

## SUPREME COURT OF THE AUSTRALIAN CAPITAL TERRITORY

**Case Title:** Spence v Neilson

**Citation:** [2018] ACTSC 273

**Hearing Dates:** 5-7, 10 and 11 September 2018

**Decision Date:** 12 October 2018

**Before:** Mossop J

**Decision:** See [167]

**Catchwords:** **TORTS** – NEGLIGENCE – Breach of duty – medical treatment –  
– temporal relationship between varicose vein surgery on obese patient and an injury to the right buttock and hip – various breaches alleged including failure of surgeon to provide appropriate advice as to the benefits and risks of varicose vein stripping surgery – evidence given by plaintiff that she would not have proceeded with surgery if advised there were no immediate risks to her health in not proceeding – whether plaintiff established that advice during consultation involved breach of duty – breach of duty not established – turns on own facts  
**TORTS** – NEGLIGENCE – Causation – medical treatment –  
temporal relationship between varicose vein surgery on obese patient and an injury to the right buttock and hip – injury not a known risk of varicose vein surgery – mechanism of injury not established – causation established by reason of temporal connection between surgery and injury

**Legislation Cited:** *Civil Liability Act 2002* (NSW), s 5D  
*Civil Law (Wrongs) Act 2002* (ACT), ss 45, 45(1)(b)  
*Court Procedures Rules 2006* (ACT)  
*Evidence Act 2011* (ACT), s 46

**Cases Cited:** *Chong v CC Containers Pty Ltd* [2015] VSCA 137  
*Precision Plastics Pty Ltd v Demir* (1975) 132 CLR 362  
*Reberger v R* [2011] NSWCCA 132  
*Spencer v Bamber* [2012] NSWCA 274  
*Wallace v Kam* [2013] HCA 19; 250 CLR 375

**Parties:** Colleen Spence (Plaintiff)  
Wendell Neilson (Defendant)

**Representation:** **Counsel**  
A Muller (Plaintiff)  
K Oldfield (Defendant)  
**Solicitors**  
Slater and Gordon (Plaintiff)  
Ken Cush and Associates (Defendant)

**MOSSOP J:**

**Introduction**

1. The plaintiff, Dr Colleen Spence, has claimed damages arising out of her treatment by the defendant, Dr Wendell Neilson, who she consulted in relation to her varicose veins and who performed varicose vein removal surgery upon her. She has claimed that a disabling hip and tendon condition from which she now suffers is a result of the surgery that she underwent.

**Chronology**

2. The plaintiff is almost 63 years old. She grew up in Spokane in Washington State in the United States. She studied in Nebraska and Iowa and received a PhD in chemistry. In 1988 she obtained a post-doctoral position at the Australian National University for a period of 18 months. She subsequently became a lecturer at the Australian Defence Force Academy. During that period (in 1991) she suffered an injury to her back. That injury involved a difficulty with a disc and she underwent a surgical laminectomy and discectomy. She recovered fully. Prior to the incident involving her back, she had two children. Following the surgery, she went on to have three more children. She returned to cycling, bushwalking, aerobics and occasionally swimming.
3. In 1995, the plaintiff joined the Australian Public Service and was employed as an evaluator at the Therapeutic Goods Administration. She left that employment in 2002 and obtained teaching qualifications in that year. She then taught at Merici College. She started as a teacher, then became the information technology (IT) lead teacher and ultimately the Assistant Principal (Student Welfare).
4. In 2009 she moved to Marist College Canberra as the Head of Science. In 2012 she became Assistant Head of School (Learning and Teaching). This was a high-pressure role. It involved some teaching as well as assisting other teachers, running professional learning programs, some responsibility for student welfare and also running Year 11 and 12 retreats and camps. She had no physical restrictions on her capacity to perform the work involved in this job.
5. The plaintiff had varicose veins in her legs. In the late 1980s or 1990 she underwent some injections into the varicose veins that were then present in her legs. She did so for cosmetic reasons. Those injections led to those veins no longer being prominent. At the time she had the treatment, she was advised that if she had further children the varicose veins would return. She subsequently had three more children and the advice about the return of the varicose veins proved to be accurate.
6. In 2014 she had a discussion with a friend of hers at a teachers' network meeting. That friend told her that if she had varicose veins then she had "better take care of them now". That was because this woman had suffered a blood clot as a result of varicose veins which had broken apart and resulted in a serious condition which required hospitalisation. As a consequence, on 7 April 2014 the plaintiff attended her general practitioner, Dr Prema Rajendra, who said "they're pretty bad and it would be a

good idea to have them looked at". Dr Rajendra gave the plaintiff a referral to the defendant. That referral was as follows:

Thankyou for seeing Colleen who presented to me with a history of- Varicose vein B/L leg. Could you see and for your advise please. Thankyou for your help in Colleen's further management [sic].

7. The plaintiff denied that she was suffering from any discomfort or identifiable problem with the varicose veins at the time. After the referral, but prior to her consultation with the defendant, she attended Dr Rajendra again and the doctor's notes record that she was complaining of "L-leg thrombophlebitis- local area". Dr Rajendra explained in oral evidence that this entry related to varicose veins in the left leg even though there was no reference to varicose veins in the notes for this consultation.

## **The consultation**

### *Plaintiff's evidence*

8. The plaintiff saw the defendant on 17 April 2014. The plaintiff gave the following evidence about this consultation. She told him about her conversation with her friend. She did not recall telling him that she had no symptoms. He suggested surgery so as to have the veins stripped:

When you spoke with Dr Neilson did you tell him about the conversation with your friend?--- Yes, I did that was how I started the consultation was explained to him why I'd come.

Did you tell him that you weren't having any symptoms?---I don't recall specifically saying that.

Did you tell him anything else that you remember now other than the story about your friend?---No not specifically.

What did he - doing the best that you can, I know it's a long time ago what did he say to you?---He suggested that I have surgery to have the veins stripped.

9. He went into detail about the operation. He drew diagrams on a piece of paper. He also provided her with a document containing information about the surgery. He explained that the risks were those risks involved with anaesthesia, the possibility of infection, the possibility of her suffering from a condition known as "drop foot". She did not recall him talking about bruising. He said that following the surgery she would have "beautiful legs". He explained that after the operation she would have her legs wrapped and bandaged and that she was likely to have pain from "castings" which were the accumulation of blood in the areas from which the veins had been stripped. He explained that she would then be able to move around, that the Steri-Strips would fall off and the wounds would heal. He estimated the surgery would take an hour and a half to two hours. They discussed the cost of the surgery.
10. He did not discuss with her any issues relating to her friend's experience. He did not discuss with her any risks that might exist if she did not proceed. He did not explain why he was recommending surgery, although he did make reference to the fact that she would have "beautiful legs". She mentioned that she had suffered from some swelling in her ankles and he said that surgery may or may not help that condition.
11. He did not discuss the possibility of injuring her hip during the course of surgery. He did not discuss the issue of her weight or recommend that she should lose weight prior to the surgery.

12. At the end of her examination-in-chief she was asked a series of questions about what she would have done in particular circumstances:

Would you have proceeded with the surgery purely and simply for that cosmetic benefit?---No.

Had you been told when you saw Dr Neilson that there were no immediate risks to your health in not proceeding with this surgery, would you have still proceeded?---No.

Had you been told that the benefit of the surgery was essentially cosmetic would you have still proceeded?---No.

Had you been told that the risks to your health of proceeding with the surgery were greater due to your overweight, what would you have done?---If I thought that my being overweight was an important factor in the risks associated with the surgery, I would have made an effort to lose weight. Especially in that interim period from when I saw Neilson to when I had the surgery.

Were you told any of those things by Dr Neilson?---No.

13. In cross-examination these answers were not challenged. During the course of cross-examination the plaintiff said that before she went to see the defendant she expected him to say that maybe the same thing that happened to her friend could happen to her and she expected him to say that she should go and lose weight and then have the surgery done. She also said that she was aware that the reason that you get varicose veins is an incompetence of the valve at the juncture in your groin. She said that she had not really thought about whether her veins would deteriorate over time. Later in cross-examination, in the course of giving an answer, she summarised the consultation as: "I explained my concerns, he recommended surgery, he talked about risks, explained the anatomy and we talked about what happens next."

#### *Letter from defendant to Dr Rajendra*

14. Dr Neilson reported to Dr Rajendra on 17 April 2014. His letter said:

As you are aware Mrs Spence is a delightful 58-year-old lady who has for many years had varicose veins. Admittedly they are not causing her any problems but she did have a friend who has developed some complications from varicose veins and as a result she is now keen to get her veins treated...

On examination, Mrs Spence is overweight and on inspection of her legs she has varicose veins in the left anterior thigh vein territory which is crossing to the lateral surface of her calf particularly around the knee region. On the right side she has varicose veins in the long saphenous vein territory and behind her knee...

Through use of a diagram I have demonstrated to Mrs Spence the aetiology of varicose veins and how varicose veins cause their problems. I have also used this diagram to explain how varicose vein surgery is used to treat varicose veins by removing them from the system. I have explained the complications of varicose vein surgery including infection and haematoma, bruising as well as potential nerve damage to the saphenous nerve. I have also consented Mrs Spence for the financial cost of this operation and she has consented to this procedure.

#### *Defendant's evidence*

15. The defendant had no actual recollection of the consultation with the plaintiff. His evidence was that he took handwritten notes at the time and that these notes were then used to dictate a letter to the referring general practitioner. That letter then formed the record of the consultation. He was able, however, to give evidence of his usual practice in relation to such consultations. He would find out why the patient was

attending and obtain a history of matters relevant to the aetiology of their varicose veins. He would identify what the patient understood the symptoms to be. He would explain varicose veins using a diagram which he drew and that often prompted the patient to identify their symptoms. He had access to the ultrasound mapping of the varicose veins. He would examine the patient. If surgery was appropriate, he would explain the process and the post-operative treatment. He would explain the possible complications, namely, infection, bleeding, bruising, casting and nerve damage. He explained that casting was a complication which affected around 10 per cent of patients. If the patient wished to proceed with surgery then he would explain the cost to do it through the private hospital system. He provided the patient with a statement outlining post-operative care.

