

AUSTRALIA / JUDGMENT

Peterkin v Tadros

[2026] NSWSC 1185**COURT**

Supreme Court

DECIDED

29 September 2026

BEFORE

Sirtes J

CASE / FILE NUMBER

2026/00209298

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Supreme Court

New South Wales

Medium Neutral Citation: Peterkin v Tadros [2026] NSWSC 1185**Hearing dates:** 7–10 September 2026**Date of orders:** 29 September 2026**Decision date:** 29 September 2026**Jurisdiction:** Common Law**Before:** Sirtes J

Decision: (1) The Defendant is liable to the Plaintiff in negligence, and the Plaintiff was contributorily negligent.
(2) The parties are to send to my chambers, by 13 October 2026, competing submissions on damages, apportionment and costs. Such submissions are to be no more than 10 pages, in size 12 font, with 1.5 spacing between each line and with margins of no less than 2.54 cm on all sides of the page.
(3) Should the parties consider it necessary, they are to contact my chambers by 5pm on 3 October 2026 for the purpose of having the matter listed for hearing on damages.
(3) Costs are reserved.

Catchwords: TORTS – negligence – medical negligence – general practitioner – where patient presenting with rectal symptoms – where defendant failed to take history of duration of symptoms – where defendant failure to refer for specialist investigation – breach of duty established
TORTS – negligence – causation – where delayed diagnosis of rectal cancer – counterfactual date of diagnosis – where cancer recurred – life expectancy – factual causation and scope of liability established
TORTS – negligence – contributory negligence – where plaintiff failed to seek further medical attention – apportionment reserved

Legislation Cited:	Civil Liability Act 2002 (NSW), ss 5, 5B, 5C, 5D, 5E, 5O, 5R
Cases Cited:	AA v The Trustees of the Roman Catholic Church for the Diocese of Maitland-Newcastle (2026) 100 ALJR 170; [2026] HCA 2 Adeels Palace Pty Ltd v Moubarak (2009) 239 CLR 420; [2009] HCA 48 Bencic v State of New South Wales [2010] NSWSC 1039 Chappel v Hart (1998) 195 CLR 232; [1998] HCA 55 Dean v Pope (2022) 110 NSWLR 398; [2022] NSWCA 260 Derrick v Cheung [2001] HCA 48 Dobler v Halverson (2007) 70 NSWLR 151; [2007] NSWCA 335 Gates v City Mutual Life Assurance Society Ltd (1986) 160 CLR 1 Lederer Group Pty Ltd v Hodson [2024] NSWCA 303 Rogers v Whitaker (1992) 175 CLR 479; [1992] HCA 58 Rosenberg v Percival (2001) 205 CLR 434; [2001] HCA 18 South-Western Sydney Local Health District v Gould (2018) 97 NSWLR 513; [2018] NSWCA 69 St Paul’s College Ltd v Allan [2026] NSWCA 22 Tabet v Gett (2010) 240 CLR 537; [2010] HCA 12 Trustees of the Roman Catholic Church for the Archdiocese of Sydney v Kondrajian [2001] NSWCA 308 Uniting Church in Australia Property Trust (NSW) v Miller; Miller v Lithgow City Council [2015] NSWCA 320 Venues NSW v Kane [2023] NSWCA 192 West v Government Insurance Office of NSW (1981) 148 CLR 62; [1981] HCA 38
Category:	Principal judgment
Parties:	Ross Peterkin (Plaintiff) Dr Abram Tadros (Defendant)
Representation:	
Counsel:	A Campbell (Plaintiff) M Hutchings (Defendant)
Solicitors:	Gerard Malouf & Partners (Plaintiff) Moray & Agnew (Defendant)
File Number(s):	2026/00209298

JUDGMENT

Introduction

This is a claim in professional negligence brought by a patient against a general practitioner. The Plaintiff, Mr Ross Peterkin, has been diagnosed with incurable colorectal cancer. His life expectancy is limited. For that reason, these proceedings have been expedited.

The Plaintiff claims damages for personal injury against the Defendant, Dr Abram Tadros. It is alleged in the Statement of Claim that the Defendant failed properly to investigate the Plaintiff's symptoms when he presented at the Defendant's medical centre on 23 August 2022 (the August 2022 Consultation). Had the Defendant done so, the Plaintiff says, his life expectancy would not have been foreshortened.

