raising money for the purchase of a plasmapheresis machine for the Mater

Children's Hospital is likely to have contributed to his ability to make the diagnosis. He did not express an opinion as to whether other medical practitioners exercising due care and skill should have made a like diagnosis. Nor did Dr Grant who had seen the plaintiff on 6 August at the Redland Hospital. Dr Grant, in cross-examination, said that if he were to see a patient now with the symptoms reported in his examination on 12 August in the QEII Hospital, recalling that he had seen the patient 5 days before complaining of general aches and pains and knowing that the patient had been admitted to hospital for a day in the intervening period he would probably admit the patient to the Princess Alexandra Hospital to be seen by a consultant physician or neurologist.

[77] At the time of the trial Dr Grant was an emergency specialist at the Gold Coast Hospital. He had seen several cases of GBS and remarked –

> "Having seen several cases, your index of suspicion rises and your threshold for referral lowers".

[78] His opinion was directed solely to what he would do now having regard to his own experience, skills and inclination and thus sheds little light on the questions I am required to answer. I note that Dr Grant pointed to the difficulty in making a diagnosis of a neurological disorder on the state of the information available on 12 August 1992.

[79] The conduct of the treating doctors must be considered without the benefit of hindsight and against the background in which they operated in providing emergency services in the public health system. Theirs was not a world of limitless time and resources. It may be accepted that it is part of the role of a medical registrar or house officer to identify the complaints of patients which are outside his or her expertise or experience to fully diagnose or treat and to seek appropriate assistance or make a referral in a timely way. As part of that role however, the doctor must exercise professional judgments as to matters such as when to refer, whether to refer, whether to conduct more tests, whether to admit for observation or whether to wait for a change in symptoms. Different doctors may make differing judgments about these matters, but it does not follow that one set of judgments is necessarily right and that another and different response is necessarily wrong or that the latter results in a breach of duty whilst the former does not.

[80] I prefer the evidence of Drs Cameron and Silburn to that of Professor Dwyer on the question of whether a doctor exercising due skill would or should have made a referral to a specialist on 7 or 8 August. Apart from the matters I have mentioned already, I have distinct impression that they have greater practical experience than Professor Dwyer in the diagnoses of neurological disorders. It is not completely clear that Professor Dwyer would have maintained his criticisms if he had understood the plaintiff's explanation of his symptoms to be as I have found. In the course of cross-examination he remarked, "… it all depends on what the patient told the doctors". Furthermore, I consider that Professor Dwyer's criticisms of the Authority's employees is explicable in part by the views formed by him after receiving the plaintiff's version of events. I note that, even on that basis, Professor Dwyer's opinion in his report of 16 November 1998 was –

> "In summary, a definitive diagnosis of Mr Smit's Guillain-Barré Syndrome should have been made by 10 August 1992. The diagnosis could have been made earlier and I am taking a conservative approach in giving 10 August as the latest day when any delay in diagnosis could be defended."

[81] The following passage from the reasons of Denning LJ in *Roe v Minister of Health*[18] gives felicitous expression to some of the matters relevant to the questions under consideration –

> "It is so easy to be wise after the event and to condemn as negligence that which was only a misadventure. We ought always to be on our guard against it especially in cases against hospitals and doctors. Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risks. Every surgical operation is attended by risks. We cannot take the benefits without taking the risks. Every advance in technique is also attended by risks. Doctors, like the rest of us, have to learn by experience; and experience often teaches in a hard way. … One final word. These two men have suffered such terrible consequences that there is natural feeling that they should be compensated. But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. … We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure."

[82] I find that no breach of duty has been established. On the contrary, the evidence shows that the plaintiff was treated carefully and with appropriate skill at all relevant times.

Findings on the question of the nature of the complaint from which the plaintiff suffered

[83] I find that the plaintiff suffered from acute idiopathic sensory neuropathy and not sensory GBS.

[84] I prefer the opinions of the other three experts to those of Professor Dwyer on this point. Professor Dwyer based his opinions, to a substantial degree at least, on his understanding that –

(a) It is a common feature of GBS but not of SGN that the condition be preceded by a viral like illness;

(b) the plaintiff had a marked elevation of protein which, although a feature of GBS, did not occur in SGN;

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18 [1954] 2 QB 66.

(c) the plaintiff had a positive response to his plasma transfer therapy "albeit slow" whereas "there is no response to plasma exchange in …sensory axonal neuropathy".

[85] The correctness of proposition (a) was a contentious issue and there is no need for me to resolve it, if indeed I could. But if, as the evidence shows, SGN may follow a viral illness or even be triggered by a viral illness, this proposition, even if correct, would appear to offer little support for Professor Dwyer's diagnosis.

[86] I accept the evidence of the other three doctors that there was no "marked elevation of protein". They gave emphatic evidence on the point and nothing was pointed to by Professor Dwyer in cross-examination or by Mr Morris in addresses which cast doubt on the explanations made in support of their viewpoint.