16. Although his evidence was of his usual practice, some of it was given in a manner which suggested it related to the plaintiff's circumstances. The following appears in his examination-in-chief:

Right, thank you. So if you could return to your usual practice - - -?---Yes.

- - - in the first consultation and continue your answer?---Where were we up to? So we go through the - why the patient has come now. She came to see me because of potential complications of varicose veins. ***She did not have any symptoms herself but I explained to her that varicose veins is a very, very slowly pathological disease.*** It generally gets set up - the main etiological cause is pregnancy. The majority of women have their pregnancies in their 20s and 30s, we see the majority of women with symptomatic pains in their 60s, 70s, 80s. There is a 30 - 20 or 30, 40 year gap between the start of the veins and the start of their symptoms. Having explained that I then examined Mrs - Dr Spence and noted that she was overweight. She had a cluster of varicose veins running down her leg in the anterior thigh vein territory which then went round the lateral side of her knee, and on her right leg they were in the long saphenous vein territory. We then sat down and I discussed how surgery is used to treat varicose veins, explained to her what the operation would entail, the post-operative course which includes use of compression bandaging and compression garments. What to expect after the operation, and then also if she was agreeable to the operation we then spoke about the associated cost of having it done through the private hospital.

Right. So unpacking each of the steps?---Yes.

So the first step was talking about how surgery could be of assistance?---Yes.

What would you usually say to a patient in the plaintiff's position?---***Because she was asymptomatic I would have told her that this would be purely elective surgery, there is no rush to go in and have this surgery done, it should be done at her convenience.*** I have plenty of patients - just slightly off track, plenty of patients that have varicose veins that have very minor symptoms or no symptoms, but they would still like to have them treated, and when I explain to them the post-operative course with the use of compression bandaging and explained how that can be quite uncomfortable in the warmer weather, they often like to postpone it to the following autumn or winter to have their surgery done, and because it is a very slow, mild, very minor slowly progressive disease, there is no poor outcomes from that, and that is why we have a waiting list for varicose vein surgery to be done in the public hospital because these are the kind of patients that are able to wait without any progression of their disease, or major progression of their disease to have their surgery done electively. Having explained that, I presume then that Dr Spence decided she wanted to have her veins treated as a pre-emptive or a - as a pre-emptive course and we decided on the operation date in early July of 2014.

(Emphasis added.)

17. In the plaintiff's case, the date of 8 July 2014 set for the surgery was as a result of the patient's choice having regard to the timing of the school holidays.
18. In cross-examination the following appears:

You did record the particular life event that had led her to consult you?---Yes.

That was of a friend who had told her about complications with her own varicose veins?---Yes.

You record that history but you don't make any other observation about it in your letter?---Correct.

I take it from your earlier evidence that you don't have any recollection at all of any discussion about that issue, either what was said to you - - -?---I'm sure I would have gone into what complications she had, if she knew, but I do not recall what that was and certainly I did not record that. Just that that was the reason why she came to see me.

All right. Ms Spence, of course, says that other than her provision of that history as a reason for seeing you, it wasn't otherwise discussed and do I understand your evidence to be that you can't confirm or deny that because you don't have any independent recollection?---Could you just repeat that question, please?

Yes. Ms Spence's evidence is - - -?---Yes.

- - - that having provided you with that history - - -?---Which history? Of the friend?

The history of the friend as the reason for her being there - - -?---Yes.

- - - that there wasn't - the discussion then moved on to her rather than there being any discussion about the friend?---Correct, because - - -

When you say correct?---That is correct. That's how the discussion would have gone.

All right?---But I don't remember specifically the discussion.

Okay and the particular concern that she had based on her friend's experience was that the veins had progressed to clotting and concern about embolus, the clot breaking away and consequent embolus?---Sure.

Her evidence is that there was no discussion about those issues in the context of her case?--Mm'hm.

You - again, you are not able to confirm or deny - - -?---No.

- - - whether that is so?---No but I could speculate.

Well, speculation doesn't assist us, doctor, but - - -?---Okay.

- - - can I just then put this question to you? Is it a fair thing to say to you that if you had had any concerns about those types of issues in Ms Spence's case, you would have recorded them in your letter to the GP?---Yes.

The plaintiff also says that on a number of times during the consultation, you told her that she would have beautiful legs after this procedure. My saying that, does that trigger any memory of - - -?---No, I would never use that term.

19. In relation to his denial of using the term "beautiful legs" he referred to a particular aspect of his medical training that he recalled which, in his mind, rendered the use of such language inappropriate.
20. In cross-examination he said that it wasn't unusual to see patients whose varicose veins were asymptomatic. If there was symptoms such as aching towards the end of the day, throbbing in bed or itching, then he would have recorded those symptoms.
21. The defendant said that he didn't generally discuss the weight of the patient. He noted that the plaintiff was overweight but didn't consider that to be a major factor increasing the risk of complications. He didn't make a practice of weighing the patient or obtaining the patient's height and, as a consequence, did not obtain a Body Mass Index (BMI). He said that he made a clinical assessment of the patient's weight in order to

determine whether it had implications for the type of surgery to be performed. He said that when he had in the past asked patients to lose weight prior to surgery, they invariably were not able to, and as a consequence he makes a clinical decision about whether or not surgery is appropriate in light of the patient's weight.

## **The operation**

### *The operation record*

22. The operation report recorded that the plaintiff had been placed supine on the operating table. It indicated that the long saphenous vein above the knee was removed using an inversion technique and that the varicose veins below the knee were removed using a "multiple stab avulsion" technique. There is no reference in the operation report to any need to manipulate the plaintiff's legs or hip during the operation or the extent of any such manipulation.

### *The evidence of Dr Don Lu*

23. Dr Lu, an anaesthetist, gave evidence that he was the anaesthetist for the plaintiff's operation. He did lots of these operations with the defendant. He could not specifically recall the operation of the plaintiff. The records that he made at the time of the operation were shown to him. He identified that if anything unusual had happened during the course of the operation, whether from a strictly anaesthetic point of view or more generally in relation to the surgery, then he would have recorded that on his documentation. There were no records indicating anything out of the ordinary occurred during the plaintiff's operation. He agreed in cross-examination that the plaintiff was supine and that in order to get access to some of the veins it would have been necessary to bend her legs and tilt them outwards to get access to the relevant areas.

### *Evidence of the defendant*

24. The defendant gave evidence about the operation. Once again, he had no specific recollection of the operation but he gave evidence based upon the available records and his usual practice. He described that he would see the patient on the day of the surgery and that, either when being admitted or in the anaesthetic bay, he would have the patient stand and mark the veins to be removed. That was because the veins were easy to see when the patient was standing upright. He described the recorded operation time of two hours and 36 minutes as being nothing out of the ordinary for a procedure of this nature. His practice would be to record any unusual events during surgery and none were recorded in either his handwritten surgery report made immediately after the operation or in the typed up report which he made later that evening.
25. The defendant described that the patient would be swabbed with Betadine from the navel down and that the patient's legs would be lifted so as to permit swabbing with Betadine underneath the legs. Whilst the patient was supine, the incision would be made in the groin so as to sever and ligate the top of the long saphenous vein. The stripper would be inserted and when the incision was made in the knee then the vein would be stripped out. After this, the removal of the veins on the lower part of the leg would proceed. When access was required to be obtained to the back of the patient's legs, the legs would be bent and the defendant would hold the leg, bent outwards and

reach round behind so as to get access to the area behind the knee. His evidence was that he never forced a limb beyond its range of movement.

#### *Blood transfusion and discharge*

26. After the operation, the defendant spoke to the plaintiff. He said that the surgery had gone longer than anticipated and that she had “the biggest, ugliest veins I’ve ever seen”. He said that things were okay but there had been some blood loss.
27. The defendant approved her discharge from the hospital. Subsequently, prior to discharge, a nurse got the registrar to examine the plaintiff and the registrar ordered that she be given two units of blood prior to being discharged.

#### **After the operation**

28. The plaintiff left hospital with her legs bandaged. Those bandages remained on for about five days until she removed them. Following her return from hospital, she suffered “incredible pain” which she understood was from the castings. She described the pain as 11 out of 10 and that it was worse up the back of her thighs. This made movement hard. She also noticed pain in her hip although this was minor and she didn’t differentiate it from what she understood to be the pain of the castings.
29. She consulted her general practitioner on 18 July 2014. The doctor’s notes record that there were a “few infected holes”. The plaintiff complained of pain in her legs and right buttock or right hip. In the balance of these reasons, I will refer to this as right hip and buttock pain. She was told that the pain in her legs was the result of castings and the pain in her right buttock was probably a pulled muscle that might have occurred during surgery.
30. She saw the defendant for a post-operative consultation on 21 July 2014. The scheduled post-operative appointment had been for 19 August 2014, however the plaintiff made an earlier appointment. The plaintiff’s evidence was that, at that stage, there was pain in her hip but that it was minor and the defendant had said that her pain was almost certainly from the castings and that the pain in her hip was as well.
31. The defendant’s reporting letter to Dr Rajendra refers to the pain that she was experiencing and explained it as being a result of “casting”. The letter said that he had reassured the plaintiff that it was not uncommon and that the appropriate treatment was a simple anti-inflammatory medication. In oral evidence the defendant denied that the plaintiff had made a complaint of right hip and buttock pain. He said that if she had made such a complaint, he would have recorded it. It was not a complaint that he had ever heard of after a varicose vein stripping operation. He said that if there was a report of such pain, he would have tried to ascertain when and where it arose and what caused it. He indicated he would have documented it for the general practitioner and recommended an x-ray and a referral to an orthopaedic surgeon.
32. The plaintiff saw him again on 19 August 2014 and reported that the pain in her medial thighs had settled and her scars were “maturing nicely”. The plaintiff said that at this consultation she reported the right hip and buttock pain to the doctor but he didn’t give her any advice in relation to that pain. The plaintiff assumed that the problem was muscular and would resolve.