The proceedings concern myriad alleged failures to provide reasonable care during a single medical consultation between the Plaintiff and Defendant on 23 August 2022. Sadly, at the time of the consultation, the Plaintiff had undetected colorectal cancer.

The core issues in dispute are the applicable standard of care in light of what the Plaintiff told the Defendant at the consultation, what the Defendant made of that information, what the Defendant ought to have made of that information, and the results of the Defendant's examination of the Plaintiff.

Issues for determination

The parties invited the Court to determine questions of exact damages and apportionment (in relation to contributory negligence) separately. I agreed to that course. Accordingly, this judgment concerns liability only. The parties will have an opportunity to provide written (and, if necessary, oral) submissions on damages, apportionment and costs.

At the close of the hearing, the parties provided a joint list of issues to be decided for the purpose of liability. Those issues, with respect to the alleged breach of duty, are:

What occurred during the consultation between the Plaintiff and Defendant on 23 August 2022?

What symptoms did the Plaintiff report at the consultation?

Did the Defendant fail to refer the Plaintiff?

Did the Defendant act in a manner that was widely accepted in Australia by peer professional opinion as competent professional practice pursuant to s 50 of the Civil Liability Act 2002 (NSW)?

The issues with respect to factual causation are:

Can the Plaintiff establish that he would have acted on a referral issued on 23 August 2022?

If so, by what date would the Plaintiff have seen a specialist?

If so, by what date would the Plaintiff have undergone a colonoscopy?

With respect to medical causation:

What type of tumour was detected at the colonoscopy in May 2024?

What type of tumour would have been detected had a colonoscopy been performed on the alternative colonoscopy date?

What was the consequence of any delay between the alternative colonoscopy date and May 2024?

With respect to contributory negligence:

If negligence is found, should a deduction be made for contributory negligence?

I have decided all of those issues, albeit not under the same framework as presented by the parties.

Procedural history

The Plaintiff commenced these proceedings on 21 May 2026. The Plaintiff alleges that he presented at the August 2022 Consultation complaining of painful defecation, a sense of urgently needing to open his bowels, as well as rectal bleeding. Those symptoms were said to have affected him for one day. The Defendant's clinical notes from the August 2022 Consultation recorded a medical history of haemorrhoids. The Defendant says he visually examined the Plaintiff's anus. He did not perform a digital examination.

The Statement of Claim notes that the Plaintiff's prognosis is uncertain and he has a "limited life expectancy". This is addressed further below.

The central allegation against the Defendant is that a reasonable and competent person in his position would have taken precautions to minimise the risk of harm materialising pursuant to s 5B(2) of the Civil Liability Act 2002 (NSW) (the CLA). There are 18 bullet points under the heading "Particulars of Precautions" alleged against the Defendant as well as a further 18 "Particulars of Negligence".

The Plaintiff filed an Amended Statement of Claim on 3 September 2026. Only two paragraphs were amended.

The first amended paragraph corrected the date of the Plaintiff's consultation with the Defendant and added that the Plaintiff denies reporting (or having) any history of haemorrhoids.

The second amended paragraph added that Dr Etemad (the Plaintiff's usual general practitioner) did not perform a physical examination of the Plaintiff's anus or rectal region on 8 October 2023. It also noted Dr Etemad's referral letter to Dr Hamilton (a colorectal specialist) "for an opinion and management of rectal bleeding ([haemorrhoid]?)" [sic].

The Defendant relies upon ss 5B, 5C, 5D and 5O of the CLA. Should negligence be found, he relies upon s 5R. I will deal with each of these as they arise.

The meaning of "negligence" is contained in s 5 of the CLA, being "failure to exercise reasonable care and skill".

The alleged breach of duty is based on the pre-conclave reports of Dr Chambers. As to causation, the Plaintiff relies on the evidence of Associate Professor Pendlebury, oncologist, whose report contains certain factual assumptions. The Defendant claims that those assumptions are erroneous and that, once they are removed, the Plaintiff is unable to establish breach of duty or causation.

Background

The Plaintiff is a 43-year-old man who lives with his wife, Mrs Kristy-Lee Peterkin, and their five-year-old daughter. They intended to have a second child, though those plans have been affected by the Plaintiff's illness.

The Plaintiff worked for approximately 15 years as a personal trainer. He has been on unpaid leave since November 2025. Mrs Peterkin says that, before his illness, the Plaintiff was energetic and heavily involved in every aspect of their family life.