[87] I conclude that there was no positive response to the therapy. Professor Dwyer, again, is the sole contender for the contrary conclusion. In his oral evidence on the point he referred to a positive but unquantified response "albeit slow". In his report of 16 November 1998 he said –

> "Indeed considerable benefit was obtained as soon as plasma exchange was introduced into Mr Smit's management".

The reason for this change in opinion was unexplained. I think it likely that after reviewing the hospital records and the Authority's experts' reports Professor Dwyer concluded that his earlier view was unsustainable but that there was some evidence supporting a weaker stance.

[88] That evidence, which consists of unspecified entries in the nursing notes, offers faint support, at best, for Professor Dwyer's opinion. Dr Silburn and Dr Staples, in particular, gave evidence that the results of appropriate neurological examinations all pointed unambiguously to the conclusion that the treatment had not improved the plaintiff's condition. That aspect of their evidence was not the subject of any persuasive challenge, was supported by Dr Cameron and gained clear and strong support from the hospital records. For example, the doctor in charge of the plaintiff's treatment wrote on his chart on 14 August "No real change" and after the plaintiff's three treatments the records note, "admitted ICU for plasmapheresis X 3. No real alteration in clinical state".

[89] Dr Silburn put any positive comments or impressions in the nursing notes down to feelings of relative well being or improvement brought about by hospitalisation and its effect on the plaintiff. I accept the evidence of Dr Silburn and Dr Staples that there is no reliable evidence of any weakness in the plaintiff's muscles caused by deterioration of motor nerves and that, if his complaint was sensory GBS, signs of muscle wasting would be apparent. In response to the suggestion that the plaintiff had a recovery in motor strength, Dr Staples observed –

> "… there has never been any profound weakness and all the notes from Dr Henderson in intensive care say "strength normal". What I think has happened with time is that Mr Smit has become

> functionally much better because he's learnt to adapt to his disabilities and proprioceptive loss."

[90] Doubt has thus been cast on significant aspects of the foundation for Professor Dwyer's opinion. On the other hand, no material flaws have been established in the processes of reasoning which lead to the contrary point of view. That point of view is strengthened by the fact that the therapy was tried within the time recognised in medical literature as suitable for its effective application and failed. The evidence is that the treatment is effective, if administered within 14 days of the onset of symptoms in a substantial majority of cases. As mentioned earlier, some studies suggest a longer period for efficacious treatment. The failure of the treatment (and also the absence of recovery, whether aided by treatment or not), whilst not establishing that the plaintiff did not suffer from GBS, offers some support for that conclusion. Drs Silburn, Cameron and Staples were all of that opinion.

[91] Guillain-Barré Syndrome, by definition, is a condition which involves demyelination. It responds to plasmapheresis in a substantial majority of cases but, as Professor Dwyer said, the success rate in the sensory variant of the Syndrome is not as high.[19] Each of Drs Cameron, Silburn and Staples, however, gave evidence that experience showed that where the sensory nerves were attacked by a process which did not involve demyelination the condition did not respond to plasmapheresis. It did not seem to me that any significant doubt was cast on their evidence in this regard. I note that a research paper[20] on the topic, in the context of a discussion of the differences between acute sensory neuropathy and sensory GBS concludes –

> "The most important distinction between these two entities lies in the clinical outcome: in acute sensory neuropathy the recovery rate is poor, whereas in sensory GBS the recovery is good, as noted in our cases."

[92] Even if it were to be accepted (contrary to what I perceive to be Professor Dwyer's ultimate conclusion) that the plaintiff suffered from a GBS variant, it would not follow that the commencement of plasma transfer treatment on 8 or 9 August would have resulted in a material improvement in the plaintiff's condition.

[93] Professor Dwyer's explanation for the likely efficacy of treatment administered at such a time seemed to be that as the condition was a Guillain-Barré variant (or a condition resembling it) and some sensory variants of Guillain-Barré Syndrome respond to immune therapy, the plaintiff's condition should respond. Also, he explained in re-examination that, as the condition appeared to be an immune based attack on the nervous system, "the empiric therapy that removes anti-bodies from the blood stream would be likely to help". In his view the ability of therapy to assist was not necessarily dependent on the condition being a Guillain-Barré Syndrome variant.

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19 Dr Simmonds in his paper *Variants of Guillain-Barré Syndrome (supra)* observes in respect of severe axonal GBS variants, "Clinical outcome is generally poor, and the disease typically results in death or in prolonged incomplete recovery".

20 On SJ, La Ganke MD, Claressen G, *Guillain-Barré Syndrome, Neurology* 2001: 56: 82-86.

[94] There is a body of professional opinion that plasma exchange, although hastening the recovery of a Guillain-Barré Syndrome sufferer, does not tend to influence the long term outcome of the disease. Dr Silburn and Dr Staples were adamant on this point and it was Dr Cameron's opinion also. Mr Morris submitted that Professor Dwyer's view gained limited support in this regard from Dr Cameron's oral evidence but when the evidence is looked at as a whole, Dr Cameron's views were more consistent with those of Drs Silburn and Staples than those of Professor Dwyer. He was certainly rather less dogmatic than Dr Silburn on the point and, as mentioned earlier, pointed to French studies which give some support to the view that long term outcomes may be improved by the giving of treatment. Dr Cameron's oral opinion was that the plaintiff was treated in time for the treatment to be effective if the plaintiff's condition was ever going to respond to such treatment.