33. The castings pain subsequently subsided. However, the right hip and buttock pain did not. That pain was particularly noticeable when she was walking up stairs or up an incline.
34. The plaintiff's evidence of complaint of right hip and buttock pain was corroborated by her husband, Robert Spence, who said that when the castings pain down her leg subsided, the pain in her hip did not. I take this evidence to refer to both the hip and buttock pain. She told him about it frequently. He was not cross-examined and his evidence was not challenged. On the basis of the plaintiff's evidence and that of her husband, I find that her experience of right hip and buttock pain started after the operation and became apparent as the castings pain subsided. It is likely that the plaintiff did not effectively communicate to the doctors her distinct pain in a manner which caused them to address it separately.
35. By November 2014 the pain in her right hip and buttock had become worse. It interfered with her walking. She saw her general practitioner on 6 November 2014 and the general practitioner referred her for physiotherapy.
36. The plaintiff gave evidence that she thought that she had attended her general practitioner on one or two occasions between the July and November 2014 consultations. There was, however, no record of any such consultation in the doctor's notes or any of the Medicare records. I therefore find that there was no additional consultation with Dr Rajendra.
37. The problems with her right hip and buttock made it hard to do her job. That is because she had difficulty walking and getting up and down stairs. This made it difficult to get around the school to visit particular areas. It made it difficult to perform her supervision duties in the playground. She also had difficulty writing on the board when teaching.
38. In order to manage her pain she took a lot of Voltaren. She had a break over the Christmas period. At that time she had more control over what she did on a daily basis and, as a consequence, suffered from less pain.
39. When she returned to school in 2015, after a couple of weeks, the pain came back. She had to modify her activities, giving up a co-curricular activity and stopping going to the maths department as that involved too many stairs. Outside of school, she used a walking stick.
40. In August 2015 she changed general practitioners. She did so because she considered that her general practitioner had not been taking her right hip and buttock problem seriously enough. She saw Dr Kristin O'Neill for the first time on 19 August 2015. The doctor's notes recorded the plaintiff's complaint as "feels that right hip has been uncomfortable since. Ache. Still present 1 year post the surgery. Unable to sleep at times due to the discomfort. Felt at right buttock area, occasional radiation to outer thigh". She was referred to a physiotherapist. On 21 September 2015, she had an ultrasound of her right hip and groin. She was then referred to an orthopaedic surgeon, Dr Wisam Ihsheish, for review in relation to her ongoing buttock and hip pain. She saw Dr Ihsheish on 9 October 2015. The doctor sent her for a magnetic resonance imaging (MRI) scan which was performed on 15 October 2015. The doctor described the MRI as showing large tears of her gluteal tendons with tendinopathy and significant bursitis around the right greater trochanter. He suggested ultrasound guided steroid injections and if that failed then surgery sometime in the future. The plaintiff

gave evidence that he said that surgery to reattach the tendons did not have a high rate of success.

41. The plaintiff then obtained a referral to another orthopaedic surgeon Professor Paul Smith, who she saw on 10 November 2015. Professor Smith also recommended an ultrasound guided steroid injection and she had this performed the next day. This resolved her bursa pain but did not resolve the pain in her right buttock. She subsequently had physiotherapy and hydrotherapy treatment. Her physiotherapist taught her different ways in which she could walk and go upstairs so as to reduce the resultant pain.
42. The plaintiff saw Dr Smith again in December 2015.
43. She has maintained the improvement in the condition so long as she takes steps to manage her condition. She does that by knowing what she can do and for how long. For example, she will only walk for one kilometre at most, she will avoid stairs beyond one flight per day. She does not walk on uneven ground and if she is uncertain about where she will be walking, she takes a walking stick. As such, she can now only do bushwalking where there is a level, maintained path. She doesn't walk on the beach, walk the dog, go canoeing or go snorkelling.
44. The pain varies. On a bad day it will, with management, be between five and six out of 10. On a good day it will be between one and two out of 10.
45. Her sleep is affected in that when her pain is bad she cannot sleep on her side at all. She perceives that the depth of her sleep has been reduced. When her pain is bad she feels tired all the time, although she can't differentiate between the effects of poor sleep as opposed to the increased stress of dealing with the pain. She deals with her pain by taking Voltaren and, when necessary, Panadeine.
46. The plaintiff's evidence was that her disabilities have had an effect on her mood. She always perceived herself to be a "can-do" and competent person. She does not see herself in that way anymore, identifying that her pain and restrictions on her activities and problems at work have left her in a depressed state. The plaintiff's husband corroborated the plaintiff's evidence about the impact upon her mood.
47. Her general practitioner prescribed antidepressant medication. She also obtained assistance from a psychologist at the end of 2017 and anticipates having further consultations in the future. She found the psychological assistance useful.
48. As a result of her physical condition, she and her husband are down-sizing – proposing to move to a smaller house with fewer steps which would be more manageable for her.
49. At the beginning of 2017, she saw Dr Smith complaining of pain that was in her lower back. Following a whole-body scan, he recommended injections into the L4/5 facet joint. This occurred in February 2017 and was helpful.
50. The plaintiff did not obtain any support or accommodation from the Headmaster of Marist College Canberra who indicated to her that it was unsatisfactory that she spent so much time in her office. She ultimately decided to resign. Up to the point of her resignation, she considered that she was doing her job in all respects except insofar as she had difficulty with the physical requirements of the job.
51. Following her resignation, she obtained a job commencing at the beginning of 2018 at Karabar High School. This was a role supporting distance education students from

around New South Wales. She did not have a classroom, did not have any playground supervision duties and the role was all round physically less challenging. The job, however, paid significantly less.

## **Expert medical evidence**

### *Dr Alan Spigelman*

52. Dr Spigelman is a general surgeon. He is also a professor at the University of New South Wales. He said that during the course of the operation the plaintiff was supine with her legs slightly externally rotated. Her legs would have been bent at the knees to obtain better access at some point during the procedure and moved to allow access for the multiple “stab avulsions”. The existence of varicose veins “posteriorly across the popliteal fossa” of the right leg would have required manipulation of that leg by elevation or internal rotation, or both, of the hip for access to be gained. Having regard to the results of the MRI on 13 October 2015, he expressed the view that it was more likely that the tears identified in that were traumatic in origin because of the temporal relationship between the surgery, the positioning changes during surgery, and the onset of right hip pain. He also expressed the view it was more likely than not that the hip tears were occasioned by trauma during the surgery. He said that the mechanism of the injury was that “the right leg would have likely to have been manipulated significantly to gain access to the varicosities in the right popliteal fossa [so] that they could be avulsed”.
53. He was also asked whether a reasonably competent surgeon exercising reasonable care would have recommended that the plaintiff undergo the subject procedure at the time that she did. He expressed the view that because the varicose veins were not causing any problem, there was room for caution in performing an elective operation on a patient who was significantly overweight without at least providing advice or referral, or both, concerning weight loss. That was the case notwithstanding the patient’s wishes. He therefore considered that a reasonably competent surgeon would not have recommended the plaintiff undergo the subject procedure at the time that she did.
54. In cross-examination he explained that the need to externally rotate the patient’s legs would have occurred in order to get access to the varicose veins at the back of the knee. He agreed that his conclusion in relation to the cause of the plaintiff’s hip and thigh pain was based upon the close temporal relationship between the operation and the onset of the pain. Although his opinion was that there was no urgency because the varicose veins were asymptomatic and it was desirable that the plaintiff lose weight prior to surgery, he agreed that his opinion left open the possibility that a vascular surgeon acting reasonably might have performed the operation on the plaintiff.

### *Dr John Cummine*

55. Dr Cummine reported to the solicitors for the defendant. His report and evidence went to the issue of causation. His view was that the right hip and buttock pain was not related to the surgery undertaken by the defendant.
56. His opinion was that, notwithstanding the ultrasound and initial MRI findings reported in her right hip, the most likely cause of her symptoms was degenerative joint disease including whichever of the L4/5 or L5/S1 disc was operated on in 1992 as well as bilateral L4/5 advanced facet joint arthritis. He considered that the initial MRI scan (13 October 2015) was “significantly over-reported” and that the persistence of her

symptoms, notwithstanding the marked improvement in MRI appearance of her right hip over a 14 month period, made it most unlikely that the pathology identified in the region of her right hip correlated with her symptoms. The 14 month period that he referred to is the period between the MRI scan performed on 13 October 2015 and a second MRI scan performed on 15 November 2016. The second MRI showed “much improved appearance in relation to the severity of the right greater trochanteric bursitis” as well as “resolution of the inflammation around the gluteal tendons and their insertions including an improvement with resolution of the submedius bursitis noted on the previous examination”.