The August 2022 Consultation occurred on 23 August 2022, when the Plaintiff attended the Defendant's medical practice in Gledswood Hills. The Defendant was not the Plaintiff's usual GP. At the appointment, the Plaintiff complained that it was painful to defecate and that, after defecating, he would experience minimal bright rectal bleeding.

The Defendant, after allegedly inspecting the Plaintiff's anus visually, diagnosed him with haemorrhoids. The Defendant prescribed a suppository and supplied the Plaintiff with an educational pamphlet concerning haemorrhoid symptoms and treatment.

On 8 October 2023, the Plaintiff attended the same medical practice and saw his usual GP, Dr Samira Etemad. Dr Etemad's notes from this appointment record that the Plaintiff complained of rectal bleeding several times a week, though there was no pain when defecating. Dr Etemad, who observed that the Plaintiff had a "small haemorrhoid", referred him to Dr Aurelius E Ricardo Hamilton "for an opinion and management of rectal bleeding ([haemorrhoid]?)".

The Plaintiff did not see Dr Hamilton before his next consultation with Dr Etemad on 22 February 2024, when he again complained of rectal bleeding. At that appointment, Dr Etemad advised the Plaintiff to see Dr Hamilton as soon as possible. She advised him that a colonoscopy was needed to determine whether the Plaintiff's issues were being caused by polyps, cancer or haemorrhoids. She provided the Plaintiff with another referral to Dr Hamilton. That referral was printed again on 7 March 2024, seemingly at the Plaintiff's request.

On 8 May 2024, the Plaintiff again saw Dr Etemad. His presentation was largely unchanged from 22 February 2024. He had already attended a consultation with Dr Hamilton on 7 March.

On 15 May 2024, the Plaintiff attended Dr Hamilton at Campbelltown Hospital for the purpose of having a colonoscopy. Dr Hamilton's digital examination of the Plaintiff found a hard rectal mass. The colonoscopy found that the 6 cm mass had broken through the Plaintiff's rectal mucosa.

An MRI taken five days later revealed that the Plaintiff had a "mid to high rectal tumour" which had grown into the surrounding tissue. There were two likely regional metastases.

On 28 May 2024, the Plaintiff was diagnosed with mid-rectal adenocarcinoma. He was to undergo an intensive chemotherapy regimen followed by long-course radiotherapy and further chemotherapy.

The tumour's size and location necessitated a defunctioning colostomy. The surgery was delayed until after the Plaintiff completed neoadjuvant therapy, which covers a range of preoperative therapies designed to shrink a tumour before surgery.

By 9 October 2024, the Plaintiff had completed his initial chemotherapy.

On 20 February 2025, the Plaintiff underwent a surgical resection (with a diverting ileostomy). A histopathology report revealed that, despite the neoadjuvant therapy, a "large amount of residual malignancy" remained. The cancer had metastasised to four lymph nodes. He recommenced chemotherapy.

The Plaintiff attended review appointments with Dr Hamilton on 7 July and 15 October 2025. At the latter appointment, Dr Hamilton noted that a recent CT scan indicated that the cancer may have metastasised to two lymph nodes.

On 5 November 2025, the Plaintiff underwent surgery to reverse his ileostomy. By that time, the cancer had spread to blood vessels and lymphatic channels near the tumour.

On 27 December 2025, the Plaintiff underwent surgery for a permanent colostomy and the insertion of a stent in his left ureter, which had become obstructed by lymph nodes swollen by the cancer's invasion.

Evidence

The Plaintiff's lay evidence comprised his affidavit sworn 25 June 2026 together with an exhibit, being a thread of Facebook Messenger messages between the Plaintiff and Mrs Peterkin on 23 August 2022, plus the Plaintiff's oral evidence taken on commission on Wednesday 1 July 2026 (the EOC). Mr Campbell of Counsel appeared for the Plaintiff in that examination and Mr Hutchings of Counsel appeared for the Defendant. Both also represented their respective clients at the hearing.

The Plaintiff also read the lay evidence of Mrs Peterkin, dated 25 June 2026, and a statement of Dr Samira Etemad, dated 4 September 2026.

The Defendant's lay evidence comprised his own statement, dated 30 July 2026, to which his curriculum vitae was annexed.

