LOWNS

v.

WOODS, BY HIS NEXT FRIEND THE PROTECTIVE COMMISSIONER and ORS

PROCOPIS

v.

WOODS, BY HIS NEXT FRIEND THE PROTECTIVE COMMISSIONER and ORS

SUPREME COURT OF NEW SOUTH WALES

COURT OF APPEAL

[1996] Aust Torts Reports 81-376

Kirby P, Mahoney and Cole, JJA

14-15 December 1995, 5 February 1996

Kirby P

This Court has before it two appeals from a judgment entered in the Common Law Division of the Supreme Court by Badgery-Parker J. For convenience, and because the injury and damages were alleged to be common, his Honour heard the two cases together. The two appeals were likewise heard together. But each relates to a separate case of alleged medical negligence.

MATTERS NOT IN DISPUTE IN THE APPEAL

It was common ground that:

1. If each of the appellants succeeded in their respective challenges to the judgment entered against them by Badgery-Parker J, the result would be

substitution of verdicts and judgment for the defendants at trial, so that an injured plaintiff would recover no damages;

2. If the consequence of the appeal was that the appeal of one only of the appellants only succeeded, the result would be that the judgment against him would be set aside and the entire damages of the injured plaintiff (Mr Patrick Woods) would be recoverable from the unsuccessful appellant;

3. The fate of the claim by the injured plaintiff's father (Mr Harry Woods) for nervous shock, and the appeal against the judgment in that regard, would follow the fate of the appeal against the injured plaintifFs verdicts and judgment;

4. There was no challenge otherwise to the quantification of damages found either in the injured plaintiff's or his father's actions;

5. In the action against Dr Peter Lowns, the determination by the primary judge, rejecting the assertion of Dr Lowns that he had engaged in no conversation with the injured plaintiff's sister, Joanna, and had not been requested to go to the assistance of the injured plaintiff, was not open to serious contest in the appeal. This concession appears to have been properly made, having regard to the repeatedly stated authority of the High Court of Australia. See eg Devries and Anor v Australian National Railways Commission and Anor (1993) 177 CLR 472, 477; and

6. The general expression of the duty of care required of a medical practitioner to a patient in Australia is that stated by the High Court in Rogers v Whittaker, (1992) 175 CLR 479, although it was pointed out for the appellants that this was not a case of the provision of advice or information to a patient concerning alternative treatment available to him but one concerning diagnosis and treatment. See ibid, 489.

CLAIM FOR NEGLIGENT REFUSAL TO ATTEND PATIENT

The basic facts are stated in the reasons of Cole JA.

The claim against Dr Lowns concerns his alleged refusal to respond to an urgent request made to him by the sister of Patrick Woods. On 20 January 1987, Patrick, then aged eleven years, was found by his mother to be in the throes of an epileptic seizure. The mother had been out walking for about twenty-five minutes. When she returned, she immediately appreciated the significance of the seizure then in progress, for this was the fifth seizure which Patrick had undergone. She took the best action that was available to her. She despatched her son, Harry, to summon an ambulance from the station close by. She despatched Joanna to "get a doctor". Dr Lowns' surgery was also close by. The request by Joanna to Dr Lowns is described in the reasons of Cole JA. At the trial, Dr Lowns simply denied that any such conversation had occurred. Badgery-Parker J rejected that denial. He accepted the testimony of Joanna.

Different considerations arise in respect of negligent omission or failure to act than in the case of positive and careless action. See eg The Council of the Shire of Sutherland v Heyman and Anor (1985) 157 CLR 424, 507. The common law has generally been reluctant to impose upon persons, except in defined circumstances, duties of positive action to prevent injury or damage to others. The reasons for this are explained by Deane J in Heyman. See also Hawkins v Clayton and Ors (1988) 164 CLR 539, 578.

However, in the present case, that problem melts away because Dr Lowns himself acknowledged that within the ordinary standards of a local medical practitioner in his position, had he received the emergency call deposed to by Matthew Woods' sister, he would have been obliged to, and would in fact, have responded. This acknowledgment does not foreclose contrary evidence or prevent a contrary conclusion. But it is powerful testimony (confirming impressionistic understanding or ordinary medical practice in this State) as to what that practice requires.

The Medical Practitioners Act 1938, s27(2), applicable at the time, did not impose a duty for the breach of which, as such, Matthew Woods and his father could sue for civil damages. Yet the subsection reflects the expectations which were accepted as appropriate and proper

amongst medical practitioners in responding to a call to the aid of a "person ... in need of urgent attention". This is a high standard. It goes beyond what is expected, and imposed by the law, in the case of other professions. It goes far beyond what may be expected and demanded of an ordinary citizen. But in the noble profession of medicine, it is the rule which Parliament has expressed; which the organised medical profession has accepted; and which Dr Lowns himself acknowledged and did not contest.

I therefore agree with the analysis of the primary judge, and with the reasons of Cole JA for holding that, in the special circumstances, the relationship of proximity between Patrick Woods and Dr Lowns was established, notwithstanding their lack of previous professional or association. Having regard to the Medical Practitioners Act 1938, s27(2) (then in force) and, indeed, to Dr Lowns' own acknowledgment of his duty in such circumstances, I have no hesitation in concurring in the conclusion which Cole JA has reached. Duty and breach are clearly established. The only question upon which I entertain doubt is that of causation.

However, if Dr Lowns had responded to the request for urgent attention to a young boy described as "having a bad fit", who could not be brought down to him, on the primary judge's conclusions of fact which I would not disturb, Dr Lowns would have administered intravenous diazepam (Valium) once (or possibly twice) to Patrick. This would have been done at 9.15 am or, if two injections were required, by 9.30 am. Had this been done, it was open to the primary judge, in the evidence, to conclude that the risks of brain damage to Patrick would have been "very low indeed". The supplementation of the care provided by the ambulance officers would have been critical. The prolonged fitting probably would have been controlled. Profound brain damage would probably have been avoided.

None of these are certain conclusions. This Court (like Badgery-Parker J at trial) is being asked to consider what might have been. Obviously the variables include the starting time of Patrick's seizure (not exactly known as his mother was then walking); the probable arrival time of Dr Lowns had he responded to the urgent request; the skill and knowledge of Dr Lowns in appreciating that the correct response to the situation was the administration of Valium; the risk, albeit very small, of an adverse reaction to an injection; the possibility (which Dr Lowns himself rejected) that he might have failed to achieve injection; the risk that he might have been unaware of (or had unavailable to him) intravenous Valium; the possibility that he might have reasonably concluded, that the best course, the ambulance being available, was simply to expedite Patrick's transfer to a hospital, avoiding the delay of any attempted treatment on his own part.

These considerations were carefully weighed by Badgery-Parker J. I see no error of fact-finding or of approach in his Honour's reasons. I therefore agree with his conclusion:

"Duty, breach and causation [are established] and he is entitled to a verdict."

The consequence is that Patrick Woods is entitled to recover the judgment entered against Dr Lowns. Accordingly, so is his father in the claim for nervous shock. In coming to this conclusion I agree with the reasons of Cole JA, who dismissed Dr Lowns' appeal. That leaves the question whether Patrick and his father are entitled to recover against Dr Procopis so that he will share the judgment and carry the burden of half the damages.

FAILURE TO ADVISE ON RECTAL VALIUM

The case against Dr Procopis was quite different from that against Dr Lowns. Badgery-Parker J found that, at two consultations with the parents, namely in July 1985 and again on 28 April 1986, Dr Procopis, in the exercise of reasonable care and skill as a specialist paediatric neurologist, should have instructed the parents about the use of rectal diazepam (Valium), and how and when to administer it to Patrick in exigencies such as later occurred on 20

January 1987. According to his Honour, failure to do this constituted breach of his duty of care to Patrick. It led to the delay in the control of the prolonged seizure which occasioned the brain damage which caused Patrick's profound injuries and disabilities. On the probabilities, his Honour found that had Dr Procopis so instructed the parents, Patrick's mother would, in the circumstances, have administered rectal Valium to Patrick in time to prevent the severe brain damage which resulted from the prolonged seizure.

Dr Procopis did not dispute the existence of a duty of care, He could scarcely do so given that the parents, on behalf of Patrick, consulted him, as a specialist, for the best possible advice, treatment and care. He did, however, contest the scope of the duty found by the primary judge. He also disputed any breach on his part of the duty of care owed to Patrick. He relied upon the standards of care of a reasonable specialist in his position with the knowledge of Patrick's condition, available forms of treatment and the normal practice of the expert branch of the medical profession in which he was skilled.

Before Rogers v Whittaker (above) it was often asserted that:

"... A doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion, even though other doctors adopt a different practice and in short, the law imposes a duty of care: but the standard of care is a matter of medical judgment."

See Sidaway v Board of Governors of the Bethlem Royal Hospital [1985] AC 871 (HL), 881 per Lord Scarman describing the Bolam principle. See Bolam v Friern Hospital Management Committee [1957] 1 WLR 582 (QB). By that standard there would be little doubt that Dr Procopis was shown by the medical evidence to have fulfilled his duty of care to Patrick and his parents. The evidence is overwhelmingly to the effect that Dr Procopis, in not advising the parents about the availability of and contingent administration of rectal Valium, acted in accordance with the overwhelming, if not invariable, practice of specialist neurologists in Australia at the relevant time.

However, in Rogers v Whittaker the High Court of Australia rejected the Bolam principle. It preferred the approach of Lord Scarman's dissenting speech in Sidaway (see ibid, 876) and the approach favoured by the Full Court of the Supreme Court of South Australia in F v R (1983) 33 SASR 189 (FC). In that last-mentioned case, King CJ, at 194, explained the limited, but still important, use to be made of evidence concerning normal medical practice of persons of the same expertise as the medical practitioner pursued:

"The ultimate question is not whether the defendant's conduct accords with the practices of his profession or some part of it, but whether it conforms to the standard of reasonable care demanded by the law. That is a question for the courts and the duty of deciding it cannot be delegated to any profession or group in the community."

Earlier, the Supreme Court of Canada in Reibl v Hughes [1980] 2 SCR 880 (SC) at 894-895 had reached a similar conclusion:

"Expert medical evidence is, of course, relevant to findings as to the risks that reside in or are as a result of recommended surgery or other treatment. It will also have a bearing on their materiality but this is not a question that is to be concluded on the basis of the expert medical evidence alone. The issue under consideration is a different issue from that involved where the question is whether the doctor carried out his professional activities by applicable professional standards. What is under consideration here is the patient's right to know what risks are involved in undergoing or foregoing certain surgery or other treatment."