57. Dr Cummine expressed the opinion that the limited limb movement during varicose vein repair was “unlikely in the extreme” to be responsible for the imaging appearance of the patient. He first dealt with the issue of bursitis. He expressed two reasons for his conclusion that the surgery was not the cause of this aspect of the imaging. First, the amount of movement would have been minimal. Second, both the MRI scans showed fluid in the left trochanteric bursa which was asymptomatic. They also showed a dramatic reduction in the amount of fluid in the right trochanteric bursa even though symptoms persisted.
58. In relation to tendinopathy he said that this involved age-related changes within the tendons, the vast majority of which are asymptomatic.
59. So far as tendon tears were concerned, while physical tears were possible, the vast majority are part of the ageing tendinopathic process, most of which are asymptomatic. He said that the likelihood of an acute tear or multiple tears occurring in an anaesthetised patient on a table is “remote in the extreme”. The possibility of such injury was even more remote if a relaxant anaesthesia was administered (although he did not know whether this was the case).
60. So far as osteoarthritis in either of the patient’s hips is concerned, the joint space narrowing (or loss of articular cartilage) which is the hallmark of arthritis was reported as symmetrical. On the second MRI (of the right hip only) there is no mention of loss of articular cartilage. He was of the view that the first MRI report, noting “the hip joint spaces are narrowed”, was either in error or inappropriate for three reasons:
  - (a) there were no complaints of groin pain;
  - (b) there was no evidence of increased uptake in either hip on bone scanning; and
  - (c) the bone scan identified increased uptake in a variety of joints but not in either hip.
61. Finally, he expressed the opinion that degenerative lumbar spine disease was very common and the patient had a clear history of a degenerative disc at either L4/5 or L5/S1. He said that because back pain is such a universal symptom, and one of its common manifestations is pain experienced in the buttock and radiating into the proximal leg, it is highly likely that degenerative disc disease in the lower lumbar spine was the cause of the plaintiff’s symptoms. He said that this was consistent with the opinion of Dr Smith expressed in February 2017 after reviewing the results of a bone scan.
62. In oral evidence the doctor said that he currently had a practice limited to medicolegal matters and that had been the case for eight years. In examination in chief he went

through the areas of disagreement with Dr Anthony Kam's second report. In particular he noted that there was a symmetrical reduction in the cartilage interval in the patient's left hip which suggested that the reduction was, for this patient and at her age, normal for her. He maintained his view that he did not believe that the patient had osteoarthritis in her right hip.

63. In cross-examination he identified that he had not examined the plaintiff and the history or chronology was that which he had gleaned from a perusal of the medical records which were provided to him. He agreed that in summary his opinion was that notwithstanding the hip scan findings, the more likely cause of pain in the plaintiff's case was degenerative joint disease in the lumbar spine. He noted the persistence of symptoms, notwithstanding the improvement shown on the two MRI scans 14 months apart, and confirmed his opinion that the scans of the hip made it unlikely that the pathology in this case was hip related. In that regard, he repeated his opinion that if the volume of fluid in the bursa was the result of an inflammatory process, then the symptoms should have decreased having regard to the improvement shown in the second MRI scan. He accepted that the injections into the right trochanteric bursa "might" provide an explanation for the reduced inflammation in the joint on later scanning. However, he maintained his opinion that there might just have been an increased volume of fluid rather than inflammation.
64. He was asked to assume that the back pain did not arise until late 2016 and that it improved as a result of facet joint injections in February 2017. On those assumptions, it was suggested to him that the source of the back pain commencing in late 2016 were the facet joints. He responded "possibly" and said:

The localisation of pain causes in back pain, buttock pain, and proximal thigh pain, continue to bedevil the orthopaedic profession. There are multiple different symptom complexes that are believed to be a reflection of either facet joint disease or disc disease, both of which exhibit in this [patient's] degenerative change.

65. He agreed that the response to injections was a factor to be considered but did not accept it as being conclusive. He accepted that the right buttock pain would be consistent with a combination of underlying degeneration including tendinopathy, the presence of greater trochanteric bursitis and degenerative disease in the lumbar spine. He accepted that if there was a two-year gap between the localised lower back pain and the surgery, then those conditions would not be linked causally. He accepted that tendinopathy was present and that there was more fluid in the right trochanteric bursae on the left, but thought that the significance of the finding was dubious. He accepted that if there were no pain or symptoms in either hip and no restriction in either hip but degenerative change on both sides, and after surgery she had pain in the right hip, then it made it more likely that there was a causal connection between pain and surgery.

*Dr Charles Fisher*

66. Dr Fisher is a vascular surgeon. He reported to the solicitors for the defendant. He was asked to express an opinion, based on the medical treatment records, whether the plaintiff's varicose veins were likely to be symptomatic at the time that she consulted the defendant and also about what a reasonably competent vascular surgeon would have advised the plaintiff in the circumstances of the consultation on 17 April 2014.

67. So far as whether or not the varicose veins were symptomatic, he expressed the opinion that they were likely to have been very obvious to an observer but not necessarily experienced as uncomfortable by the patient. He did however note that in his experience some patients with bilateral veins only appreciated the ache and discomfort from the veins after one side had been treated.
68. In relation to the consultation, the opinions expressed in his report were as follows: a reasonably competent vascular surgeon would have offered the plaintiff a varicose vein stripping procedure but only after discussion of the relevant aspects of her presentation. It would be reasonable for there to have been a discussion of her friend's complications from varicose veins, including whether those complications were likely to occur in the plaintiff.
69. It would be reasonable that there be a discussion of the increased risks of undertaking the procedure in a patient with a higher BMI and advice provided regarding weight loss prior to surgery. He agreed with Dr Spigelman that a reasonably competent vascular surgeon would have provided the plaintiff with advice or referral, or both, concerning weight loss.
70. He said that a reasonably competent vascular surgeon would have provided the patient with a brochure such as that available from the Fellowship of the Royal Australian College of Surgeons (or similar) setting out the risks of the varicose vein stripping procedure.
71. He also said that a reasonably competent vascular surgeon would have warned the patient of the risks including bleeding, bruising, casting, infection and damage to the saphenous nerve, although given the location of the veins, saphenous nerve damage was not relevant in this case.
72. While the patient's weight was not an absolute contraindication, any decision to proceed to surgery would depend upon balancing the risks and benefits of the procedure as well as the risks and benefits of not performing the procedure. In that regard, the patient's assessment of the risks as well as those of the surgeon would be relevant.
73. During the operation, the patient would be supine and some degree of hip adduction and hip flexion would have been required in order to reach the veins, but the extent of such movement would be well within the usual range of movement of the hips with the foot remaining in contact with the operating table.
74. He was not aware of any association between such surgery and hip–gluteal tendon injury and could not find any case reports or other studies associating the two.
75. In cross-examination he was asked about and gave evidence about a variety of alternative methods of treating varicose veins. No submissions were made by the plaintiff based upon the evidence about these alternative methods. He was also asked about the matters that he would discuss with a patient contemplating varicose vein surgery. The effect of his evidence was that the likely development of varicose veins, issues of weight and risks of surgery would all be discussed. He agreed with the proposition that a reasonably competent surgeon would not proceed with surgery in an asymptomatic but obese patient without having a discussion about weight loss. He also gave evidence that he would not routinely weigh a patient for the purposes of a

consultation about varicose vein surgery and he had performed surgery on patients with a similar BMI to that of the plaintiff.

76. He was also asked about the mechanics of surgery and how he would obtain access to the varicose veins on the rear of a patient's legs. This evidence did not indicate a likely mechanism by which the plaintiff may have aggravated her tendinopathy or tendon tear or by which symptomatic bursitis would have been caused.

## **Psychiatric evidence**

### *Dr Michael Robertson*

77. Dr Robertson is a consultant psychiatrist and an associate professor at the University of Sydney. He reported to the solicitors for the plaintiff on 6 January 2017. He gave his opinion on the basis that the plaintiff suffered a chronic soft tissue injury to her left gluteal region during intraoperative trauma during the surgery. He expressed the opinion that she suffered from somatic symptom disorder and chronic adjustment disorder with anxiety and depressed mood as described in the Diagnostic and Statistical Manual (DSM 5).
78. In cross-examination Dr Robertson explained that somatic symptom disorder was a diagnosis introduced with the publication of the DSM 5. He made the diagnosis because he thought that some of the plaintiff's maladjustment to pain was explained by reference to her complex childhood.

### *Dr John Saboisky*

79. Dr Saboisky, a consultant psychiatrist, reported to the solicitors for the defendant on 12 October 2017. He made what he described as essentially the same diagnosis as Dr Robertson, namely, adjustment disorder with anxiety and depressed mood. He identified that this responded well to antidepressant medication and psychological treatment. He disagreed with the diagnosis of somatic symptom disorder because he considered that her pain was the product of a torn muscle and not a psychological injury.

## **Other expert medical evidence**

### *Dr Leon Le Leu*

80. Dr Le Leu, an occupational physician, reported to the solicitors for the plaintiff on 8 May 2017. He took a history from the plaintiff and undertook an examination of her. He diagnosed the plaintiff as having suffered from right trochanteric bursitis, gluteus medius tears and gluteal tendinopathy. He expressed the view, largely based on the history taken, that the symptoms arose immediately after the operation and that it was more likely than not that the conditions were caused by the operation. He thought there was no particular reason to believe that there would be long-term deterioration of the plaintiff's condition although it would fluctuate up and down. He considered that, subject to certain significant restrictions on her physical activities, she was able to continue to work full-time. He expressed the view that the prospect of further improvement was very uncertain. Based on the history that he had taken, he expressed the opinion that the domestic assistance required in the past was five hours per week and that in the future he estimated it at four hours per week, but suggested that an occupational therapist would be able to assess that more accurately.

81. In cross-examination he was asked a variety of questions largely relating to the history that he took. He agreed that his conclusion in relation to causation was based upon the temporal association between the operation and the onset of pain.

*Dr Gregory Burrow*

82. Dr Burrow is an orthopaedic surgeon with a subspecialty in shoulder and knee surgery. He reported to the solicitors for the plaintiff. He took a history of the injury and the plaintiff's present condition. He undertook an examination of her and reviewed the previous imaging and reports. His diagnosis was:

Degenerative osteoarthritis at the hip with degenerative changes to the gluteal tendon insertion with a secondary associated trochanteric bursitis of the right hip with similar findings on MR and bone scan of the left hip gluteal musculature.

83. He was asked whether the plaintiff's presentation was consistent with having sustained traumatic tears to her right gluteal muscle and tendon. He said:

From the medical evidence available to me it is not possible to confirm or exclude that your client's presentation is due to trauma. Dr Spence has tendinosis of the gluteal tendons. It is not possible to attribute this to a traumatic tear in itself, however I note the left hip is also described as having degenerative changes of gluteal tendons and associated trochanteric bursitis both on MR scan and bone scan.