The Plaintiff relied upon the following liability and causation expert evidence:

a report of Dr Dianne Chambers, general practitioner, dated 22 August 2025;

a report of Associate Professor Susan Pendlebury, radiation oncologist, dated 19 February 2026;

a supplementary report of Associate Professor Pendlebury, dated 24 July 2026;

a supplementary report of Dr Chambers, dated 29 July 2026;

a report of Dr Siddharth Sethi, gastroenterologist, dated 30 August 2026; and

a further supplementary report of Associate Professor Pendlebury, dated 4 September 2026.

The Defendant relied upon the following liability and causation expert evidence:

a report of Professor David Garne, general practitioner, dated 1 July 2026;

a report of Professor Stephen Clarke OAM, oncologist, dated 3 July 2026; and

a report of Associate Professor Vincent Ho, gastroenterologist, dated 27 August 2026.

The Plaintiff provided the following expert quantum evidence:

a report of Professor Richard Fox, oncologist, dated 22 April 2026;

a report of Dr Leon Turnbull, psychiatrist, dated 12 March 2026; and

a report of Keshika Naidoo, occupational therapist, dated 15 May 2026.

The Defendant provided the following expert quantum evidence:

a report of Victoria Gracey, occupational therapist, dated 9 July 2026.

The oncologists, Associate Professor Pendlebury and Professor Clarke, provided a joint report, dated 12 August 2026, arising from their expert conclave. The expert general practitioners, Dr Chambers and Professor Garne, also participated in an expert conclave and produced a joint report dated 13 August 2026. Because of the bifurcation of liability and quantum, no quantum evidence was read before me.

The August 2022 Consultation

It is convenient first to set out the events of the August 2022 Consultation, including where the parties disagree. I will then make my findings about the areas of disagreement.

The Plaintiff attended the practice where the Defendant worked on 23 August 2022. The appointment was booked by Mrs Peterkin at the Plaintiff's request. The Plaintiff saw the Defendant because Dr Etemad was fully booked that day. The Plaintiff felt that he could not wait for an appointment on another day.

The Plaintiff says that his symptoms had appeared that morning. Since waking, he had experienced significant abdominal pain; pain around his "backside"; blood on defecation; and a constant urge to open his bowels, which he described as "unremitting, intrusive and extremely uncomfortable". In his EOC, the Plaintiff described having a "severe urgency to go to the toilet" but not being able to "pass much". He described the pain accompanying the urgency as "quite severe". After defecating, there would be "tiny little bits of blood" on the toilet paper. He stated, in his evidence on commission, that the escalation "was like going from a scale of... 3 out of 10 to 9 and 10 out of 10".

At 12.47 pm, he messaged Mrs Peterkin the following:

“I am so fucking uncomfortable. I can hardly concentrate. I am bloated too, so hopefully I am just constipated but [I will] have to change my diet if that is the case.”

At 1.02 pm:

“This is fucked, I need to go to the toilet so badly nothing comes out.”

At 1.08 pm:

“I am actually starting to feel like shit too.”

The Plaintiff’s evidence is that he described his symptoms to the Defendant “quite vividly” and in somewhat “graphic detail”. He wanted to convey to the Defendant how severe his discomfort was at that time, saying during his evidence on commission:

“So I just explained the urgency going to the toilet, the intermittent blood on the toilet paper very minor, pain and severity of the pain when I needed to go to the toilet and defecate but not being able to get anything out, yeah, bloated, feeling constipated, just all of those related – related symptoms, and that it had been escalating going on for quite a few hours and I was just getting no relief ...”

The Plaintiff was emphatic that he did not report any history of haemorrhoids to the Defendant. The Plaintiff maintained that he had never experienced, nor suspected he had, haemorrhoids before the August 2022 Consultation.

The Plaintiff described the Defendant’s visual examination of his anus as “very, very brief”. The Plaintiff said that he lay down and the Defendant “only briefly separated [the Plaintiff’s] buttocks” and looked externally. He says that the Defendant moved his right buttock and stated, “yeah, haemorrhoid”. The Plaintiff described the Defendant’s examination as “burnt into [his] brain”. The Plaintiff said that he assumed the Defendant would perform a digital examination, but the Defendant did not do so.

There is no dispute that, after the visual examination, the Defendant informed the Plaintiff that he had haemorrhoids, wrote a prescription for a suppository, and provided an informative pamphlet on haemorrhoids.

The Plaintiff’s evidence is that the Defendant did not raise possible serious diagnoses, such as bowel cancer or some other serious bowel pathology. He stated that he was not informed that further investigation was necessary. He also did not recall the Defendant making mention of a colonoscopy or a hospital emergency department. He was not referred for urgent specialist review or testing.