In Ainsworth v Levi, Court of Appeal (NSW), unreported, 30 August 1995, Handley JA (with the concurrence of Meagher JA) at 13f might be understood to have endorsed a rule that where the medical practitioner sued is proved to have followed standard medical practice, then unless the Court is satisfied that the medical evidence is "manifestly wrong", it should reject the contention that the particular medical practitioner before the Court was in breach of his or her duty of care. With respect, I have some difficulties with this formulation although I do not for a moment question the decision in the particular case. I am not sure that Handley JA did endorse the principle as claimed. It would be wrong to qualify the very clear decision of the High Court in Rogers v Whittaker and to restore the Bolam principle by the imposition of an evidentiary test requiring a patient to demonstrate the "manifest" error of current medical practice. Ainsworth should be read to indicate nothing more than that, if the medical practitioner who is sued establishes that he or she has conformed to ordinary medical practice within the specialty in question, the forensic burden shifts to the patient to satisfy the Court that, this notwithstanding, the ordinary practice did not conform to the reasonable care demanded by the law in the circumstances.

Dr Procopis sought to distinguish Rogers v Whittaker upon the basis that the present was a case of medical treatment, not one of a warning or advice to a patient of the risks of a particular procedure. I would reject that argument. I take the principle in Rogers v Whittaker to be one of general application, governing the relevant communications between a medical practitioner and a patient. But in any case, if the present facts were to be classified according to the distinction suggested for Dr Procopis, I would regard the case as fitting more comfortably into the category of advice rather than treatment. Dr Procopis would not have been actually administering rectal Valium to Patrick. On the given hypothesis, he would have been discussing the future medical management of his condition, with its attendant dangers and risks. What was involved, as in Rogers v Whittaker, was the sharing of as much of the medical expertise of the medical specialist with the patient or his carers as was necessary to discharge the duty of care imposed by the law.

This said, and with every respect to Badgery-Parker J, who had before him a difficult and profoundly sad case, I have concluded that the better view of the medical evidence led at the trial was that, by the standards of the time, Dr Procopis fully met the requirements of advice and treatment which reasonable care and attention required of a medical practitioner of his expertise and experience.

A number of qualified specialist witnesses were called, with extensive experience in the treatment of epileptic children and dealings with their parents. The thrust of their evidence was that the proper advice to be given to parents was to get the fitting child to a hospital as quickly as possible and, if possible, to secure assistance from a medical practitioner who could administer diazepam (Valium) intravenously. They spoke with one voice that Dr Procopis' advice, as described, had conformed to the highest standards of medical practice in Australia. Those standards, certainly in 1987, did not involve informing the parents of children with a history of epileptic seizures of the availability and advisability of rectal diazepam (Valium) to control the seizure.

Only one expert medical witness asserted to the contrary. This was Dr Gwilym Hosking, an honorary consultant paediatric neurologist at a major children's hospital in London. He gave evidence to the effect (as described by the primary judge) that the administration of rectal diazepam, certainly prior to January 1987, was so well established as appropriate treatment in the case of a patient such as Patrick Woods amongst those involved in the relevant field of medical practice, as to compel the conclusion that the omission to advise such treatment for him fell short of a proper standard of good medical practice at the time.

I allow for the advantages which Badgery-Parker J enjoyed in viewing the competing evidence of the medical experts. I am assisted in this respect, by his Honour's clear sighted appreciation that, as a witness, Dr Hosking had presented a number of defects. He was forced to withdraw an opinion concerning other medical practitioners (with whom this Court has not been concerned). This, and the manner of his giving evidence, caused Badgery- Parker J to say:

"... It raises a very substantial concern as to whether he was indeed, as one would have hoped and expected him to be, an expert offering an independent expert opinion, or whether he did not rather perceive his function to be that of an advocate for the plaintiff's cause. I regret to say that in the end, I reached a firm conclusion that in some respects he abandoned the role of independent expert in favour of that of the advocate. That does not mean that all of his opinions are necessarily to be rejected, but it does demand that they be scrutinised with a great deal of care."

These observations by the primary judge require this Court to be even more circumspect than in the ordinary case before disturbing ultimate conclusions reached after such a clear-sighted evaluation of the evidence of a vital witness for the two plaintiffs. Badgery-Parker J certainly knew what he was called upon to do in offering his conclusion on this point:

".... Notwithstanding that the omission to give such advice accorded with the then accepted medical practice the omission to give the advice was a breach of the duty of care which Dr Procopis owed to Patrick Woods."

With the greatest of respect, having read all of the medical evidence on behalf of Dr Procopis and weighed this against the conflicting evidence of Dr Hosking, I simply cannot reach the same conclusion. Numerous reasons were given as to why advice on the administration of rectal diazepam (Valium) was not part of the practice of specialist paediatric neurologists in Australia at least prior to 1987. They included:

a) The absence, as it was asserted, of an established practice anywhere in the world to recommend parental instruction in such use as a general precautionary advice for emergency situations;

b) It is not the practice in the United States of America, where litigation drives very high duties of care to give advice to parents in the use of rectal diazepam;

c) In the United Kingdom its predominant use is in the case of febrile convulsion;

d) Insofar as such advice was given in Australia it was usually only in limited circumstances and then ordinarily prophelactically for the control of febrile fits;

e) There are possible risks associated with the administration of diazepam in home circumstances without medical supervision, including the risks of respiratory depression, shock and hypo-tension;

f) There is a strong medical preference for intravenous diazepam because of its far greater efficiency;

g) Numerous authoritative texts at the relevant time do not mention rectal administration of diazepam as a possible treatment for epileptic seizures;

h) Medical experts agreed that the most authoritative text on childhood epilepsy (Arcadie, The Management of Status Epilepticus in Infants and Children, second ed, 1994, 243, 252, 302), makes no recommendation for rectal diazepam. Similarly, a leading, authoritative article published in the New England Journal of Medicine by Delgado and Escueta makes no reference to the use of rectal diazepam in emergency situations,

i) Publications of the Epilepsy Association of New South Wales to the date of the trial make no mention on the use of rectal diazepam as a possible means of treatment for emergencies;

j) Diazepam is not licensed for rectal use in Australia and according to some evidence is not available in Australia in a form suitable for rectal use;

k) MIMS Annual did not to the time of the trial mention rectal administration of Valium as an option in such cases; and

l) Before giving such advice to parents, medical practitioners would have to consider the risk that they might administer an incorrect dose or administer the drug, in inappropriate circumstances.

Badgery-Parker J did not resolve the difference between the medical experts on the basis of the impression which their demeanour made upon him. Cf Ahmedia v Ahmedi (1992) 23 NWLR 288 (CA). On the contrary, he was not impressed with the demeanour of Dr Hosking. He sought to apply principles of rationality, logic and reasonableness to the testimony given. When I apply the same tests, I am unhesitatingly driven to the contrary conclusion. I simply do not believe that it was reasonable to have required Dr Procopis, in his consultations in July 1985 and April 1986, to have advised the parents of Patrick Woods about the availability of rectal Valium and the desirability of using it in certain emergency circumstances. Upon the basis of this conclusion, the claim against Dr Procopis must fail.

There is another reason for dismissing the claim. Dr Procopis contested that, even if he were found to be in breach of his duty of care, that his failure to advice the parents about rectal Valium caused the profound injuries suffered by Patrick. This argument was advanced upon two bases. The first was that the primary judge had mistaken the evidence as to the timing of the commencement of the epileptic seizure in question and the hypothetical timing and effect of rectal administration of diazepam, had this been advised and had the advice been followed. Part of this submission has already been rejected in respect of the case against Dr Lowns. In this respect I agree with what Cole JA has written. I would not rest my conclusion upon the question of timing and the efficaciousness of the rectal diazepam. A much more important issue of causation must be considered.

The uncontradicted evidence, which was not addressed in Badgery-Parker J's reasons was that Patrick Woods' mother had known about the possible use of rectal diazepam (Valium) since at least the commencement of the proceedings; that Patrick was, if anything, more at risk to further episodes of epileptic seizure following the incident of 1987 with its profound consequences; and that notwithstanding the foregoing, when questioned during evidence, Patrick's mother acknowledged that she had not acquired rectal Valium to keep at home against the possibility of further seizures.

In these circumstances, it is extremely improbable that Patrick's mother would have acquired rectal Valium, assuming that she could, before the critical seizure. If she did not trouble to obtain it after all that she had gone through, it is not very persuasive to say that she would have done so before such a devastating experience. On the contrary, it seems much more likely that she and Patrick's father would have left Patrick's care to skilled medical and paramedical people, as was done in 1987 and as they have been content to do since.

Alternatively, even if rectal Valium had been acquired by Patrick's parents, there remains a question as to whether it would have been administered on 20 January 1987 in such a way as to diminish the seizure then in the throes of occurring. Patrick's mother was told that the primary rule (about which all witnesses agreed) was to get the fitting child as quickly as possible to hospital. Even if Dr Lowns did not come quickly, the ambulance officers certainly did. In the crisis which presented, it seems unlikely to me that the mother would have

attempted, and succeeded, in administering diazepam rectally to Patrick with beneficial effect. Even Dr Hoskings' evidence as to the probability that rectal Valium would arrest the seizure was based on an assumption that Patrick had been left unattended (and therefore possibly fitting) for a maximum period of thirty minutes.

I emphasise that the conclusion on causation are additional grounds for casting doubt upon the judgment entered against Dr Procopis. The primary ground is that he was not in breach of his duty of care to Patrick Woods by failing to advise on the availability and advisability of the rectal administration of Valium by the parents. Respectfully, I consider that this constitutes the imposition of an unrealistic obligation upon Dr Procopis, beyond that which the law requires, as reasonable care, skill and attention. It betokens a great deal of wisdom after the event rather than a statement of the demands of reasonable professional care before the event.

For these reasons, the judgment against Dr Procopis must be set aside.

CONCLUSIONS AND ORDERS

Mahoney JA and I favour dismissing the claims against Dr Procopis, with Cole JA dissenting. The orders of the Court will follow in those proceedings.

Cole JA and I favour upholding the judgment against Dr Lowns and dismissing his appeal against that judgment, with Mahoney JA dissenting. The Court's orders will follow that majority opinion.

The orders which I favour are:

IN THE APPEAL BY DR PETER LOWNS AGAINST THE JUDGMENTS ENTERED IN FAVOUR OF PATRICK WOODS AND HARRY WOODS:

Order that the appeal be dismissed with costs.

IN THE APPEALS OF DR PETER PROCOPIS:

1. Appeal allowed;

2. Set aside the judgment against Peter Procopis entered by Badgery Parker J in the Common Law Division of the Supreme Court in favour of Patrick Woods by his next friend the Protective Commissioner of New South Wales and Harry Woods;

3. In lieu thereof, order that the actions brought against Peter Procopis be dismissed with costs;

4. Order that Patrick Woods, by his said next friend, and Harry Woods pay the costs of Peter Procopis of the appeal; and

5. Order that, in respect of the costs of the appeal, the said Patrick Woods and Ham Woods have certificates under the Suitors' Fund Act 1951.

Mahoney JA

The argument in these appeals concluded on the last day of term. Circumstances make it necessary that the appeals be decided by the commencement of the new term. I understand the views of the members of the Court differ. Having had the benefit of the views of Kirby P and Cole JA, in draft, I shall state my own conclusions briefly.

I shall not repeat what has been said by my brethren as to the structure of the case and the issues involved.