84. He expressed the opinion that the plaintiff would develop full-blown arthritis in the medium to long term. He said that she would require right hip replacement surgery because of the symptomatic right hip arthritis. In relation to the left hip, he said that she would develop full-blown arthritis and require hip replacement surgery in the medium or long term.
85. In cross-examination he agreed that hip replacement surgery could worsen the right gluteal tendon injury. He also agreed that the link between the operation and the onset of hip and buttock pain was purely temporal. He also indicated that arthritis is commonly seen in the latter aspect of life and some studies, albeit studies related to the knee rather than hip, suggest there is a four or five times increase in incidence of arthritis in the obese population as compared with the general population and that this is supposed to correlate with weight-bearing joints elsewhere, but he did not have those figures.

*Dr Anthony Kam*

86. Dr Kam, a consultant radiologist, was asked to review the report of the MRI of the plaintiff's right hip dated 13 October 2015. His opinion was that the reporting of that MRI was reasonable and accurately described the findings shown in the images. In a second report dated 17 July 2018, Dr Kam was asked questions about Dr Cummine's report and the comments on the radiological material in that report. The points arising from this report are as follows:

- (a) The large asymmetric bursal fluid accumulation seen in the MRI of 13 October 2015 was abnormal and there were indications of bursal inflammation present.
- (b) Tendinopathy is often an age-related change, particularly in females with elevated body mass indices. There is a significant overlap between the radiological appearance of partial tendon tears and tendinopathy.



- (c) Low-grade gluteal tendon tears shown on the MRI often result from age-related tendon degeneration. The MRI does support the existence of early changes of right hip osteoarthritis.
  - (d) The underlying low-grade disruption of the right gluteal tendons was more likely than not to be symptomatic at the right hip greater trochanteric region.
  - (e) The plaintiff had radiological features of early right hip joint osteoarthritis. It is not reliable to determine symptoms based on radiological changes. It was more likely than not that the plaintiff suffered no symptoms of osteoarthritis from the right hip joint.
87. Dr Kam did not consider that the 13 October 2015 MRI report “over-reported” the plaintiff’s condition but agreed caution is needed when interpreting radiological findings.
88. In cross-examination he gave evidence about the possible causes of a partial disruption of the gluteal medius. He explained that any radiological assessment of the likely cause of such a disruption would be very much dependent upon the clinical context made available to the radiologist.
89. In relation to whether or not the increased fluid in the plaintiff’s bursa was as a result of inflammation, he said there were a variety of radiological techniques which could identify it but only the bursal wall thickening was available in the present case. He was “pretty sure” that inflammation would have been demonstrated by the gadolinium contrast enhancement on MRI. He said there was no linear relationship between the extent of low-grade partial tears and the occurrence of symptoms.
90. When comparing the two MRIs (13 October 2015 and 15 November 2016), he said that in light of the degree of change demonstrated in the 2016 MRI it would be reasonable to expect a decrease in symptoms.

*Ms Kate Moore*

91. Ms Moore is an occupational therapist. In conjunction with another employee of her business, she prepared a “Domestic Needs Assessment Report” for the plaintiff. That assessed the plaintiff’s domestic needs for three different periods:
- (a) August 2014 to May 2015 and November 2015 until June 2016 (70 weeks): 5.7 hours per week;
  - (b) May 2015 until November 2015 (26 weeks): 8.45 hours per week; and
  - (c) June 2016 until the date of assessment in September 2017 (65 weeks): 3.85 hours per week.
92. She also assessed future domestic care needs at 3.25 hours per week. She recommended a variety of aids and equipment costing around \$1300 in total plus some installation costs.
93. In cross-examination she gave evidence that the reference to the plaintiff complaining of swelling in her lower legs and discomfort was based upon what she was told by the plaintiff at their meeting.

## Breach of duty

94. On the question of breach of duty, the manner in which the plaintiff's claim was pleaded and particularised became important. In the plaintiff's Amended Statement of Claim the plaintiff pleaded that the defendant had breached his duty of care in five different ways. The plaintiff alleged that he:

- i. advised the Plaintiff to undergo the subject surgery in circumstances where she was substantially overweight and without symptomatic varicose veins;
- ii. failed to provide appropriate advice as to benefit and risk of the subject procedure given the plaintiff's physical state;
- iii. failed to provide appropriate advice as to benefit and risk of the subject procedure in circumstances where the procedure itself was not indicated at the time it was performed;
- iv. occasioned traumatic tears to the Plaintiff's right buttock / hip in the course of the procedure; and
- v. occasioned aggravation of underlying degenerative changes in the right hip/and buttock region as a result of the procedure.

95. The defendant drew attention to the fact that in answers to particulars which requested identification of the risk referred to in (ii) and (iii) the plaintiff answered:

This is a matter of evidence by an appropriate expert, however, the relevant risk of injury in this matter is the risk of injury which materialised, that is an injury to the right buttock / hip.

96. In opening the case for the plaintiff, counsel for the plaintiff did not either expressly or impliedly indicate that the plaintiff's case was to go beyond that which had been particularised. In final submissions, counsel for the plaintiff did, however, submit that in light of the expert evidence that had been given which addressed a number of different subject matters of advice that should or might have been given, it was clear that the parties had litigated the matter on a basis that departed from the particulars.

97. I will address each of the particulars of negligence below.

*(i) Advised the Plaintiff to undergo the subject surgery in circumstances where she was substantially overweight and without symptomatic varicose veins*

98. It was uncontroversial that the plaintiff was substantially overweight at the time of her consultation with the defendant. There was factual controversy as to whether or not her varicose veins were "symptomatic". The plaintiff's evidence was that they were not symptomatic in the sense of causing pain or discomfort.

99. The defendant pointed to the reports of a number of doctors and what the doctors had been told by the plaintiff so as to suggest that her veins were not completely asymptomatic. Dr Le Leu recorded that prior to the surgery, "[the plaintiff's] symptoms were entirely confined to her legs and resulted from her varicose veins". In cross-examination he said that this was based on the history provided to him by the plaintiff but that he did not record or recall any specific symptoms. He assumed she would have had usual symptoms, namely, heaviness and generalised pain in the legs. Ms Moore, the occupational therapist, recorded that prior to the surgery the plaintiff would "experience right lower limb swelling and some 'discomfort' due to the presence of the veins". Ms Moore indicated that the word 'discomfort' was a term used by the

plaintiff. Dr Burrow recorded that the plaintiff “had a long history of bilateral limb varicose veins” but said the plaintiff had not elaborated with specific symptoms and had simply said that the veins had been there for a considerable period of time. In cross-examination the plaintiff admitted to having lower limb swelling prior to the surgery but indicated that she thought this was a side effect of the Zanidip, for which she was prescribed, or from standing on her feet for prolonged hours as a teacher and not due to her varicose veins. On this issue, I accept the evidence of the plaintiff that her varicose veins were, so far as she perceived them, free of pain or discomfort. That is consistent with what she told the defendant at the time of the consultation and what the defendant recorded in his reporting letter.

100. The expert evidence did not establish that in those circumstances no reasonably competent vascular surgeon would have advised the plaintiff to undergo the subject surgery. Dr Spigelman said that given there was no need for urgency, the plaintiff should have been advised to lose weight prior to the surgery to minimise risks, but he nevertheless left open the possibility that a reasonable surgeon might have performed this surgery on the plaintiff. Although the defendant said he could not recall the consultation with the plaintiff, he said that after taking the plaintiff’s history (and noting the complications of the plaintiff’s friend that led to the consult), he would have explained the elective nature of the surgery as she was asymptomatic, discussed potential complications associated with the surgery and examined Dr Spence, noting that she was overweight. Dr Fisher said that a reasonable competent vascular surgeon would have offered the plaintiff the subject procedure but only after a discussion about the risks and benefits had occurred. In this case, he said that it would have been appropriate to discuss the timing of any intervention given the patient’s lack of pain or discomfort (at that time), the circumstances of the plaintiff’s friend and how her complications may differ from the plaintiff’s, the increased risks of the procedure given the plaintiff’s BMI of around 40 and general risks associated with the surgery. On this issue, I accept the evidence of Dr Fisher that neither the plaintiff’s weight nor asymptomatic presentation necessarily precluded a reasonably competent vascular surgeon from advising the plaintiff to undergo the procedure. This appeared to be evidence of an experienced, competent and pragmatic vascular surgeon.
101. For those reasons, this ground of negligence is not established.
102. Even if this particular of negligence had been established, causation would not have been proven. That is because:
  - (a) even though the plaintiff may have attempted to lose weight if she thought it was an important factor in the risks associated with surgery, she did not give evidence that she would have declined to proceed with the surgery: see [12] above;
  - (b) no injury or disability is proven to have arisen because of her weight at the time of the surgery.

*(ii) Failed to provide appropriate advice as to benefit and risk of the subject procedure given the plaintiff’s physical state*

103. On this issue, I accept the defendant’s submissions that the manner in which the claim was particularised confines the relevant risk to that which materialised, namely, an “injury to the right buttock/hip”. I do not accept the submission of the plaintiff that the answers given to the request for particulars effectively deferred the question of

particulars to the expert evidence. When the answers given by the plaintiff's solicitors are read in context, it is clear that a distinction was drawn between those answers which referred only to the issue being one for expert evidence and those answers which substantively responded to the request. The answer provided to the request in relation to the risk the subject of this ground made it clear that it was the risk of the injury which materialised. Neither the opening nor the scope of the expert evidence led either expressly or by necessary implication expanded the nature of the claim to which the defendant was responding.