The Plaintiff recalled the entire consultation as lasting around 20 minutes. At 1.39 pm, the Plaintiff messaged his wife “haemorrhoid and constipation”. He claims he sent that message immediately after the appointment concluded.

The Plaintiff's cross-examination during his evidence on commission

The Plaintiff was extensively cross-examined during his EOC. Seven themes emerged during that cross-examination. I will deal with them seriatim.

The first concerned the Plaintiff's reliability, the danger of reconstructed memory and his conceded errors of fact. It became evident during cross-examination that the Plaintiff's recollection of dates was frequently inaccurate. Although he maintained that he remembered his 23 August 2022 consultation with the Defendant "quite vividly", he later said his recall was "a little bit hazy because [he] was in a lot of pain at that point... so [his] concentration was probably waning". Nevertheless, he said he remembered "most of- ... 90% of" the August 2022 Consultation.

He struggled to recall the dates on which other events occurred, such as when he was prescribed Voltaren, the date on which he ceased working at Anytime Fitness, the year he commenced working at Fairfield City Council, and his daughter's birth year. Mr Hutchings, fairly, did not criticise the Plaintiff for his difficulty in remembering those matters.

I find the Plaintiff to be an honest witness. While his recollection of dates was unreliable, he was candid in conceding as much. I accept his evidence where it is consistent with the contemporaneous records and messages.

The second theme concerned the duration of the Plaintiff's symptoms leading up to the 23 August 2022 appointment. The Plaintiff was shown messages he exchanged with Mrs Peterkin some hours before the August 2022 Consultation began. At 9.39 am, the Plaintiff had the following exchange with Mrs Peterkin:

PLAINTIFF: "I think I need to go to the doctor finally about my bowels after covid"

MRS PETERKIN: "Yeah its [sic] a year next month"

MRS PETERKIN: "Its [sic] not normal for it to go on 3 or 6 months yet alone [sic] a year"

MRS PETERKIN: "If theres [sic] blood I suggest sooner rather than later"

At 10.17 am that same day, responding to a message the Plaintiff sent about the likelihood of needing a colonoscopy, Mrs Peterkin messaged the Plaintiff:

"Probably but its worth doing if its been going on for a year"

The Plaintiff later said that he did not associate having a colonoscopy with cancer.

Since September 2021, the Plaintiff had almost constantly felt an urgent need to go to the toilet for a bowel movement. This sense of urgency is termed "tenesmus". The Plaintiff regarded it as a lingering effect of COVID-19, which caused issues with his bowels when he contracted it in September 2021. However, at that time, the urgency was not accompanied by pain. By August 2022, the Plaintiff made sure he was aware of the nearest toilet whenever he went out in public.

The Plaintiff ultimately conceded that he had been suffering for “maybe 5 to six months” from intermittent blood on toilet paper after defecating. When asked whether he could have been suffering the symptoms for perhaps a year, he did not exclude the possibility, saying “it’s entirely possible, but I don’t recall anything like that”. His wife had asked him about the blood several times prior to 23 August 2022. This is consistent with the message she sent to her husband before making the appointment.

The third theme concerned the acute nature of the Plaintiff’s presentation at the August 2022 Consultation. The Plaintiff claimed that he presented at the consultation with all of the symptoms set out at [46] above. However, he accepted that, before that date, he had regarded his symptoms as “a niggling problem” that “wasn’t very severe at all”. His evidence in cross-examination was that, before 23 August 2022, the feeling of urgency was not accompanied by pain. He said that until the day of the August 2022 Consultation, his urgency was not painful, and about two-thirds of his bowel movements were not painful either. The blood that accompanied his defecation was “pinkish in colour... just traces... it was never dark red”.

He maintained that he told the Defendant he felt very bloated, which he put down to constipation.

The following exchange occurred during cross-examination of the Plaintiff:

Q. ... You thought you might have a haemorrhoid for about a day or so?

A. Yeah, like, I thought it could be a haemorrhoid. In terms of timeframe, I’m not sure whether it was ... I said it was just one day or that day I said. You know, I was just guessing at what I thought it was.

The fourth theme comprised *Browne v Dunn* questioning with respect to the August 2022 Consultation. A substantial part of the cross-examination consisted of Mr Hutchings confronting the Plaintiff with the Defendant’s evidence regarding the consultation. The Plaintiff often did not deny that evidence; he merely could not recall whether it was correct.