1. THE LIABILITY OF DR PROCOPIS:

Dr Procopis was the child's (consulting) treating doctor. He saw the child periodically and advised as to how, medically, he should be treated. He therefore

owed the child a duty of care. The essential question is whether he failed to do what that duty of care required of him.

At the trial and on appeal, there was an issue as to whether, if there was a breach of duty, it caused the damage of which the child complains. I agree in this regard with the conclusion of Kirby P and generally with his reasons. I shall not pursue my own statement of what leads to that conclusion.

It is important to understand clearly what is the nature of the breach alleged. It is that Dr Procopis made (in the sense to which I shall refer) a clinical judgment as to what the child's treatment required; that that decision was wrong; and that, in making it, the doctor was in default of his obligations of care, skill and judgment qua the child to the extent that he should be found negligent.

It is not in contest but that, in principle, it is for the courts to determine what is the content of the duty of care which a medical practitioner owes to a patient in his/her care. The content of that duty is not to be decided "solely or even primarily by reference to the practice followed by or supported by a responsible body of opinion in the" profession: Rogers v Whitaker (1992) 175 CLR 479 at 487; (1991) 23 NSWLR 600.

But two things may be said in this regard. First, this does not mean that, in deciding as a matter of fact whether what the doctor has done fails to satisfy the standard required of a medical practitioner in his position, the court will simply or readily put aside the considered judgment and/or experience of those skilled in the field and their opinion of what the care of the patient warranted. As was suggested by this Court in Ainsworth v Levi (Court of Appeal, 30 August 1995, unreported); to persuade a court to a factual conclusion that those skilled in the field are wrong in concluding that, eg, a particular treatment should/not be followed will require cogent reasons. It can be done; but the burden of factual persuasion will ordinarily be a heavy one.

Second, what will warrant the conclusion that the practitioner did not do what his duty of care required will, in practice, be affected by the nature of the decision or judgment that he made. This, in my opinion, is of particular importance in the present case. The decision of Dr Procopis which is here impugned is (I put the matter compendiously) the decision not to advise the child's parents that, in certain circumstances, they should inject valium into the child's rectum. That decision was, as I have described it, a clinical decision. I mean by this that it was a decision made by a treating doctor not simply as the result of deductions or inferences drawn from general principles; it was a decision made after weighing the circumstances of the child's individual case. The decision was made having regard to the child's medical history of which the doctor was aware, after weighing the needs which, at the relevant time, the patient had, after assessing the likelihood of further fitting and the extent of the detrimental effects (if any) apt to flow from any further fitting, and after balancing the advantages and disadvantages - and the dangers - of involving lay persons in a procedure such as the rectal injection of a drug.

In my opinion, when a clinical decision of this kind is made, a court will be slow to find the decision wrong and, a fortiori, so wrong as to be negligent. There are, of course, cases in which it will do so. But, in my respectful opinion, this is not a case in which, having regard to the evidence, the court should reach such a conclusion.

I am conscious that, in a detailed and carefully reasoned judgment, Badgery- Parker J concluded that he should find the clinical judgment made by the doctor to be wrong. I am

particularly indebted to his Honour for the way in which he has detailed the relevant considerations and his reasoning from them. What his Honour has said enables me more readily to examine the reasons why the judge came to the conclusion that he did.

The judge's decisions did not depend upon his acceptance of the demeanour of one witness over another or upon his preference for one expert witness over another: compare The Public Trustee v The Commonwealth (Court of Appeal, 20 December

1995, not yet reported). It followed from a chain of reasoning which his Honour detailed at length. It is the acceptance or otherwise of that reasoning upon which the decision turns. I shall indicate why I do not adopt the reasoning on which his Honour's decision depended.

From the evidence two things, inter alia, emerged. First, the doctor's decision not to advise the parents that they should become involved in the injection of valium into the child's rectum accorded with the generally accepted views of the medical profession at that time. The trial judge, in the course of his judgment, assessed the evidence of a number of doctors in this regard. He accepted from that evidence "that the omission to give such advice accorded with the then accepted medical practice". Notwithstanding this, his Honour held the doctor's clinical judgment to have been negligent: his Honour said in terms that it was "notwithstanding that the omission to give such advice accorded with the then accepted medical practice, the omission to give that advice was a breach of the duty of care which Dr Procopis owed to Patrick Woods" (2560).

That leads to the second matter: why, and upon the basis of what reasoning, the judge came to the conclusion that the doctor's judgment not to involve the parents was wrong and, a fortiori, negligent.

His Honour, in a careful and detailed consideration of what was "the reasonable response to the risk" by Dr Procopis judged the matter according to his own assessment of "what was a reasonable response to a foreseeable risk" after "balancing the chance that the foreseen risk will eventuate as a reality against the likely consequences should such occur": his Honour cited Wyong Shire Council v Shirt (1980) 146 CLR 40 at 47. His Honour said:

"In the present context, it is necessary to balance the risk of status epilepticus and consequent brain damage against the risk that the prescription of treatment by way of the rectal administration of diazepam by the plaintiff's parents and the carrying out by them of

treatment in accordance with that prescription would itself have inflicted harm upon the plaintiff."

His Honour set out what he saw to be the factors on the one side and the other and he then made his own - as I would see it to be - clinical judgment. He saw the principal concern of the medical witnesses to be "the risk of respiratory depression" and shock with "a serious and potentially fatal drop in blood pressure". He referred to the difficulties inherent in the intrusion into the body of the child by lay people but he inferred from the fact that in some circumstances (he referred to what he understood to be "areas remote from medical care") the injection of valium through the rectum could be used and saw this as implying "acceptance that administration by parents is feasible and at least that the risk (if any) attaching to its use may be outweighed by the urgency of the situation". He inferred the doctor was "satisfied that rectal diazepam could be safely administered in the home, although he was not yet convinced of its efficacy". Taking these matters into account and weighing them against the possible damage from prolonged uncontrolled fitting, he concluded that the involvement of the parents would have been "a reasonable response on the part of Dr Procopis to the foreseeable risks".

His Honour was properly influenced by what Dr Procopis had said as to the circumstances in which valium might appropriately be used. He summarised those circumstances in a way to which no exception, as a summary of portions of the evidence, could be taken. But, in my respectful opinion, what resulted was an oversimplified picture of the doctor's views and one from which it was not correct to draw the simple deductions which the judge drew. And he failed to take account of the reasons why, as the doctor said, he had arrived at the conclusion that it was not appropriate to involve the parents in rectal injection of the drug.

Dr Procopis and other doctors had long not been satisfied as to the overall effectiveness generally of valium. He, and I think they, had gradually come to the view, by the relevant date January 1987, that the use of valium to control fitting was

appropriate, at least in some cases and with some persons. The judge stated his findings (at 2541-2542) as follows:

"Dr Procopis was prepared to accept that from some time after 1981, namely in the mid-1980's and certainly before January 1987, the use of rectal diazepam was better known and regarded as being more safe than it would have been earlier on (although still not proven effective (t.633)) but that the appropriate indications for its use and for instructing the parents of epileptic children about its use did not exist in the case of Patrick Woods.

Dr Procopis commenced to advise the use of rectal diazepam at some time after 1981, and probably before publication of his own article in 1983, but in certain particular situations only, namely:

1. For prophylactic use in the case of children subject to febrile convulsions. Rectal diazepam could be used, at the onset of fever, for the purpose of avoiding the onset of convulsions....

2. In non-febrile children who had-frequent seizures, particularly frequent and prolonged seizures, despite adequate doses of anti epileptic drugs....

3. For children who were institutionalised because of severe intellectual handicap resulting from brain damage, and from that cause subject to very severe and very prolonged epilepsy. In such situations, it would be appropriate that the carers in the institution be equipped and instructed to administer rectal diazepam to avoid the need for rushing children off to hospital or getting doctors in.

4. In a hospital emergency room if, exceptionally, it proved impossible to gain venous access.

5. For children who have less than optimal seizure control with anti epileptic regime and who live in areas remote from medical care (t.679). He related that to a situation of a child who could not be got to a doctor or hospital within an hour, because in his opinion, a seizure was not likely to do any harm unless it lasted well in excess of one hour.

Dr Wise, Dr Hopkins and Dr Somerville endorsed the opinion of Dr Procopis generally as to the indications for the prescription of rectal valium.

I accept that after 1981 and up to 1987 (which is the only period that I a n concerned with) it had never become the practice of specialists in the field in Australia to recommend the use of rectal diazepam except in the specific situations identified by Dr Procopis.

It follows that the decision by Dr Procopis not to prescribe the use of rectal diazepam accorded with what was regarded by his peers in this country as the proper standard for Patrick Woods, both before and after 1981, of good medical practice at that time. That, of course, does not conclude the matter in the defendant's favour for it is the law, not the medical profession, which determines the standard of care which is required."

The judge saw the present case as falling within paragraph numbered 5 (above). It was because of that finding, and that alone, that he found the doctor negligent. He concluded that the child fell within the circumstances there specified and that the omission by the doctor to have the parents prepared to inject valium through the child's rectum was wrong and negligent. His Honour, weighing the factors in accordance with "the law, not the medical profession", arrived at the conclusion to which I have referred.

With respect, such an approach fails fully to take into account the nature of the judgment which the doctor made and why he made it. In several contexts during the evidence, the doctor was invited to indicate why the use of valium was not discussed. He saw the position to be more complicated and of a different nature.

It was his view that, having regard to the circumstances of the child at the time, the use of valium was not indicated at all as part of his treatment. It was not shown to be "effective or safe medication to be given to children outside hospital". And this view of proper practice accorded with the accepted medical assessment - the accepted clinical assessment of the uses of valium at the time.

He had been treating him essentially with phenobarbitone: apart from the use of valium on one occasion at a hospital, he had not seen his condition as warranting or requiring valium.

The doctor was asked in his evidence-in-chief why he had not mentioned the possible use of rectal valium at the child's home. He said:

"I think the answer would depend on two factors. Firstly, the proven ability for rectal diazepam to be effective in such circumstances and, secondly, the need for that advice to be given. Now, after the seizure that I first saw him in March 1979, I do not consider that the use of rectal diazepam was sufficiently proven to be either safe or effective for that advice to be given and the same goes for after the third seizure in August 1981. Between 1981 and 1986 Patrick's epilepsy was completely controlled. It had been quite clearly shown that while he was taking anti-epileptic medication he had no seizures. And in January 1986 when he had his fourth seizure, that was when medication was being withdrawn and the seizure was a very short seizure. It stopped spontaneously and he was put back on his medication. So he was then back in the same situation as he was in the five years where his seizures were completely controlled and although in the mid-80's the use of rectal diazepam was more well-known and regarded as being more safe than it would have been earlier - although, I might add, not proven to be effective - it would not be considered that because he was in a state of complete control of his epilepsy and taking anti-epileptic drugs that he would have required rectal valium to be prescribed."