104. The evidence did not establish that any injury which materialised to the plaintiff's hip and buttock was one which should have been the subject of advice from the defendant. The expert evidence of Dr Spigelman and Dr Fisher was that a gluteal injury was not a known risk of this kind of vascular surgery even though some movement of the patient was necessary during the course of the surgery.
105. Having regard to the manner in which the claim was particularised, that is sufficient to lead to the rejection of this particular of negligence. However, if the relevant risks extended to those which did not manifest themselves, such as risks due to obesity or arising from anaesthesia, then the particular would not have been made out. That is for the following reasons.
106. So far as obesity is concerned, based upon the plaintiff's evidence, I am satisfied that the defendant did not tell her that she should lose weight prior to surgery or that surgery should be postponed until she had lost weight. However, I accept the defendant's evidence that at the consultation he would have made a clinical assessment of whether or not a patient's obesity would materially affect whether he could perform the surgery or the manner in which he performed the surgery. His evidence was that having regard to the distribution of the plaintiff's weight, the plaintiff was not so overweight as to affect or have had any material impact upon the surgery. He has not been proven to have been wrong in his assessment.
107. In light of the fact that any possible risk arising from the plaintiff's obesity did not materialise, I am not satisfied that the failure to expressly discuss that issue with the plaintiff amounted to a breach of duty. It certainly might have been the situation that the plaintiff's body weight was distributed in a way that meant that the risks arising from surgery were increased in a way which required the issue to be expressly addressed. However, in this case, notwithstanding the plaintiff's high BMI, the evidence does not establish that the risks of surgery of this type on her legs were increased in a way that compelled a discussion different to that which occurred.
108. So far as anaesthetic risk was concerned, the evidence of the defendant was that while referring to the risk of an anaesthetic in a general sense, he deferred any consideration of the specific anaesthetic risk to the anaesthetist. That was consistent with the evidence of Dr Fisher. I accept that in this case no breach of duty is demonstrated by adopting that course.

*(iii) Failed to provide appropriate advice as to benefit and risk of the subject procedure in circumstances where the procedure itself was not indicated at the time it was performed*

109. This allegation of negligence is subject to the same particularisation as the previous one which confined the relevant risk to the risk of the injury which materialised, namely, the hip and buttock pain.

110. As this particular was argued, it focussed on the failure of the defendant to specifically address the circumstances of the plaintiff's friend and to thereby identify that the risks which manifested themselves in the friend's case were not risks which she immediately faced if she did not proceed to surgery on her varicose veins. This contention was based upon her evidence that the defendant did not discuss any risks if she did not proceed with the surgery, and the question and answer referred to at [12] above that if she had been told that "there were no immediate risks to your health in not proceeding with this surgery", she would not have proceeded with the surgery. For the purposes of this particular of negligence, this would involve a failure to provide appropriate advice about the limited benefits of the procedure in the circumstances of the plaintiff.
111. It is clear from the defendant's letter to Dr Rajendra that:
- (a) he was made aware of the circumstances of her friend "who has developed some complications from varicose veins"; and
  - (b) he dealt with the plaintiff on the basis that she was not presently suffering from any symptoms: "they are not causing her any problems".
112. The plaintiff's evidence was that the only reason that she got the referral was because of her friend's experience. She could not specifically recall telling the defendant anything about why she came to see him other than the story about her friend. She said that he then suggested that she have surgery to have the veins stripped: see [8] above. As the evidence was given, such an abrupt transition during the consultation is implausible. It must reflect, as the plaintiff appeared to accept, a limited recollection of what occurred at the consultation.
113. While the defendant had no specific recollection of the consultation, he did give evidence of his usual practice. The evidence of his usual practice referred to above was that he would have explained that varicose veins is a "very, very slowly pathological disease" and that "this would be purely elective surgery, there is no rush to go in and have this surgery done": see [16] above. In cross-examination he also said that he would have gone into what the plaintiff's friend's complications were and that he then would have moved the discussion on to the plaintiff. He said that he was not able to confirm or deny the plaintiff's evidence that there was no discussion about the issue of emboli in the context of her case. He said that if he had any concerns about that kind of issue, he would have recorded that in his letter to the general practitioner.
114. Depending upon the nature of the interaction at the consultation, a failure to give advice specifically directed to whether or not the plaintiff faced risks similar to her friend may or may not have been a breach of duty when giving advice about the benefits of surgery.
115. If her friend's experience was simply a trigger to get advice about varicose veins then there is a better argument that it would not be necessary for the defendant to undertake an exercise of comparing and contrasting the circumstances of the plaintiff with those of her friend.
116. If, on the other hand, the interaction was one involving an inquiry about whether or not the plaintiff faced similar risks to those faced by her friend, a failure to address that inquiry prior to recommending surgery would be more likely to establish a breach of duty.

117. Although I have described these as binary alternatives, in reality there would be a spectrum of interactions which placed greater or lesser emphasis upon the “mere trigger” scenario or the “inquiry” scenario. Whether the consultation fell towards one or other end of the spectrum is very much dependent upon the subtleties of the interaction during the consultation. However, because of the limitations upon the evidence given by the plaintiff and defendant those subtleties are missing. Bearing in mind the limitations on the evidence and the burden upon the plaintiff to establish that there has been a breach of duty, I consider that the circumstances are more appropriately categorised as falling at the “mere trigger” end of the spectrum rather than the “inquiry” end. That is for a number of reasons:

- (a) The plaintiff’s evidence about the critical part of the consultation was limited in that she could not recall specifically telling him anything other than the story about her friend before he suggested that she have surgery to have the veins stripped.
- (b) The plaintiff only gave very limited evidence of having any particular belief about the risks that she faced which would have been dispelled by the doctor’s advice. She mentioned an expectation that the doctor would say that maybe the same thing would happen to her. It is only indirectly by an inference from her description of her friend’s medical complications and from the answer in which she stated that she would not have proceeded with the surgery, that it could be deduced that she had some belief about the extent of the immediate risk from her varicose veins. What that belief was was not clearly explained.
- (c) The plaintiff did not give evidence of having made any specific inquiry about whether she faced the risks that manifested themselves in her friend’s case. The closest that the evidence comes is that in a summary of the consultation she referred to having “explained my concerns”.
- (d) Had there been a specific inquiry, it is unlikely that an intelligent and scientifically literate professional person, such as the plaintiff, would have allowed it to go unanswered before taking the step at the consultation of booking in to have the surgery conducted.
- (e) The defendant’s evidence was more consistent with treating her friend’s circumstances as merely a trigger for the consultation rather than a matter upon which specific advice was sought.

118. In my view, while it was open to the plaintiff to establish that the nature of the consultation was such as to require a discussion of whether or not the risks that manifested themselves in her friend’s case were risks that she faced, the evidence is not sufficient to establish that in this case. I therefore do not find any breach because of the failure to have such a discussion.

119. More generally, so far as the benefits of surgery were concerned, I am satisfied that the plaintiff was told that the varicose veins were a slowly pathological disease (indicating some benefit in the surgery) but that in her circumstances the surgery was elective surgery (rather than being required because of her symptoms or an “immediate risk”). That is consistent with the defendant’s evidence as to what he would usually have explained to a patient who was asymptomatic. This reinforces my conclusion that this particular of negligence is not made out.

120. Before concluding consideration of this ground it is necessary to refer to three other matters. They are:
- (a) the decision in *Wallace v Kam* [2013] HCA 19; 250 CLR 375 ('*Wallace*');
  - (b) the failure by the defendant to challenge the plaintiff's answer that had she been told that there was no immediate risk to her health she would not have proceeded with the surgery; and
  - (c) the plaintiff's evidence that the defendant referred to "beautiful legs" as an outcome of the surgery.
121. **Wallace:** One of the submissions made by the defendant in answer to this particular of negligence was that, based upon the particularisation of the "risk" referred to in the particulars as being limited to the risk which materialised, the decision in *Wallace* was a complete answer to this aspect of the claim. I do not accept that this is the case.
122. In *Wallace* the High Court was considering the operation of s 5D of the *Civil Liability Act 2002* (NSW) which is relevantly the same as s 45 of the *Civil Law (Wrongs) Act 2002* (ACT). It contains a provision dealing with factual causation as well as a provision dealing with the appropriateness of the scope of the negligent person's liability extending to the harm caused.
123. In *Wallace* a surgeon failed to warn a patient of two material risks of physical injury inherent in a recommended surgical procedure. One was the risk of neurapraxia and the other the risk of permanent paralysis. The surgical procedure resulted in neurapraxia. If the patient had been warned of both risks, he would have not undergone the surgery. If warned only of the risk which in fact materialised then he would have undergone the procedure. Factual causation was established because had the plaintiff been properly advised (of both risks), he would not have undergone the procedure. Therefore, all the adverse consequences of the procedure would not have occurred. The question that the Court was dealing with was whether, having regard to the scope of liability provision, it was appropriate to impose liability for failure to warn of a risk which had the plaintiff been warned of he would have still proceeded with the surgery. The Court found that the scope of liability component of the section involved a normative question and that it was not appropriate to impose liability in relation to a risk which materialised in circumstances where the plaintiff would have proceeded with the surgery even if he had been warned of the existence of that risk.
124. The point arising from *Wallace* is that the scope of liability question arising under the equivalent of s 45(1)(b) prevents the recovery of damages arising from the materialisation of a risk which the plaintiff would have been prepared to bear. In the present case, the risk which materialised, namely, an injury to her hip and buttock, was one which the plaintiff would have been prepared to bear. However, the complaint made is not directed to the failure to articulate a risk of the surgery. Rather, it is a failure to advise about the risk involved in not proceeding with surgery. Put another way, it is a failure to advise about the benefits (or lack thereof) in proceeding with surgery. The complaint of the plaintiff is that the doctor did not explain to her that in her circumstances, the serious consequences that her friend had suffered, were not a realistic possibility. The plaintiff in her unchallenged evidence said, in effect, that if she was told that there was negligible risk in not proceeding with the surgery then she would not have proceeded with the surgery. As a consequence, the surgery and all the consequences of that surgery are a result of the doctor's failure to give that advice.