Specifically, he could not recall whether the Defendant took his blood pressure, heart rate or temperature; whether the Defendant used a stethoscope; whether they discussed or reviewed Dr Etemad’s care plan for a pre-existing ankle and knee injury, urinary problems and the importance of hydration. He accepted there was “probably a chance” that the Defendant told him to follow up with his GP if his symptoms persisted, even though the Plaintiff could not recall whether he was in fact told to do so.

The fifth theme concerned the haemorrhoid pamphlet the Defendant gave to the Plaintiff. The pamphlet, which the Plaintiff says he read carefully, is called “Haemorrhoids”. It contained the following advice:

“Occasionally the bleeding attributed to haemorrhoids can come from cancer of the bowel.”

And:

“Any bleeding from the anus, especially in someone over 40 should be reported to your doctor.”

The Plaintiff accepted that he put the passage regarding cancer out of his mind. He left the consultation under the impression that he had two problems: haemorrhoids and constipation.

The sixth theme concerned the apparent success of the suppository prescribed by the Defendant and the Plaintiff’s failure to prioritise his own health. The Plaintiff gave evidence that, days after his consultation with the Defendant, his symptoms subsided, though they “quite slowly crept back in” after “probably a few weeks to a month”. The following exchange occurred during cross-examination:

Q. And then when it comes back weeks and weeks later you just decide you’re just going to deal with it?

A. Yeah.

Q. Is that fair?

A. Yeah.

It was put to the Plaintiff that the Defendant’s diagnosis and the apparent success of the treatment gave him the confidence not to pursue any concerns about his bowel issues for 18 months. The Plaintiff responded, “I wouldn’t agree with such confidence, but... he gave me a diagnosis, he treated me for it, and the treatment was... somewhat effective”.

He acknowledged that he had not prioritised his health. To his mind, he put the wellbeing of Mrs Peterkin, their daughter, and his father, ahead of his own health. His father’s mental health, which was affected by business difficulties, was a source of particular stress for the Plaintiff.

The seventh theme concerned the Plaintiff’s failure to report symptoms to other practitioners he saw at the same medical centre between the August 2022 Consultation and his 8 October 2023 consultation with Dr Etemad. Those were:

- an appointment with Dr Etemad on 2 November 2022;
- an appointment with Dr Etemad on 4 November 2022;
- an appointment with Dr Sivananthan on 6 June 2023;
- a telephone consultation with Dr Etemad on 9 June 2023;
- an appointment with Dr Hussein on 23 August 2023;
- an appointment with Dr Hussein on 24 August 2023; and
- an appointment with Dr Hussein on 28 August 2023.

The Plaintiff did not mention his bowel symptoms during those appointments. Dr Etemad asked the Plaintiff about abdominal symptoms during the 9 June telephone consultation, which otherwise concerned a head injury the Plaintiff sustained playing OzTag. He reported no abnormalities.

The Plaintiff's bowel issues remained present throughout those months. He conceded during cross-examination that they never went away. The Plaintiff's explanation was that his symptoms had not progressively worsened and that he was still dealing with them.

The Defendant's evidence

The Defendant's evidence was set forth in his signed statement of 30 July 2026. He also provided his clinical note from the August 2022 Consultation, together with the associated prescription, the "Haemorrhoids" pamphlet, and the practice day sheet and file access log.

The Defendant's clinical note of the August 2022 Consultation is as follows:

"for painful defecation and haemorrhoid for 1/7

minimal bright rectal bleeding at the end of defecation

slightly constipated

PH of haemorrhoids previously

never operated

no fever, nausea or sys issues

no oozing or discharge

no urinary issues

good oral intake

-also review of mgt plan & TCA

doing well on physio & podiatrist supportive tt

symptoms improving

Examination:

General:

BP (sitting): 137/76

Pulse: 75 Regular

Temperature: 36.7

Hydration: Not dehydrated

Not clinically anaemic. No jaundice.

Gastrointestinal:

No abdominal tenderness.

No guarding. No rigidity. No rebound. No distension. Normal bowel sounds.

Genito-urinary:

No loin tenderness

-anal exam: after pt consented & chaperone offered:

No active bleeding

No oozing or discharge

No anal fissure, fistula or sinus

No skin tag or perianal haematoma

Diagnosis:

Haemorrhoids

Reason for visit:

Haemorrhoids

Review of GPMP & TCA

Actions:

Patient Education leaflet 'Haemorrhoids' printed.