The doctor referred to the fact that he had been prescribing phenobarbitone and said:

"The reason for prescribing phenobarbitone was because it seemed to me it was a good chance that fever had precipitated his convulsions and, as I mentioned in my letter, he had a complicated which means long febrile convulsion. At that time the only medication that was proven to be effective in the treatment of febrile convulsions was phenobarbitone and as it also is very effective for the treatment of other forms of epilepsy that drug was prescribed and therefore would have been effective in preventing seizures either from febrile convulsions or from post-traumatic epilepsy."

Subsequently, the doctor explained further his assessment of the risks that were involved in the child's case. He said:

"Relevant to this particular case is what was the likelihood in children who have no prior neurological abnormality, which is the group that

Patrick fell into. In fact, the work that is now current is that these children who have no neurological abnormality and who do not have an acute precipitating cause for their status very very rarely sustain any neurological damage after status epilepticus. In fact the vast majority, greater than ninety-seven per cent who have seizures and are in that category do not get any neurological abnormality even after prolonged seizures and it is apparent that the neurological damage in these children after status epilepticus is more likely to be due to the thing that precipitated it such as meningitis and encephalitis or their pre-existing disease than the status itself. There are some recent articles which attest to that."

The doctor said that he drew from that the proposition "that because the risk of serious neurological damage is slight or statistically slight and does not occur in the average case for quite some number of hours". He said that he drew from what he said "that the risk is overstated but, nevertheless, there is a very small risk that neurological damage can occur. If we look at this particular case of Patrick, certainly he was normal beforehand and after his event he was abnormal and continues to be so. I think it is in dispute as to how long he actually fitted for, I do not think we really know. But we know the minimum period of time that he fitted for. One also has to bear in mind that there is the complication as well of hepatic failure, that is liver failure, and that may well have been an additional unpredictable event which added to the risk of brain damage and I think it is not unlikely that a combination of prolonged seizure plus liver failure was because of his brain damage". His Honour asked the doctor whether it was his view "that because brain damage is not likely to occur in a comparatively short period of time that that sort of advice is unnecessary". The doctor said:

"Yes, I was drawing that conclusion. It obviously depends on the case itself as to when you make the decision and weigh the risk against the benefits of that treatment."

His Honour asked the doctor about the circumstances in which he advised the use of rectal valium in patients and the doctor dealt with the matter at some length.

He emphasised that the child in question was not neurologically abnormal and so did not fit into the various categories to which initially he referred. He then said:

"Other indications are children who have less than optimal seizure control with anti-epileptic regime, who live in areas remote from medical care. My definition of remote would be different from Dr Hosking's definition of remote and I really mean where there is no ready availability of a doctor or medical care, not just around the corner."

He said:

"Part of the advice I give to parents with epileptic children is that fits will usually stop within a few minutes. If a child has a fit, apart from the first aid measures I mentioned, of stopping him from hurting himself, etc they do not need to seek medical attention.

If however the seizure lasts for more than ten minutes then you should seek medical care. Then I will say a seizure is not going to do any harm unless it lasts for more than half an hour and in fact probably more than an hour and that is being on the conservative side.

Therefore if they do not fit within that definition, and you cannot get medical attention within that timeframe, that is, under an hour, then in the mid-1980's and subsequently that would have been a consideration for prescription of rectal valium. The final indication that I would have used then is children who were institutionalised and by that is implicit that these children are neurologically abnormal."

Subsequently in his evidence, the doctor was asked why he had not referred to the use of rectal valium. He said:

"As I have explained before I do not believe that rectal valium was an option for treatment in those days and so that the discussion I would have had with the parents was firstly, well, children with epilepsy should have to - should be encouraged to lead as normal lifestyle as possible on medication. There is a very small risk of his having further seizures and in fact that was the case but I obviously couldn't completely rule it out. So, it would have been known to the parents that there was a small risk and if that seizure did occur then the advice given about getting medical help urgently was the correct advice at that time. Clearly if the parents did not wish to take that small risk, then they would need to be at a place where medical attention could be obtained more readily than it could have been at The Basin.

Q. Doctor, do you have a recollection dim or otherwise as to whether or not you mentioned possible use of rectal diazepam in that holiday situation.

A. No, I would not have.

Q. Why would you not have mentioned that at that stage?

A. Because I did not believe that rectal diazepam was effective - had been shown to be effective or safe medication to be given to children outside normal medical institutions at that time."

I have referred to this evidence to indicate that the doctor's advice was based upon his assessment of the factors involved and upon whether the advice as to the use of rectal valium would have been "an effective or safe medication" at the relevant time. It has not, I think, been shown that that assessment was wrong.

The reasoning espoused for the plaintiff has been, in effect, that the existence of a possibility of fitting, to the extent that would create unacceptable danger was such as to warrant putting aside the doctor's decision that this was not a case in which valium was in question. I do not think that that conclusion should be adopted. The reasoning on which the trial judge based his decision did not, I think, deny the correctness of these views as such. But the judge pointed to the existence of a possible danger, which he isolated in terms of his summary of the paragraph numbered 5 in his summary of the doctor's views. He formed his own assessment of that possible danger. The doctor saw the risk as not warranting the use of valium and the involvement of the parents in rectal injection of it; the judge substituted his own conclusion on that matter.

A judge can substitute his own judgment of what a medical risk involves for that of a treating doctor: Rogers v Whitaker makes that clear. But, at least in the case of a clinical judgment, there must be reasons in the nature of the factual material warranting such a factual decision. As on a rehearing I have come to a different conclusion. It is on this basis that, with greatest respect, I differ from the trial judge.

I would add one further comment. Having regard to what was said in Rogers v Whitaker, in the High Court of Australia and in this Court, I am conscious that, in the end, this Court may substitute its conclusion as to what a duty requires for that of the medical profession. It is right that it be able to do so. But, as I have suggested, the Court should have regard to the nature of the judgment made in the instant case. In my respectful opinion the courts should be slow to intervene where what is involved is the weighing up of advantages and disadvantages, medical necessities and the like by the profession and then by the courts the mere substitution of the latter for the former. There are, of course, extreme cases. But there must, I think, be strong reasons why a clinical judgment properly arrived at is to be put aside as wrong and, a fortiori, as negligent. I would not put aside the doctor's judgment in this case nor would I find it to be negligent.

2. THE LIABILITY OF DR LOWNS:

The position of Dr Lowns is different. The issue - and, in the end, the only issue - is whether the Court should impose on him a legal obligation which did not previously exist and, by doing so, require him to pay $3 million and more. I think we should not do so. My colleagues think we should. What I say will not alter the result. Therefore I shall state my reasoning dogmatically, believing that my propositions could, if there were time, be justified.

Oversimplified, the position is: (a) the Court must determine whether there is a legal obligation upon a general practitioner to attend a person with whom he has no relationship; (b) before this case, he had no legal obligation to do so; (c) the courts can impose - and on occasion have imposed - a legal obligation where none previously existed; (d) in principle, it should not do so in this case; and (e) the imposition of such an obligation is not required by the way in which the trial was conducted.

(a) THE ISSUE IN THIS CASE:

It is important to emphasise that we are not concerned with obligations in morals or charity, with professional obligations, or with statutory obligations. Dr Lowns is not liable because (if he did) he had a moral or a professional obligation to go to the child in this case.

Assuming the facts to be as found against him, the doctor may have had a moral obligation. Any decent person would help a child in trouble if he could: at least, if special cases be put aside. It may be that charity required that he go.

But moral obligations are not legal obligations. The two must not be confused. A great deal of the time of the legislature is taken up in deciding whether moral obligations should become legal obligations, under what circumstances, and with what qualifications and exceptions. Law, as an instrument of social control, is a blunt instrument. It is often inappropriate to the qualifications and exceptions to which, if made law, a moral obligation should be subject. But the imposition of a legal obligation produces consequences which often make it inappropriate as a means of enforcing moral obligations. We are concerned with whether the moral obligation to which (as I assume) the doctor was subject should be a legal obligation.

Nor are we concerned with professional obligations. As the Court may know, those who, in a learned profession, decide what conduct is to be expected of a member of the profession, would no doubt think that, as a matter of general principle, a general practitioner should answer a call to help a child. But, as every practitioner will know, there are to this many qualifications and exceptions. To take but some examples: the doctor called on may not be (or be simply) a general practitioner. He may not deal with the problem the patient is said to have. He may be otherwise occupied. Any general practitioner will instance patients who call for help needlessly, who seek help at home which could and should be given at the surgery, or whose calls derive from emotional problems rather than actual illness. If professional sanctions are to be imposed, they will ordinarily be imposed in terms which do not impose an absolute obligation and they will be imposed in a way which allows those regulating

the profession to assess the circumstances of the case, the qualifications and exceptions to which the general principle is subject, and in the end to do what appears appropriate. That no doubt is why, when failure to attend upon a patient is described as professional misconduct or the like, it is conduct which may, not must, attract professional sanctions: sanctions are applied only when the circumstances require.

I do not doubt that the default here in question is of this kind. Those concerned with the regulation of professional conduct would see the requirement that a doctor attend a sick

person as being, first, a qualified-requirement, and second, as warranting sanctions only if all the circumstances required them.

I should add that no statutory obligation is here involved. It is accepted that no statutory obligation has been imposed and this part of the child's case was abandoned. The issue is, therefore, whether a legal obligation should now be imposed.

(b) NO LEGAL OBLIGATION NOW EXISTS:

This is not in doubt. The learned judge, in my opinion correctly, said:

"In general the common law does not impose a duty to assist a person in peril even where it is foreseeable that the consequence of a failure to assist will be the injury or death of the person imperilled. Something other than the foreseeability of harm is required before the law imposes a duty to intervene. It has been held in other common law jurisdictions that a doctor is under no duty to attend upon a person who is sick, even in an emergency, if that person is one to whom the doctor has not and never has been in a professional relationship of doctor and patient: see Jones, Medical Negligence, Sweet and Maxwell 1991 at 24, par 2.21; Kennedy and Grubb, Medical Law, Butterworths (2nd ed) 1994 at 79; Hurley v Eddingfield (1901) 59 NE 1058; Childers v Frye (1931) 158 SE 744; Buttersworth v Swing (1938) 188 SE 770; Findlay v Board of Supervisions of the County of Mohave (1951) 230 P 2d 526; Agnew v Parkes (1959) 343 P 2d 118 at 123; Hister v Randolf (1986) 17 P 2d 774. Although there is no Australian authority in which the general proposition has been specifically applied in respect of a medical practitioner, the general principle is clear, and there is

certainly no Australian case in which a doctor has been held liable for damages because of a failure to attend upon and treat someone who was not already his patient.'

Counsel have not been able to find any case in support of the present existence of such an obligation. Nor has any member of the Court. No case has been put to the contrary.

I am conscious of the fiction that what the law creates has always been the law. But the implications of this case are great. The law now acknowledges what the law does. In this, as in other areas of the law, the Court now faces squarely the nature of its decisions: it prefers reality to fiction. Therefore, it is not inappropriate that I describe what the Court is here asked to do as imposing a legal obligation which presently does not exist.