125. When put in this way, the liability in damages of the defendant would not be limited to the right hip and buttock pain suffered as a consequence of the surgery but would include the surgery itself. That is because, on the plaintiff's hypothesis, the surgery should never have occurred. The plaintiff's pleadings do not however make a claim based upon the surgery itself constituting damage. Rather, the damage is identified in the Amended Statement of Claim as the conditions of the "right buttock/hip" or aggravation of underlying degenerative change in the "right hip/buttock". Inconsistently with the pleading (but consistently with the manner in which the argument at trial was put) the Statement of Particulars includes the whole cost of the surgery as being out of pocket costs arising from the defendant's alleged negligence. I consider that the plaintiff is bound by her pleadings which do not include the surgery itself as part of the damage which she seeks compensation for. The inclusion of damages arising from the actual surgery in the Statement of Particulars cannot expand the scope of the claim outlined in the Amended Statement of Claim.
126. The position is, therefore, that *Wallace* is not a complete answer to this aspect of the claim. However, because of the manner in which the plaintiff's claim has been pleaded, she is not entitled to claim that the surgery itself is part of the damage arising from any negligence.
127. **Failure to challenge evidence:** Counsel for the defendant did not challenge the plaintiff's evidence given in the questions and answers set out at [12] above or her evidence that the defendant did not discuss any risks that might exist if she did not proceed. That was notwithstanding that the defendant's evidence-in-chief was that his usual practice for a patient in the plaintiff's circumstances was to indicate that that varicose veins was a slowly progressive disease but that surgery was purely elective. That evidence was impliedly inconsistent with the plaintiff's evidence because, as pointed out above, the question and answer given by the plaintiff carried with it the implication that she believed that there was some immediate risk to her health if she did not proceed.
128. Counsel for the plaintiff relied heavily upon the failure by counsel for the defendant to have cross-examined on the critical evidence given by the plaintiff that there was no discussion of the risks if she did not proceed and that had she been told there were no immediate risks to her health, she would not have proceeded with the surgery. This is a fair point. Notwithstanding the absence of any specific recollection on the part of the defendant of the consultation, his usual practice and the failure by the plaintiff to give any evidence about her belief as to the risks, if any, that she faced meant that there was a proper basis for cross-examination.
129. The failure to cross-examine a witness on a particular issue is something which will often lead the Court to accept the witness's evidence on that issue. The Court is entitled to treat the party who has failed to cross-examine as taking no issue with the accuracy of the witness's evidence: *Chong v CC Containers Pty Ltd* [2015] VSCA 137 at [201]-[204]. Prima facie, unchallenged evidence should be accepted by a tribunal of fact although a court is not bound to accept such evidence: *Precision Plastics Pty Ltd v Demir* (1975) 132 CLR 362. However, a court can sometimes reject evidence that has not been cross-examined on if, for example, it was inconsistent with other evidence that the court accepts, or it was inherently incredible: *Reberger v R* [2011] NSWCCA 132 at [48]; *Spencer v Bamber* [2012] NSWCA 274 at [134].
130. In this case:



- (a) no objection was taken to the leading of evidence from the defendant about his usual practice to the extent to which it was inconsistent with their having been any discussion of the purely elective nature of the surgery; and
  - (b) no application was made to recall the plaintiff under s 46 of the *Evidence Act 2011* (ACT) to address any part of the defendant's evidence about his usual practice.
131. In the circumstances, I do not consider that the defendant's failure to cross-examine the plaintiff, upon her denial that there was any discussion of her friend's experience compared to her own situation, requires the Court to accept that evidence and the matters implied by it. Rather, I consider that the whole of the evidence must be considered, including the fact that the plaintiff's evidence was not challenged in cross-examination.
132. The plaintiff was a credible witness. There was nothing in her demeanour which would lead me to have doubted her evidence. Her evidence about what occurred at the consultation was, however, limited.
133. In particular, her evidence did not explain how the consultation moved from the circumstances of her friend to the possibility of the surgery. It is much more likely that, as the defendant indicated was his usual practice, during the conversation the defendant discussed the circumstances of the plaintiff's friend, the circumstances of the plaintiff, elicited the fact that she was asymptomatic and went on to explain the slowly progressive nature of varicose veins, illustrating the disease and the surgery by reference to a hand-drawn diagram.
134. As pointed out above, the plaintiff gave no positive evidence that she was under any particular misapprehension about the risks that she faced if no surgery was performed. It is only by reference to the single answer that she gave at the end of her examination-in-chief that some uncertain inference might be drawn.
135. In those circumstances, I do not accept the plaintiff's evidence to the extent to which it suggested that she was unaware that the surgery was purely elective or that she was operating under some (unstated) misconception about the degree of risk that she faced if the surgery did not proceed. It also means that I do not accept the plaintiff's evidence that had she been told "there were no immediate risks" to her health then she would not have proceeded with the surgery. That is because I have not accepted the assumption embedded in the question that she was unaware that the risks that materialised in her friend's circumstances were significant considerations in her case.
136. (In reaching this conclusion I have treated the critical question and answer upon which the plaintiff relied about her intentions if there were "no immediate risks to [her] health" as directed to the kind of risks which materialised in her friend's case. I observe that the context in which the critical answer was given were questions which suggested that the surgery was "purely and simply for... cosmetic benefit" or "essentially cosmetic": see [12] above. That is a proposition which is not, in my view, made out on the evidence. The evidence of the defendant and of Dr Fisher was that the varicose vein condition was a progressive one, albeit slowly developing. As a consequence, while the surgery was elective, it would involve an overstatement to characterise it as of cosmetic benefit only. The surgery removed the potential for the condition to continue to worsen over time. I have dealt with the answer given by the plaintiff about proceeding with the surgery if there were no immediate risks to her health on the basis

that her answer addressed the circumstances that her varicose veins involved a progressive disease process but involved no significant immediate risks of emboli. If because of the context in which the question was asked, the witness was answering it on the basis that the surgery was purely cosmetic then no *Browne v Dunn* issue would arise because the assumption in the question was more clearly not made out.)

137. ***Beautiful legs***: The plaintiff in her evidence said that on a number of occasions during the consultation the defendant said that she would have “beautiful legs” after surgery. The plaintiff said that she did not accept or rely upon any such statement. The defendant denied he used such language and gave a specific credible reason for that denial. It is not necessary to make a specific finding about this. The only relevance of such a statement might have been to characterise the defendant as using such language to actively promote or “sell” the benefits of the surgery. However, the plaintiff did not make such a submission and any such proposition was not supported by the evidence. The plaintiff gave no evidence that that was the approach that the defendant took. The defendant’s evidence (and my impression of him when giving evidence) would not support any such inference.

*(iv) Occasioned traumatic tears to the plaintiff’s right buttock/hip in the course of the procedure*

*(v) Occasioned aggravation of underlying degenerative changes in the right hip/and buttock region as a result of the procedure*

138. The plaintiff did not ultimately press these grounds of breach of duty. If she had done so then she would need to have demonstrated that a reasonably competent vascular surgeon would have done something differently during the course of the surgery because of the risk that the pleaded damage or aggravation might occur. The plaintiff did not attempt to do so. Rather, the manner in which the plaintiff put the case was that had she received appropriate advice then she would not have proceeded with the surgery. Therefore, it was not necessary to prove any negligence during the course of the surgery, but, rather, only that the plaintiff would not have undergone surgery if proper advice had been given. That position was made clear both in the plaintiff’s opening and in the plaintiff’s final submissions.
139. The issue of whether the plaintiff’s hip and buttock condition actually arose from something that happened during surgery is addressed below.

### **Was the right hip and buttock condition caused by surgery?**

140. If any of the particulars of negligence were made out then the plaintiff’s case would still be dependent upon a conclusion derived from the temporal relationship between the operation and the plaintiff’s complaints of right hip and buttock pain, specifically that her current condition is a result of something that happened during or arose from the surgery. The plaintiff’s evidence was that as the pain from the castings diminished it was possible to discern separate pain in her hips and buttock. The plaintiff’s evidence was corroborated by her husband, Mr Spence. On the other hand, the defendant submitted that the medical records only disclosed complaints of distinct right hip and buttock pain in November 2014 and, as a consequence, the temporal relationship which might provide a basis for a conclusion of causation was not made out.

141. I accept the evidence of the plaintiff that she made complaints of hip and buttock pain at the consultation with the defendant on 21 July 2014. I also accept that she made more specific reference to her hip pain at the subsequent consultation with the defendant in August 2014. I also accept her evidence that she raised it with Dr Rajendra on 18 July 2014. I do not consider the fact that the specific complaint is not recorded in the doctors' notes or reporting letters as being determinative of whether or not the plaintiff raised the issue. The undoubted difficulties with castings following the operation and the absence of any obvious connection with the surgery provide reasons why the doctors have not made reference to any mention of pain in these areas by the plaintiff in their notes or letters.
142. The evidence does not demonstrate that anything done during the course of the operation was out of the ordinary or put the plaintiff's limbs in a position that was beyond their usual range of movement. There was, therefore, no obvious physical cause of the plaintiff's condition arising from the operation.
143. Following the operation, the plaintiff's legs were bandaged for about five days. Those bandages were tight and uncomfortable, the purpose being to reduce the incidence of casting. It is possible that something to do with the bandaging or the manner in which the plaintiff moved when bandaged aggravated the tendinopathy, tendon tears or caused or contributed to her bursitis. The difficulty is that the evidence did not disclose a probable mechanism by which the plaintiff's right hip and buttock pain was caused. It might be bursitis, it might be tendon tears, it might be tendinopathy, it might be pain arising from the degenerative condition of her spine. The evidence of Dr Spigelman, Dr Le Leu and Dr Burrow was simply that the close temporal connection between the operation and the onset of pain made it more likely than not that it was some aspect of the operation or post-operative care that resulted in the plaintiff's pain and disability. Dr Cummine considered that the pain was the result of degenerative joint disease in the lumbar spine but accepted at least the possibility that there was separate bursal and back pain.
144. I consider that the temporal connection is a significant matter and find on the basis of that connection that the plaintiff's hip and buttock pain was caused by the operation or post-operative treatment. However, because it is not possible to identify, on the balance of probabilities, any particular event or mechanism leading to the bursitis, tendon tear or tendinopathy, the only finding that can be made is that some event occurred which caused or rendered symptomatic one or more of those conditions. Given the absence of any identifiable physical event during the operation or post-operative care, the underlying condition of the plaintiff was, more likely than not, subject to manifest itself or being rendered symptomatic. That means that, even without the operation, it was likely that the plaintiff would, by reason of events in her ordinary life, have suffered or have rendered symptomatic one or more of those conditions.
145. These conclusions would have been sufficient to establish a factual causation but in a manner that required a substantial discount of any damages awarded.
146. As pointed out above (at [122]-[125]) the decision in *Wallace* does not require that, in this case, the scope of liability question be answered adversely to the plaintiff.