[95] It was not suggested in cross-examination that these opinions were unconventional. They have support in the medical literature and the contrary view point was not put forward by Professor Dwyer as one which had general professional acceptance.

[96] Indeed, in a letter of advice to the plaintiff's solicitors dated 14 July 1994 Professor Dwyer observed –

> "Plasmapheresis and/or intravenous gammaglobulin administration can shorten the course of Guillain-Barré syndrome."

[97] If follows from what I have said already that I do not accept Professor Dwyer's opinion that had plasmapheresis been administered from 9 August there was a 70% chance that the plaintiff's "damage would not have been as extensive as if he had been treated earlier". How Professor Dwyer arrived at the 70% assessment is unclear. Perhaps it was linked with his evidence that –

> "The studies clearly show it makes a difference to the benefit of the patient to treat people. It's in 70% of cases."

[98] Those observations were made in the context of debate about whether such treatment for Guillain-Barré Syndrome merely hastened recovery or improved the extent of ultimate recovery. In my view, the weight of evidence strongly favours the conclusion that earlier treatment would have been of no material benefit to the plaintiff.

[99] Another difficulty faced by the plaintiff is that it has not been established that, if he had been diagnosed as suffering from sensory GBS on 7 or 8 August, he would probably have been given plasma exchange treatment within two or three days. Upon diagnosis the plaintiff would have been admitted to the Princess Alexandra Hospital, but it is possible to infer from the evidence of Drs Cameron, Silburn and Staples that the plaintiff would not have been given plasma exchange treatment automatically after diagnosis.

[100] In Dr Cameron's opinion –

> "You only plasmapherese where the person's in respiratory peril or they are bedridden because then [there is a risk of] … significant morbidity … It is only used for those who are rapidly evolving, who

> have gone off their legs, who are going into respiratory compromise."

[101] Dr Staples' evidence was that such treatment would be given to patients who were unable to walk but only where the inability to walk resulted from other than sensory loss. He too referred to the risk of administering such treatment. I am prepared to accept that had the diagnosis been made earlier the plaintiff's weakness would have been regarded as not being entirely sensory in nature. It is thus probable that the plaintiff would have been given plasmapheresis but not before he became unable to walk or, if his condition was plainly worsening, when it seemed that he was about to lose his ability to walk. The evidence does not disclose that the plaintiff was in "respiratory peril".

[102] Professor Dwyer's evidence was that, in his experience at the hospitals in which he practised, treatment was administered at an earlier stage as a matter of course. That evidence does not establish though that the more conservative approach to treatment taken at the Princess Alexandra Hospital was wrong, or medically unjustifiable.

[103] It is difficult to determine with precision the date on which a specialist at the Princess Alexandra Hospital would have recommended plasmapheresis if diagnosis of GBS had been made on 7 or 8 August.

[104] The evidence of Drs Munster and Rice and their respective notes of 7 and 8 August do not suggest that the plaintiff was in or approaching a condition in which he had lost the effective use of his legs or was considered to be about to do so or was suffering severe respiratory difficulty. The same may be said for the nursing notes. There are no later medical records in evidence before those of 12 August. The first entry of that day, made by Dr Grant, does not suggest that he plaintiff had lost the effective use of his legs or was suffering severe respiratory difficulty. Nor does the second entry. Probably by the time the plaintiff saw Dr Wuth at about 1900 hours on 12 August, and certainly by the following day, the plaintiff's condition was such that plasmapheresis was likely to be recommended. I am unable to find though, that prior to 12 August, the plaintiff's symptoms were such that plasmapheresis would have been recommended following a diagnosis of GBS.

[105] In summary, my findings are –

(a) The plaintiff was suffering from SGN, not a sensory variant of GBS;
(b) Plasma exchange therapy, whenever administered, was quite unlikely to have improved the plaintiff's condition;
(c) Plasma exchange therapy was administered within the time recognised by the medical literature as allowing effective treatment, but was ineffective;
(d) It is probable that even if a diagnosis of GBS had been made on 7 or 8 August, plasma exchange therapy would not have been administered before 12 or 13 August;
(e) The fact that the treatment was ineffective and that the plaintiff's condition continued to deteriorate despite treatment is evidence that the plaintiff was not suffering from GBS and that the commencement

of treatment a few days earlier would have made no difference to his condition.

(f) Consequently, even if employees of the Authority had breached their duties of care in not referring the plaintiff to a specialist on 7 or 8 August, the breach or breaches of duty were not causative of any loss or damage;

(g) It has not been established that employees of the Authority breached their respective duties of care when treating the plaintiff. The evidence suggests that the employees of the Authority responsible for the plaintiff's treatment performed their respective duties carefully and completely.

[106] For the above reasons, the plaintiff's claim must be dismissed. The appropriate order appears to be judgment for the sixth defendant with costs to be assessed on the standard basis but I will hear submissions on the form of order.