(c) THE COURT CAN IMPOSE LEGAL OBLIGATIONS WHICH DID NOT PREVIOUSLY EXIST: This, of course, is not in doubt. In Ballina Shire Council v Ringland (1994) 33 NSWLR 680 at 723 et seq, in dissent, I expressed my view as to the principles involved and referred to cases from which the detail of them may be taken. I shall not multiply the authorities. In the Ballina case: at 733; I said:

"As I have said elsewhere the courts, and this Court, will change the law if it is necessary to do so to achieve justice. In a sense, what a court can do is what the court does."

What is in question here is not whether the Court can but whether it should do so. In my respectful opinion there are limits to what the Court should do.

(d) IN PRINCIPLE. THE COURT SHOULD NOT DO SO IN THIS CASE: I shall not detail at length why this obligation should be imposed. It is sufficient to say that: the obligation to be imposed is not an obligation of the nature proposed by the plaintiffs, viz, an obligation in negligence. The obligation is not, in its nature, one which the courts should impose by judicial decision; the legislature can deal with the matter, it has made some provision in relation to it, and it is best fitted to

deal with it; and the effect of imposing an obligation in this case, retrospectively as it must be, would be unjust.

The obligation which the plaintiff contends should be imposed have been pleaded and argued as an obligation in negligence: the plaintiff's claim has been that Dr Lowns breached a duty of care which he owed to them in negligence. The plaintiffs have sought to justify the their claim upon the basis, as it has been put, that the doctor was in a position or relationship of proximity to the child and that, because of that relationship, a duty of care in negligence was imposed upon him. The trial judge and the plaintiff in argument, called in aid the "principles of proximity" enunciated by the High Court in Jaensch v Coffey (1984) 155 CLR 459; Sutherland Shire Council v Heyman (1985) 157 CLR 424; and Cook v Cook (1986) 162 CLR 376.

In argument, I asked counsel to address the question whether the obligation sought to be imposed upon the plaintiff was in fact an obligation in negligence or an obligation of a different nature.

The reasoning upon which was based the conclusion that the doctor was subject to a duty of care in negligence was set out clearly and in detail in the learned judge's judgment. Summarised, his Honour concluded that there was the appropriate relationship of proximity and that, as the cases cited showed, if there was proximity there was a duty of care. (I am conscious that I do less than justice to the detail of the judge's judgment). But in the end, it was "the application of the principles laid down in" those cases which led his Honour to the conclusion that "notwithstanding the general principle of the common law that there is no obligation of rescue, circumstances may exist in which a medical practitioner comes under a duty of care" to go to a person asking for help.

But, with respect, this reasoning mistakes the nature of the question. If a claim is one which is of its nature a claim for damages for the breach of the obligation imposed by the law of negligence, then it is necessary for the plaintiff to show that there was a duty of care, a breach and damages; and to show a duty of care within the tort of negligence, the relation of proximity is necessary or at least relevant. But that is not the present question. If the question be: is this an act or omission to which the tort of negligence extends, that is not to be determined by asking whether (if it be) there is a duty of care. The issue here is not whether the doctor owed a duty of care to go to the child. If he did, his failure to do so, whether deliberate or negligent, was a breach of his legal duty. His default, if there was one, was not one based on the tort of negligence; it was based on a tort or duty of a different kind.

This is not the occasion to analyse the nature of the tort of negligence or the development of that tort. The role of negligence or default in the law of tort or civil wrong is one which may warrant even yet further analysis. I referred to some of these matters in the San Sebastian litigation: see (1983) 2 NSWLR 268 at 326 et seq; (1986) 162 CLR 340. In this regard, the law has been concerned, inter alia, with two questions. First, it was concerned with the question whether negligence or default was merely part of the various circumstances or situations in which the law would hold one person liable for the loss caused to another. Oversimplified, the law commenced with negligence or default as one of the components of the right to sue persons of particular kinds, eg, agents, persons having the care of the safety of others, and the like. It gradually developed the concept that the defendant might be sued in any case in which his negligence or default had caused damage: cf, eg, Heavener v Pender (1983) 11 QBD 503. Cf the differences that existed between, eg, Sir John Salmond and PH Winfield and others as to whether there was a tort of negligence and, if there was, whether negligence or default was a necessary element in every tort: see, eg, the Prefaces to Salmond on The Law of Torts (9th ed) and the cases referred to in the text. In due course, of course,

the tort of negligence was recognised. Whether, in the light of recent decisions touching absolutely liability, eg, in Rylands v Fletcher, and the like, negligence or default may become a necessary element in all torts remains for final determination. Second, if the tort of negligence being established, it became necessary to formulate the tests for the existence of the essential component of it, the existence of a duty of care. That has proceeded through the Donoghue v Stevenson litigation and the cases to which I have referred.

But, in my respectful opinion, none of these matters determines whether there is a duty as such upon a person having goods or skill to provide the benefit of them to another. It does not determine whether, because a person is (in whatever sense the term is used) a doctor, he has such an obligation.

I am conscious that "negligence" has been used in multiple meanings. In, eg, Fullarton v North Melbourne Electric Tramway and Lighting Co Ltd (1916) 21 CLR 181 at 189-190, there is an illustration of the early use of the term and the earlier dictionaries provide multiple examples: see, eand Stroud's Judicial Dictionary (3rd ed) at 181. But, however, the term is used, what remains here is whether there exists, or should be imposed, an obligation of the kind the plaintiffs propose. I do not think that there is such an obligation.

I come now to consider whether, if legislation there is to be, this is legislation which the courts should undertake. I do not presume to detail exhaustively what is the nature of new obligations which the court should properly undertake to impose. The courts may, of course, develop the existing law. This they have done extensively: see Ballina Shire Council v Ringland, ubi supra. Whether the Mabo decisions are to be seen as merely the reapplication of an existing principle (that occupiers of new lands take them subject to existing proprietary rights) is for others to determine. What is here involved is, in my opinion, the creation of a new civil obligation. It is appropriate to consider whether the nature of the proposed obligation is such that it is appropriate that the courts assume the task of imposing it.

As I have said, the suggested obligation is not one the nature and extent of which is simple nor is it without qualifications and exceptions. As I have said, an experienced general practitioner would immediately suggest the qualifications and exceptions to which any such principle should be subject. The doctor must be a relevant doctor: it is not clear that, eg, an ophthalmologist or a psychiatrist would be obliged to go to a fitting child. There must be qualifications upon when a doctor, a general practitioner, may be expected to go. The time of the night, the doctor's judgment as to the requirements of the stated illness, the appropriateness of treatment at home or in a surgery are some of the matters which would qualify any absolute statement of such an obligation. An experienced doctor may properly conclude that the stated condition was properly accommodated by, eg, ambulance officers or other paramedics or require the hospital rather than him. And there would no doubt be qualifications arising from the nature of the patient and the doctor's previous experience of his complaints.

Matters of this kind indicate that, if an obligation is to be imposed upon a doctor, it cannot be imposed in absolute terms or without qualifications and exceptions. And those qualifications and exceptions will go, not merely to matter which would be, eg, matters of excuse from the application of the general principle, but matters qualifying and limiting the nature and extent of the obligation itself. An obligation of this kind is, in my opinion, not one appropriate to be imposed by judicial fiat.

It is not sufficient to say that the application of qualifications and exceptions, such as exist, can be worked out by the courts over time in the development of the general principle. My purpose in referring to the varied nature of the qualifications and exceptions to which the

principle is subject has been to indicate that, if a sanction is to be imposed upon a doctor in such a context, it must be imposed after a consideration and assessment of all of the relevant factors and following the exercise of a careful discretion. This, in my opinion, is not appropriate to the imposition of a general principle of the kind here in question.

The legislature can deal, and has dealt, with this question. It may readily deal with the obligations of medical practitioners and has shown no reluctance to do so. It has indeed dealt with an obligation of this nature: reference was made by counsel to the Medical Practitioners Act 1938 s27. This is not a situation in which the courts must intervene because justice otherwise is not likely to be done.

I have referred to the effect which the imposition of such an obligation will have upon those on whom it is imposed. What is here in question is no small thing. The effect of it may be tested by recalling that in the case of Dr Lowns the application of the principle will require payments by him of the order of more than $3 million.

The effect of the imposition of a new obligation is sometimes minimised by deprecating "flood gates" arguments. That is a traditional response. But, as I have said, the effect of it upon the present defendant and those in his position can be measured. If such an obligation is to be imposed, it should not be imposed retrospectively; it should be imposed to the extent that examination of the consequences of it require and prospectively so that the burden of it may be dealt with.

In saying these things, I am conscious of the great loss which the child has suffered. It is a tragic loss and the burden of it has and will in the future fall upon those of his parents who must deal with him. But the question remains: should that loss be imposed retrospectively upon another. I do not think that that is appropriate for such legislative power as the courts should claim to have.

(e) THE PRESENT CASE:

Mr Milne QC, to whose argument I am indebted, has pointed to - as he urged it to be - the way in which the case was conducted at the trial. I shall not pursue all of the matters to which he referred but deal with what are, I think, the main ones. He has submitted, inter alia, that the only - or the only substantial - issue at the trial was: did the doctor refuse to go to the child? The suggestion has been that the other issues were not the subject of argument and that therefore they should not be argued here.

I do not think that the case was so simple. No doubt there was concentration upon the factual issue; the doctor may have expected to win it. But the legal liability of the doctor was in issue. The judge dealt with it in the course of his judgment. It is an issue which remains for determination here.

Mr Milne then emphasised the doctor had himself admitted that he should have gone to the child: if he had been requested, he would, he conceded, have felt obliged to go. But, in my opinion, this does not amount to a concession that he had a legal obligation to go or that there was no issue as to the legal obligation. The doctor may well have been conscious of the moral considerations involved. But such concession as was made was not a concession of legal liability. As I have said, legal liability remained to be determined by the court.

In view of the argument advanced, I shall add a final observation. If it be relevant for a judge of the court to express his opinion upon the matter, I would record that the balance of social utility would lie in favour of the imposition of some form of obligation to attend a person upon call. But that obligation is, for the reasons to which I have referred and otherwise, one which must be subject to qualifications and exceptions. And to have as the sanction for

breach of it a simple award of damages would be inappropriate; if a sanction is to be imposed, it must be imposed after consideration of all of the circumstances and only to the extent that, in the particular case, the social considerations requiring the imposition of the obligation warrant. The imposition of the obligation by the creation of a tort sanctioned by damages would, in my opinion, be an inappropriate method of dealing with the problem.

For these reasons, I would uphold the appeals in respect of each of the defendants. I would set aside the judgments and enter judgments for the defendants. Costs here and below should follow the event.