## **Contingent assessment of damages**

147. In case I am wrong in my conclusion that breach of duty has not been established, I set out below my assessment of damages.

### *General damages*

148. As explained above (at [126]), although the basis upon which the plaintiff has established negligence would permit the conduct of the surgery to constitute damage, the manner in which the case was pleaded precludes that. Therefore, general damages awarded to the plaintiff would be to compensate for the consequences of the hip and buttock pain which has arisen as a consequence of the surgery rather than the surgery itself.
149. Having regard to the nature of the injury and the inability to identify a causal mechanism, in assessing general damages it is necessary to take into account the likelihood that even without the operation some relatively ordinary event in the plaintiff's life would have triggered the condition from which she presently suffers. The evidence about what was involved in the operation and the process of bandaging following the operation is such that if the hip and buttock condition was aggravated by these relatively innocuous activities, then the chance of being aggravated in the course of ordinary life was high.
150. As a result of the plaintiff's right hip and buttock pain, her capacity to walk without significant pain is very limited. She manages her pain by limiting her activities. She does not walk for greater than one kilometre. She uses a walking stick. She can now no longer walk on the beach, walk her dog, go bushwalking cycling or snorkelling. She is unable to garden. She limits her driving. On days when she is suffering significant pain she is exhausted by her work and has little capacity to do more. She is no longer a "can-do" person. Because of the pain that she has suffered and continues to suffer she suffers from an adjustment disorder with anxiety and depressed mood. Because of her condition she has lost the opportunity for and satisfaction of continuing her high level teaching career.
151. In my view, the starting point is an award of damages of \$160,000 with half attributable to the past. However, having regard to the prospect of the disabling condition occurring in any event (and other vicissitudes) a discount of 30 per cent upon the past component and 60 per cent upon the future component would be appropriate. While, having regard to the uncertainty surrounding the mechanism of injury the level of discount cannot be precise, the intention is to recognise a significant likelihood of the condition arising in any event. That gives an award of \$88,000 (\$56,000 plus \$32,000). Interest on the past component of that would be \$4760 (\$56,000 x 4 per cent x 0.5 x 4.25 years).

### *Economic loss*

152. The plaintiff has claimed damages for the loss of earning capacity. The plaintiff's claim is for the difference between the amount earned in her current job as opposed to her likely earnings had she not been injured. Her current job pays \$97,853 per annum whereas her previous job paid \$136,166 per annum. The after-tax difference is approximately \$430 per week. Had she not been injured, the plaintiff intended to stay in a senior role and anticipated advancing to an assistant principal or principal position.

She is five years older than her husband and was thinking of continuing work until the age of 69 or 70.

153. The plaintiff suffers from a number of other conditions. She suffered from high blood pressure which is managed with medication. At one point she suffered from chest pains but this turned out to be unrelated to any heart problem. In 2018 she suffered from a stroke but, as at the date of the trial, made a full recovery except that she continued to suffer some fatigue.
154. In relation to the period of loss, the period is between 1 February 2018 and the date of judgment during which her loss would be \$430 per week. However, consistently with the approach to general damages, the assessment of economic loss in the past needs to take into account the chance that her hip and buttock condition would have been rendered symptomatic by other events. Adopting the same chance of the condition of arising in any event (30 per cent) gives a figure of \$10,836 (\$430 x 36 weeks x 70 per cent). I would award interest on that amount at *Court Procedures Rules 2006* (ACT) rates.
155. In relation to the future, in final submissions the plaintiff contended for an award based upon her continuing work until the age of 69 or 70. That was largely based upon the fact that she was some five years older than her husband and hence was more likely to continue to work so long as he was working. I accept that approach as it appears reasonable having regard to the type of position that she would have held in a school and the difference in age between the plaintiff and her husband. Having regard to that age difference it is appropriate to award damages on the basis of employment up until the age of 69, namely, six years. However, consistently with the approach to the award of general damages, it would be necessary to discount the figure for future economic loss on the basis of the real prospect of her hip and buttock condition manifesting itself in any event. I would have adopted a discount of 60 per cent with no further reduction on account of vicissitudes. That would result in an award of \$49,347 (six years (multiplier 286.9), \$430 a week, discount of 60 per cent).
156. I would have awarded superannuation upon these amounts on the basis claimed by the plaintiff, namely, 11 per cent of the net figures. This would give past superannuation of \$1,192 and future superannuation of \$5,428. No interest on past superannuation was claimed.

#### *Griffiths v Kerkemeyer/s 100*

157. As a result of her condition the plaintiff has difficulty changing bedclothes, sweeping, mopping, vacuuming and doing anything that involves reaching up or being on a stepladder. She has difficulty moving anything heavy. Doing the laundry is manageable but she can no longer use a washing line. She has difficulty cleaning the bathroom because it involves stooping over the bath or shower. Cooking remains possible. She has groceries delivered but gets her husband or son to collect them when they arrive. Whilst previously she was active in the garden, she does not do gardening activities anymore.
158. The plaintiff finds that driving for any significant period of time is difficult.
159. She found it hard to estimate the increased workload on her husband. She initially said four to five hours per week but then said it was hard to estimate. She then said that when things were bad it would be as high as about 13 hours instead of four or five

hours per week. It also fluctuated over time depending upon the pain that she was suffering. Exhibit 1 demonstrated that over the years there have been periods when her pain has got better or worse.

160. Her husband, Mr Spence, gave evidence that since the surgery he has taken over most of the cooking, does the gardening and drives her to work three days per week. His evidence, upon which he was not cross-examined, was that, when compared with the position prior to the operation, he spent approximately four hours per day assisting the plaintiff or doing tasks that the plaintiff would previously have done.
161. Notwithstanding the evidence of Mr Spence, in final submissions the plaintiff put the claim for past *Griffiths v Kerkemeyer/s 100* damages on the basis of the calculations in the occupational therapy report of Ms Moore. The defendant submitted that a figure only slightly lower was appropriate. I would have dealt with this issue on the basis of the occupational therapy report (subject to the calculations in the plaintiff's Statement of Particulars) but incorporated the same discount in relation to past as adopted in the other heads of damage, namely, 30 per cent. This gives a figure of \$22,327 (\$31,896 x 70 per cent). I would have awarded interest on this amount at *Court Procedures Rules* rates.
162. In relation to the future, in final submissions the plaintiff contended for an award of four hours per week to the age of 75, recognising that from that age assistance would be needed in any event. The adoption of four hours involved accepting that Mr Spence's evidence of four hours per day did not accurately reflect the care needed caused by the plaintiff's condition but was greater than the 3.25 hours particularised on the basis on Ms Moore's report. The defendant accepted the four hours per week figure but contended that a significant discount for vicissitudes should be incorporated. I would have adopted a similar approach to that in relation to the other heads of damage on the basis of four hours per week assistance until the age of 75 but incorporating a discount of 60 per cent to take account of the chance that the condition requiring assistance would have manifested itself in any event. This gives a figure of \$29,523 (four hours x \$35 x multiplier 527.2 x 40 per cent).

#### *Out of pocket expenses*

163. Past out of pocket expenses including interest were agreed at \$9715. Consistently with the approach I adopted in relation to other heads of damage, these should be reduced by 30 per cent on account of the prospect of the condition having manifested itself in any event. That would give an amount of \$6801.
164. So far as the future was concerned, the plaintiff made a very substantial claim of \$90,373 in her statement of particulars and this was repeated in final submissions. The defendant contended for a very modest award incorporating a buffer for medications and 12 psychologist visits.
165. The plaintiff's claim was a combination of medical treatment expenses (general practitioner, physiotherapy, psychologist, antidepressant medication and painkilling medication), occupational therapy review, workplace assessment and a rehabilitation provider as well as various equipment and aids identified in the occupational therapy report. A major component of the claim (\$51,357) was for monthly psychological attendances for the balance of the plaintiff's life expectancy.

166. In my view, each of the claims made by the plaintiff as set out in the particulars are supported by the evidence and would be appropriate in the circumstances. The exception is the claim for psychological attendances. In relation to that, I would have allowed an amount of \$9400 being a buffer based on 40 attendances at \$235 per hour. This would give a total of \$48,416 (\$39,016 plus \$9400). Consistently with the approach to other heads of damage, this amount would need to be discounted by 60 per cent to take into account the prospect of the right hip and buttock condition manifesting itself in any event. That would give a figure of \$19,366.

## **Orders**

167. The orders of the Court are:

1. Judgment be entered for the defendant.
2. The plaintiff is to pay the defendant's costs of the proceedings.
3. Order 2 does not take effect for a period of 14 days and, if within that period, either party notifies my associate by email (copied to the other party) that it seeks a different order, then order 2 does not take effect until further order of the Court.

I certify that the preceding one hundred and sixty-seven [167] numbered paragraphs are a true copy of the Reasons for Judgment of his Honour Justice Mossop.

Associate:

Date: 12 October 2018