Cole JA

These two appeals, heart together, are brought by Dr Peter Lowns and Dr Peter Procopis against a judgment of Badgery-Parker J delivered 9 February 1995 in which his Honour held each had been negligent. Regarding Dr Lowns, the trial judge held:

"The circumstances were such as to imposed upon Dr Lowns a duty of care, the content of which was a duty to attend upon, examine and treat Patrick Woods, and that his refusal to do so constituted a breach of that duty of care of which he may be held liable in damages for negligence."1

Regarding Dr Procopis, the trial judge found that, by 1985:

"It was incumbent upon him (Dr Procopis) in the exercise of reasonable care and skill as a specialist paediatric neurologist to instruct the parents about the use of rectal diazepam and to equip them to administer it ..2 It appears to me that even though he was not, at that time, (28 April 1986) specifically asked about the steps to be taken should a seizure occur, it was incumbent upon him the exercise of reasonable care to inform the plaintiff's parents at that stage (assuming that he had not done so earlier) of the possibility of administering diazepam by the rectal route, and that he should have prescribed the drug for than, giving them full instructions as to what equipment they need to procure, how to use it, on what circumstances and subject to what precautions3. ... The appropriate advice to have given, as I would find, was that the child should be got to a hospital at the earliest possible moment. There is no inconsistency with giving that advice and advising in addition that, should there be any delay obtaining medical assistance so that by the time it had become available the duration of the fit might have exceeded one hour, or should it be the case, that the duration of the fit was for any reason unknown, immediate treatment could be given by way of rectal administration of the medication.

I am of the view that, there being an available emergency treatment which could be administered by the boy's parents, a reasonable response on the part of Dr Procopis to the foreseeable risks that a fit might occur where its duration was unknown or in circumstances where there might not be sufficiently rapid access to medical care would have been to instruct the parents as to how and in what circumstances and subject to what precautions that treatment might be used, and to prescribe a supply of the medication with appropriate means of administration. In all of the circumstances, I am of the view that notwithstanding that the omission to give such advice accorded with the then accepted medical practice, the omission to give that advice was a breach of the duty of care which Dr Procopis owed to Patrick Woods4." ...

"It was common ground that the advice in fact given by Dr Procopis was satisfactory as far as it went, involving as it did removing the child from any dangerous objects or situations; placing him on his side and ensuring that the airway was clear, and if the fit did not stop spontaneously within five to 10 minutes, seeking urgent medical attention. Upon the findings that I have made, if Dr Procopis had done what the proper fulfilment of his duty of care

required, he would additionally have advised Mrs Light that if the seizure had commenced in circumstances where its duration was unknown but could have exceeded five to 10 mins or for any reason it appeared that medical assistance would not be available within half an hour of the known onset of the fit, they should, while pursuing every attempt to get the child to a doctor or hospital administer one ampoule (10 milligrams) of diazepam via the child's rectum; and that if there was no response after 10 minutes and it still appeared that it would not be possible to get medical assistance, the dose should be repeated. He may have qualified that advice by saying, that if possible rectal diazepam should not be administered unless oxygen was available, but that if there were no prospect that oxygen would be available within a short time, rectal diazepam should be given.

Had that advice been given and if at the time it was given a prescription was issued for the requisite medication, I have no doubt that Mrs Light would have equipped herself to give such treatment should circumstances require. She would have been in possession of a sufficient number of 10 milligram ampoules of diazepam together with appropriate syringes and cannulas."5

His Honour found a causative link between the failure of Dr Lowns to attend and treat Patrick Woods, and the failure of Dr Procopis to give the advice indicated to his parents, which resulted in the damage suffered by Patrick Woods, namely, brain damage suffered for lack of treatment which rendered him quadriplegic. Damages in the sum of $3.2 million were awarded against the doctors.

In addition, the trial judge awarded Patrick Woods father, Mr Harry Woods, damages in the sum of $57,800, principally for nervous shock.

THE TRIAL JUDGE'S FINDINGS

1. Patrick Woods was born on 26 August 1976. He suffered a seizure on 29 June 1978 and a second seizure on 13 March 1979. That was the first occasion he was seen by Dr Procopis, a specialist paediatric neurologist. He was again seen by Dr Procopis on 28 March 1979 when phenobarbitone was prescribed. That drug was continued after further consultations on 16 July 1980, 15 July 1981 and until August 1981. Whilst taking the prescribed drug no further seizures occurred. In August 1981 it was decided to endeavour to withdraw the drug but on 31 August 1981 a third seizure occurred resulting in the phenobarbitone being recommenced. That was continued until July 1985 with no further episodes. On 18 July 1985 a further endeavour was recommended at reduction of the medication but on 12 January 1986 a further seizure occurred resulting in the dosage being again increased. In April 1986 the medication was gradually changed from phenobarbitone to carbamazebine.

2. On 20 January 1987 Patrick Woods suffered the seizure the subject of these proceedings.

3. The plaintiff had been diagnosed with epilepsy. His Honour found:

"Notwithstanding the preponderance of opinion that the risk that the plaintiff would have further fits and in particular an episode of the status epilepticus was relatively low, it cannot in my view be held otherwise than that there was a foreseeable risk that further fits and indeed status epilepticus would occur. Furthermore, it was in my view clearly foreseeable that even in a modern and sophisticated society a person might experience a fit in circumstances where a delay in excess of an hour might occur before he could be got to a hospital or before a doctor could be brought to him; and it was clearly foreseeable that situations could occur where the fact that Patrick was fitting did not become known until the fit had been progressing for some substantial and, unknown and unascertainable time."6 4. If such an attack occurred and was not reasonably promptly treated, brain damage and resulting quadriplegia might occur.

5. The appropriate emergency treatment in the event of such a fit was treatment with diazepam (valium). That desirably should be administered intravenously by a medical practitioner in a hospital. A secondary emergency treatment when that was unavailable was the administration of diazepam rectally. Although there were risks associated with this secondary emergency treatment they were not such as to negate that treatment in such circumstances.7 6. Accordingly:

"It was incumbent upon Dr Procopis in the exercise of reasonable care to inform the plaintiff's parents (at least by 1986) of the possibility of administering diazepam by the rectal route, and he should have prescribed the drug for them, giving them full instructions as to what equipment they needed to procure, how to use it, in what circumstances and subject to what precautions."8

7. It was undisputed that advice was not given.

THE EVENTS OF 20 JANUARY 1987

Mrs Light, as was her custom, rose and went for a walk on the morning of 20 January 1987. She said she left at 8.00 am, insisting that she had looked at her watch and thus was clear on the time of leaving. Her walk took her 20-25 minutes. She was confident of this and, post incident, had checked that time by repeating her walk in approximately 20 minutes. Thus, she said, she returned at about 8.25am to find Patrick fitting. She immediately called out to her other children and on their attendance first dispatched her eighteen year old son Harry to get an ambulance, and a few minutes later dispatched her fourteen year old daughter, Joanna, to get a doctor. Mrs Light told her daughter, Joanna, to "go and get a doctor". Her daughter immediately changed, took the lift to the ground floor and ran to the doctor's surgery approximately 300 metres away. Joanna estimated she reached the surgery about 5 minutes after her mother's initial request.

The account accepted by the trial judge of what then occurred is as follows:

"I knocked on the door, a man came to the door. I told him "my mother sent me down here, my brother was having a bad fit, and that we needed a doctor", and could he come up?"

Q. "What did he say?"

A. "He asked me to bring my fitting brother down there. He asked me to bring him down."

Q. "What did you say?" A. "I said, "he's having a bad fit, we can't bring him down."

Q. "What did he say to that?"

A "To get an ambulance."

Q. "What did you say?" A. "I said, "we need a doctor. We have already got an ambulance."

Q. "What did he say to that?"

A. "He said, "no, I won't come."9

There was debate regarding whether the conversation set forth occurred at all, and if did, whether it occurred with Dr Lowns. It is important to recognise that, at trial the issue was not whether Dr Lowns should have gone to Patrick Woods; Dr Lowns accepted that, had the request set out in the conversation quoted been made to him, he would, and should, have gone to the child.10 His case was that the conversation never occurred. The trial judge found that the conversation had occurred with Dr Lowns. That is not challenged on appeal.

Patrick's mother, Mrs Light, said in evidence:

"Joanna came back in and said the doctor wouldn't come."11

Although this portion of the evidence is quoted in the judgment it is clear that Mrs Light was told more than that by Joanna. Mrs Light gave the following evidence:

Q. "What did she say to you?"

A. "She said "The doctor won't come. He said to bring Patrick down to him.""

Q. "What did you say?"

A. "I just said to the ambulance men "Can you get a doctor? Can you please get a doctor"?"

Q. "How did that affect you when she came back and said "The doctor won't come. He said to bring Pat down"?"

A. "I was just anxious to get him intravenous valium. I didn't know how long he had been fitting for."

Q. "You didn't know what?"

A. "How long he had been fitting for and I was just anxious to get him intravenous valium."12

Thus Mrs Light knew that Dr Lowns, although refusing to go to the child, had advised the child should be brought to his surgery. Neither ambulance officer

apparently knew of this.13 It was their practice to take patients to doctors other than Dr Lowns.

As I have said Mrs Light instructed her son Harry to go to the ambulance station about 300 metres away and call an ambulance. Harry ran to the ambulance station and within a few minutes of dispatch returned with an ambulance staffed by two officers.14 Harry travelled back to the unit with the ambulance, passing and waving to his sister Joanna who was hurrying to the doctor, whose premises, so she hat been told by Mrs Light, were next to the ambulance station. In fact they were next door but one. Thus when Joanna returned ant gave to Mrs Light the message that "the doctor wouldn't come. He said to bring Patrick town to him", Patrick was already in the care of the two ambulance officers.

The importance of these findings of the trial judge is that Mrs Light knew there was an ambulance station within 300 metres and knew there was a doctor within 300 metres. She sent her son Harry first to summons the ambulance, ant shortly afterwards sent her daughter Joanna to summons the doctor. She obviously expected both would come to the unit. The trial judge fount that, had Dr Lowns gone to the unit, with the assistance of the ambulance officers and members of Patrick's family; valium would have been administered: I am satisfied on the balance of probabilities that if Dr Lowns had responded to the call to go to treat the plaintiff, he would have been successful in effecting an intravenous injection of valium.

If on the other hand Dr Lowns had been unable to inject an intravenous injection, the probability is that if Mrs Light had been aware of the possibility of using the rectal route, she would have drawn that to the attention of Dr Lowns, and I am satisfied that on the balance of probabilities that he would have administered valium by that method if unsuccessful intravenously."15

His Honour also found that:

"Having injected the medication, he would have directed the ambulance officers to take the patient directly to hospital."

These findings were fully supported by the evidence of Dr Lowns.16 Q. "Well, I suppose that in the hypothetical situation of you going to this fitting boy, what you would have down would have been to administer valium to him intravenously?"

A. "Yes."

Q. "And with the aid of two ambulance officers, you couldn't see the that you would have had any problem about that?"

A. "Under the circumstances there would have been no problem."

Q. "I suppose that in the hypothetical situation had you gone you would have arrived at the unit within a matter of minutes?"

A. Yes."

Q. "And you would have had the valium administered to him within a matter of a few more minutes?".

A. "Yes."

Q. "And you then you would have said to the ambulance officers; Take him straight to hospital?"

A. "Yes."

Q. "Looking at it now in retrospect and assuming that the mother said to you, "you can administer this valium rectally", I suppose that on that day, had you failed to be able to find a vein, you would have been able to administer it rectally."

A. "Yes."17

It must be assumed that had Patrick been taken to Dr Lowns' surgery by ambulance the same treatment would there have been given. Subject to the question of timing of the treatment, the trial judge found:

"I find on the balance of probabilities that if Dr Lowns had not breached his duty to treat the plaintiff the plaintiff's status condition would have been brought to an end before 9.15 am and, if a second dose were necessary, before 9.30 am. Similarly, I find that if Dr Procopis had given to Mrs Light that advice which he ought to have given, she would have administered rectal valium at such a time as also would have had the effect of bringing the status epilepticus of Patrick Woods to an end by 9.15 am, or, should a second dose have been necessary, before 9.30 am.18

Further his Honour found:

"Acknowledging that there is some chance that the plaintiff may have incurred brain damage prior to 9.15 or 9.30 am, I assess the chance of that happening as very low indeed. It follows that I am satisfied as to the plaintiff's case against each defendant that he has established all of the necessary elements thereof, that is to say duty, breach and causation and he is entitled to a verdict against each defendant."19

A CRITICAL QUESTION There is a critical question, on the manner in which Dr Lowns argued his appeal, which was not addressed in specific terms by the trial judge, namely:

"Was Dr Lowns negligent in advising Joanna Woods to bring her brother Patrick to the surgery, if necessary by ambulance which he was informed had been "got", rather than attending on Patrick Woods at his unknown address?"

The reason why this issue was not specifically addressed in the evidence at the trial or in the judgment, becomes clear once the case advanced by Dr Lowns at trial is understood. As I have said, he chose to fight the case him on a simple issue, namely, whether the conversation with Joanna Woods containing the request occurred. He said it did not. He accepted in cross-examination that if it did occur, he would have gone to Patrick, and should have done so because he could well foresee damage to a fitting child if he did not attend on the child immediately and administer treatment. It was not his case at trial that Mrs Light and the ambulance men should have brought the child to him for treatment. Had it been his case, as Mr Milne QC for the respondents submitted, different and additional questions would have been addressed to Dr Lowns regarding the reasonableness of his not attending on Patrick at his residence rather than at the surgery. After Dr Lowns had the conversation with Joanna put to him, he gave the following evidence:

Q. "But if someone had come to your door and asked you to attend a child who was having a fit, what would you have done?"

A. "Had it happened, which it didn't, I would have gone to see the child. "20

Q. "And you knew in 1987 that you had an obligation, when asked, to attend in as have been described to you in this court today?"

A. "Yes."

Q. "You said yes, did you?"

A. "Yes."

Q. "And you know in such circumstances your failure to attend might easily result in damage being done to the patient that you had been asked to attend to."

Q "And you were, in 1987, able to foresee this?"

A. "This didn't happen ."

Q. "I know it didn't, you say, but in 1987 you were alive to the fact and could foresee that if you didn't attend when asked to, that damage could result to the patient?"

A. Yes."21

The case that Dr Lowns was not negligent because it was reasonable for him to request the child to be brought to his surgery for treatment rather than him going to his residence not having been raised at trial it should not be permitted to be raised on appeal. It could possibly have been met by evidence.22

THE TIMING OF EVENTS

The trial judge found:

(a) Mrs Light left the unit for her walk "somewhere between 8.25 am and 8.30 am ";23

(b) the seizure may have commenced "as early as just after 8.25 am and may have continued for up to half and hour before Patrick was discovered";24

(c) Mrs Light discovered Patrick to be fitting at about 8.55 am;25

(d) Joanna Woods reached the doctor's house "very shortly before but not as early as one minute before 9.00 am. I infer that by 9.00 am she had made her request to the first defendant that he come to the units";26

(e) the ambulance arrived outside the unit block at 9.00 am27

(f) Joanna Woods arrived back in Mrs Light's bedroom where Patrick was fitting "at the latest by 9.04 am;28

(g) had she received appropriate advice from Dr Procopis she would have administered rectal valium at about 9.05 am;29

(h) had Dr Lowns responded to the request to go to Patrick Woods he would have arrived in the unit "by about eight minutes past nine";30

(i) had he gone there, treatment would have been given by him to Patrick Woods between 9.08 and 9.10 am;31

(j) had the attempt to give valium intravenously not succeeded by 9.10 am, Dr Lowns would have administered it rectally" at 9.12 am at the latest";32

(k) at 9.10 am the ambulance made a radio call from the home unit requesting an intensive care ambulance to rendezvous with the first ambulance and take over the transport of the patient to Gosford Hospital33. Difficulties were experienced getting the stretcher into the lift from the unit on the sixth floor which delayed the ambulance's departure from outside the unit until approximately 9.20 am;34

(l) the ambulance arrived at Dr Smeeth's surgery between 9.23 am and 9.26 am;35

(m) Dr Smeeth gave an injection of valium "probably about 9.27 am or 9.28 am";36

TH KNOWLEDGE OF DR LOWNS

Dr Lowns denied any knowledge at all of the events because he said there was no conversation between himself and Joanna Woods. However the appeal has been conducted upon an acceptance of the trial judge's findings that it did occur. On that basis the following was the state of his knowledge.

Patrick Woods was not a patient of Dr Lowns. Dr Lowns did not know Patrick Woods' age or anything about him other than that he was the brother of Joanna Woods who would obviously have been about 14 or 15 years of age. He did not know where Patrick Woods was. He knew nothing of his condition apart from being told he was "having a bad fit". He was also told that "we", presumably meaning Patrick Woods' family, could not "bring him down" but was informed that "we have already got an ambulance". He did not know that Patrick Woods was in a unit on the sixth floor of a building, or that there was any difficulty in the ambulance removing him from the unit. Although he did not know where Patrick Woods was situated, he must have assumed that he was in close proximity because his sister had come on foot to the surgery. He had no reason to believe that the ambulance could not bring Patrick Woods to his surgery immediately on the return of Joanna Woods to the place where Patrick Woods was. The trial judge found it would have taken Dr Lowns "a minute or so to collect his bag and perhaps leave a message for the receptionist".37 Dr Lowns had no reason to think other than that the ambulance could within a time approximate to the time it would take him to go to Patrick Woods, bring Patrick Woods to him.

In those circumstances, whilst denying the conversation occurred, he gave the evidence I have quoted that he would, and should, have gone to Patrick Woods to give him treatment.

LEGAL PRINCIPLES

The learned trial judge was correct in his holding:

"In general the common law does not impose a duty to assist a person in peril even where it is foreseeable that the consequence of a failure to assist will be the injury or death of the person

imperiled. Something other than the foreseeability of harm is required before the law imposes a duty to intervene. It has been held in other common law jurisdictions that a doctor

is under no duty to attend upon a person who is sick, even in an emergency, if that person is one with whom the doctor is not and has never been in a professional relationship of doctor and patient: see Jones, Medical Negligence, Sweet and Maxwell 1991 at 24, para2.21; Kennedy and Grubb, Medical Law, Butterworths, (2nd ed) 1994 at 79; Hurtley v Eddingfield (1901) 59 NE 1058; Children v Frye (1931) 158 SE 744; Buttersworth v Swint (1938) 188 SE 770; Findlay v Board of Supervisions of the County of Mohave (1951) 230 P 2d 526; Agnew v Parkes (1959) 343 P 2d 118 at 123; Hister v Randolf (1986) 17 P 2d 774. Although there is no Australian authority in which the general proposition has been specifically applied in respect of a medical practitioner, the general principle is clear, and there is certainly no Australian case in which a doctor has been held liable for damages because of a failure to attend upon and treat someone who was not already his patient"38

However, a question arises regarding whether the implicit request to Dr Lowns made by Joanna Woods for him to go with her to treat her brother gives rise to such a relationship of proximity as to give rise to a duty of care, and if so what was the content of that duty.

S27(2) Medical Practitioners Act 1938, applicable at the time, provided that it was "misconduct in a professional respect" for a medical practitioner to:

"(c) refuse or fail without reasonable cause, to attend, within a reasonable time after being requested to do so, upon a person for the purpose of rendering professional services in his capacity as a registered medical practitioner in any case where he has reasonable cause to believe that such person is in need of urgent attention by a registered medical practitioner but shall not be guilty under this paragraph of such conduct if he causes another registered medical practitioner to attend as aforesaid."

Dr Lowns, whilst denying the conversation with Joanna, accepted that if it had occurred, as it did, he would have and should have attended upon Patrick at his residence. He did not seek to justify his non-attendance either upon the basis that he had reasonable cause not so to attend because the child was in care of ambulance officers, or upon the basis that the ambulance officers should have brought the child to his surgery. He simply said he was not involved at all.

It was argued that there was no sufficient proximity between Dr Lowns and Patrick Woods to give rise to a duty of care. It was contended there was absent any

relevant physical proximity, any circumstantial proximity or any relevant causal proximity in the manner in which those expressions were explained by Deane J in The Council of the Shire of Sutherland v Hayman39 and risk of injury in consequence of the omission to attend not being reasonably foreseeable, no duty of care arose.

In my opinion this submission fails. Dr Lowns accepted that injury ("damage") to a fitting child was foreseeable if he, once requested, did not attend to treat the child. There was an obvious physical proximity, for Joanna had come on foot. There also proximity" in the sense that Dr Lowns was a existed an adequate medical practitioner to whom a direct request for assistance was made in where, on the evidence presented, there was no reasonable impediment or circumstance diminishing his capacity or indicating significant or material inconvenience or difficulty in him responding to the request, in circumstances where he knew, as he must be deemed to have admitted once it is found the conversation occurred, that serious harm could occur to Patrick Woods if he did not respond to the request and provide treatment. Once it is found, as here, that administering valium at the time determined by the

trial judge would have brought an end to the status epilepticus before the onset of brain damage causing quadriplegia,40 causal proximity is also established.

In my opinion the trial judge was correct to find negligence, in this instance, against Dr Lowns.

A number of additional matters were raised on behalf of Dr Lowns: (1) His Honour should have found Mrs Light left on her walk at 8.00 am, not approximately 8.25am. Thus the attack may have occurred for longer than the trial judge found, and on the probabilities brain damage

would in any event have occurred by 9.15 am when, on his Honour's finding valium may have been administered by Dr Lowns.

The trial judge accepted as fact the independent, empirical evidence that the ambulance arrived at 9.00 am. Thus she found the child fitting at 8.55 am. Further, on admission to hospital at about 10.15 am Mrs Light gave a history of leaving the child "alone at 8.30 am", or alternatively "left unattended for about one and three quarters hours", which could relate back to leaving the child at 8.30 am. It followed that either Mrs Light was mistaken as to the duration of her walk which must have been of the order of 55 minutes if she left at 8.00 am, or the time when she left, if she walked for only some 20-25 minutes. The trial judge found the latter for reasons which he gave. Those reasons are persuasive. There is no reason for an appellate court to disturb that finding of fact.

(2) Dr Lowns may not have been able to administer valium intravenously. Dr Smeeth and the ambulance officers had difficulty doing so. First, Dr Lowns gave evidence he would have anticipated being able to give the injection, and second, the trial judge found that had he not been able to do so he would have administered it rectally.

(3) The valium, when administered, may not have stopped the attack of status epilepticus.

It is sufficient to say that in the past, Patrick responded to valium. The finding of fact was clearly open to the trial judge.

In my opinion the appeal be Dr Lowns fails.

THE CIRCUMSTANCES IN WHICH, HAD PROPER ADVICE BEEN GIVEN, MRS LIGHT WOULD HAVE BEEN ADVISED TO ADMINISTER VALIUM RECTALLY

The trial judge found that in 1987, as now, the primary and preferable treatment for status epilepticus was intravenous injection of valium as rapidly as possible after onset of the attack.41 That was not in dispute. Thus the primary response to an attack was to get the patient to a hospital or doctor for such an

injection. A hospital was preferable because such treatment involved risk of respiratory failure or hypertension. Nonetheless, it was recognised that there could be emergency situations where such hospital or medical attention was not accessible. One of five such situations was that found by the trial judge:

"5. For children who have less than optimal seizure control with anti-epileptic regime and who live in areas remote from medical care (t679). He related that to a situation of a child who could not be got to a doctor or hospital inside an hour, because, in his opinion a seizure was not likely to do any harm unless it lasted well in excess of one hour."42

That evidence was not in medical contest. Accordingly, his Honour found:

"I accept that after 1981 and up to 1987 (which is the only period that I am concerned with) it had never become the practice of specialists in the field in Australia to recommend the use of rectal diazepam except in the specific situations identified by Dr Procopis."43

His Honour also found:

"By that time, as I understand his evidence, Dr Procopis was satisfied that rectal diazepam could be safely administered in the home although he was not yet convinced of its efficacy.

It is clear that Dr Procopis was at all relevant times aware of the risks which he identified in his evidence. Nevertheless, he prescribed rectal valium for administration by parents in the situation where the child was likely to have recurrent fits (because the child's history said so) and was likely to be remote from medical care. If a situation should occur, in which a child, no matter what his or her history and no matter how unlikely such predicament was, was remote from medical care, the need for immediate treatment was no less merely because those circumstances which had eventuated were not regarded as probable (although foreseeable)."44

Against that background his Honour found that the advice which Dr Procopis should have given to Mrs Light was:

"The appropriate advice to have given, as I would find, was that the child should be got to a hospital at the earliest possible moment. There is no inconsistency between giving that advice and advising in addition that, should there be any delay in obtaining medical assistance so that by the time it had become available the duration of the fit might have exceeded one hour, or should it be the case that the duration of the fit was for any reason

unknown, immediate treatment could be given by way of rectal administration of the medication."45 and further:

"Upon the findings that I have made, if Dr Procopis had done what the proper fulfilment of his duty of care required, he would additionally have advised Mrs Light that if the seizure had commenced in circumstances where its duration was unknown but could have exceeded five to 10 minutes, or for any reason it appeared that medical assistance would not be available within half an hour of the known onset of the fit, they should, while pursuing every attempt to get the child to a doctors or hospital, administer one ampoule (10 milligrams) of diazepam via the child's rectum; and that if there was no response after 10 minutes and it still appeared that it would not be possible to get medical assistance the dose should be repeated. He may have qualified that advice by saying, that if possible rectal diazepam should not be administered unless oxygen was available, but that if there were no prospect that oxygen would be available within a short time, rectal diazepam should be given.

Had that advice been given and if at the time it was given a prescription was issued for the requisite medication, I have no doubt that Mrs Light would have equipped herself to give require. She would have been in possession of a sufficient number of 10 milligram ampoules of diazepam together with appropriate syringes and cannulas."46 This latter finding was an available finding on the evidence.47

Here the duration of fitting could have exceeded 5 to 10 minutes, it may have extended to 25 minutes, and medical assistance may well not have been available within half an hour of possible onset.

WHAT WOULD MRS LIGHT HAVE DONE IF TOLD DR LOWNS HAD ADVISED THAT PATRICK BE BROUGHT TO HIS SURGERY

Assuming that the proper advice had been given by Dr Procopis, and Mrs Light had been provided with valium, equipment and training to administer the drug in that

situation, what would she have done when told at 9.04 am that Dr Lowns had advised that Patrick be taken to his surgery known to be less than 300 metres away?

The answer depends upon Mrs Light's subjective understanding of how long the child had been fitting. It docs not depend upon how long in fact he had been fitting. Her belief whether it be right or not, was that she had been out walking for 20-25 minutes. The child was not fitting when she left but was when she returned. Joanna Woods was absent seeking to fetch the doctor for only about five minutes, and no more than ten minutes. Thus Mrs Light would have been informed, after what she would have thought was some 25-30 to 30-35 minutes after the maximum time she would have thought the child was fitting, that the ambulance should take her son to a doctor 300 metres away.

The trial judge found Mrs Light would have administered valium rectally on Joanna's return from the doctor.48 There is no cause to disturb that finding. She was confronted with the circumstances contemplated by the advice she should have been given. There is no reason to think she would not have followed it.

It was argued that the finding that she would have implemented the advice should be disturbed because, although Mrs Light has been aware that since the attack in 1987 which cause paraplegia, Patrick is more at risk of a further attack of status epilepticus, and since at least the commencement of these proceedings she has been aware of the view that rectal administration of valium is possible and desirable in the emergency situations described, she has not equipped herself to administer the drug, has not obtained a prescription for the drug and has not trained herself to administer it. This shows, it was said, she would not have followed the advice.

In my opinion this attack fails. Mrs Light's belief, whether it be true or not, is that Patrick's fitting after January 1987, was of a different type to that previously. She did not believe he would have another "status fit". As she said:

Q. "Do you have any other medication at home for Patrick in the case of an emergency attack or epilepsy?"

Q. "You to not have any valium for administration rectally?"

A. "No."

Q. "Why not?"

A. "Since Patrick has been disabled I did not know about it for quite a while and I resolved we would not take him away from the care we had in Sydney. We would not put ourselves in a position where we would be away from medical care so we always remained in Sydney even although we have gone to a beachside suburb and we knew we were in access of a doctor, there was always hospitals close by, we were not in a position where we could find any problem and the fact of Patrick, the experience we have had with the grand mal seizures that it has not been status, and we just really did not feel that he would have another status fit. Patrick suffered such immense brain damage I really did not think he would have another status fit."

Q. "And that is the reason you have not taken the precaution of having rectal valium at home even though you have known about it since at least 1987?

A. "Yes."

Q. "And you mentioned in your evidence yesterday you took Patrick on holiday last year to Byron Bay, didn't you?"

A. "Yes."

Q. "Did you take any rectal valium with you?"

A. "No."

Q. "Why not?"

A. "Because as I said he had been six years without suffering status epilepsy and I did not feel that he would, even if he had a seizure, that he would suffer status epilepsy, he being on mysoline and vigabatrin for quite a long time without any problems. We did make sure of course when we went away where the medical centre was if we needed it and we were in a position we would get him to the medical care very quickly."49

In my opinion, Mrs Light's explanation negates the drawing of any inference that she would not have followed advice if given to her, arising from her not having subsequent to January 1987, valium for emergency rectal administration.

In my opinion, Dr Procopis' appeal fails.

ORDERS

It was agreed that if the appeals failed so also would be the appeals against the judgment in favour of Mr Woods for nervous shock.

I would propose that in each of appeals numbered 40094 of 1995 and 40097 of 1995, the appeal be dismissed with costs.

Order

IN THE APPEAL BY DR PETER PROCOPIS (CA 40097/95)

1. Appeal allowed;

2. Set aside the judgment against Peter Procopis entered by Badgery Parker J in the Common Law Division of the Supreme Court in favour of Patrick Woods by his next friend the Protective Commissioner of New South Wales and Harry Woods;

3. In lieu thereof, order that the actions brought against Peter Procopis be dismissed with costs;

4. Order that Patrick Woods, by his said next friend, and Harry Woods pay the costs of Peter Procopis of the appeal; and

5. Order that in respect of the costs of the appeal, the said Patrick Woods and Harry Woods have certificates under the Suitors ' Fund Act 1951.

IN THE APPEAL BY DR PETER LOWNS (CA 40094/95)

Order that the appeal be dismissed with costs.

Counsel for the Appellant (Dr Lowns): PR Graham QC/DL Williams

Solicitors for Appellant (Dr Lowns): Tress Cocks and Maddox

Counsel for the Appellant (Dr Procopis): AJ Sullivan QC

Solicitors for Appellant (Dr Procopis): Blake Dawson Waldron

Counsel for the Respondents (Patrick Woods/Harry Woods): DB Milne QC/MB Williams

Solicitors for Respondents (Patrick Woods/Harry Woods: McCourt Charlton

1 Appeal Book. at 2583W-2584.

2 Appeal Book, at 2559M

3 Appeal Book, at 2559W

4 Appeal Book, at 2560J

5 Appeal book, at 2585U-2586P

6 Appeal Book, at 2552U.

7 Appeal Book, at 25, 42F, 2258W-2559H

8 Appeal Book, at 2559W

9 Appeal Book, at 2562-2563.

10 Appeal Book, at 604R-S, 607N-W

11 Appeal Book, at 2571

12 Appeal Book, at 247E-J

13 Appeal Book, at 1910D, 1911P.

14 Appeal Book, at 2561

15 Appeal Book, at 2588

16 Appeal Book, at 612M-W

17 Appeal Book, at 2558E.

18 Appeal Book, at 26611W-2612F.

19 Appeal Book, at 2612U.

20 Appeal Book, at 604R-S

21 Appeal Book, at 607N-W.

22 Water Board v Moustakas (1987) 180 CLR 491 and 495, 497.

23 IBID.

24 Appeal Book, at 2603D

25 Appeal Book, at 2603E-G

26 Appeal Book, at 2590P.

27 Appeal Book, at 2590H

28 Appeal Book, at 2590R.

29 Appeal Book, at 2590U.

30 Appeal Book, at 2591G.

31 Appeal Book, at 2591N.

32 Appeal Book, at 2591Q.

33 Appeal Book, at 2603S.

34 Appeal Book, at 2604C

35 Appeal Books, at 2604K-L

36 Appeal Book, at 2604B.

37 Appeal Book, at 2590X

38 Appeal Book, at 2574C-Q

39 (1985) 157 CLR 424 at 495.

40 Appeal Book, at 2612

41 Appeal Book, at 2560K

42 Appeal Book, at 2542F-L

43 Appeal Book, at 2542K-N

44 Appeal Book, 2558W-2559H

45 Appeal Book, at 2560K-P

46 Appeal Book, at 2585W-2586P

47 Appeal book, at 678.

48 Appeal Book, at 2587E.

49 Appeal Book, at 314S-315L.