Prescription printed: Scheriproct 1.3 mg; 1 mg Suppository Apply. Twice a day.

As directed.

Letter printed.

Letter written re. Medical certificate.

counselled about Haemorrhoids & necessary measures

meds use & s/e discussed

preventive measures advised

dietary & lifestyle measures discussed

short & long term mgt explained

warning signs given with actions if it happens

follow up agreed

- mgt plan & TCA reviewed with pt

goals reiterated

Review interval:

Review in 1 day.”

There was considerable disparity between the matters asserted by the Defendant in his statement or in his oral evidence (or both) and the content of the clinical note. The note did not contain a number of matters that the Defendant nevertheless maintained were discussed and communicated during the consultation. A summary of those is as follows:

the Defendant says that he made a positive finding of a haemorrhoid resembling a bulging dilated vein close to the anal verge. This was not in the clinical note. There is no reference to a “visualised prolapsing haemorrhoid” as pleaded at par 28(a)(ii) of the Defence;

the Defendant stated that he recommended a digital rectal examination, which was refused. The clinical note records that the Plaintiff was offered a chaperone and consented to an anal examination, but not the offer of a digital rectal examination or its refusal. The Defendant conceded that this (i.e. a refusal) would “usually” be recorded;

the Defendant stated that the Plaintiff told him that he felt a “lump” coming out on defecation, which shrank (or disappeared) afterwards. This was absent from the Defendant’s statement and the clinical note;

the Defendant stated that he asked whether the Plaintiff had any family history of bowel cancer, and that the Plaintiff answered that he had none. This is not recorded anywhere in the clinical note. This is relevant to the second pillar of the s 50 opinion at par 28(a)(ii) of the Defence;

the Defendant said that he asked the Plaintiff how long the bleeding had been present and was told one day. In the clinical note, however, the descriptor “1/7” attaches to the haemorrhoid. The Defendant accepted, during cross-examination, that the question of how long the bleeding had been occurring was fundamental;

the Defendant stated that he had asked the Plaintiff about the date of his previous haemorrhoids, but the Plaintiff was uncertain about the time. This is not recorded in the clinical note;

the Defendant’s statement records the Plaintiff telling him that he had the urge to defecate but could not. Nothing about urgency is recorded in the clinical note;

the Defendant said that the Plaintiff described his stool as harder than usual. This is not recorded in the clinical note;

the clinical note does not record the emergency department advice pleaded at par 28(a)(vii) of the Defence. It records “warning signs given with actions if it happens”;

during cross-examination, the Defendant identified polyps, inflammatory bowel disease and colorectal cancer as differential diagnoses where there is a longer history of the Plaintiff's symptoms. The clinical note records only haemorrhoids, and then as a formal, rather than provisional, diagnosis; and

the Defendant stated that he drew a diagram of the position of the haemorrhoid on the education sheet. No copy of any annotated sheet appears in the material.

The Defendant's credibility and reliability

Before dealing with these matters, I must first consider the character of the Defendant's recollection. I do not accept that he had any independent recollection of the August 2022 Consultation. Rather, I find that he was wholly reliant upon his clinical note. He used that clinical note to reconstruct, rather than recollect, his evidence of the August 2022 Consultation.

The Defendant was asked in cross-examination whether he had a recollection of the August 2022 Consultation. He responded:

"I remember the day, but I cannot remember like, every single detail. But I – when I go to my notes, I definitely remember what I did and what happened on the day."

He stated that everything in his consultation with the Plaintiff was put into his notes, "so I when I go to the notes, I remember the conversation". This was repeated a number of times.

Furthermore, when asked if he remembered the Plaintiff when he received the Statement of Claim, the Defendant said that he had to go to the file to have any recollection.

The Defendant was confronted directly by Counsel with the proposition that he was not telling the truth and that he was reconstructing his recollection from his notes. He responded:

"I reject that. Whatever I remember, I tell the truth, and that's what is in the notes."

When asked whether he had asked the Plaintiff how long he had been affected by constipation, the Defendant said "[the Plaintiff] told me one day... if he had told me something different, I would have been putting that on- in the notes." When asked whether the position of the haemorrhoid was recorded anywhere else in the practice records, the Defendant responded, "everything that happened on the consultation" is in the note. However, the Defendant accepted that, whilst the position of a haemorrhoid is "regularly" recorded, that information does not appear in the clinical note.

If the Defendant is correct that "everything that happened" is in the clinical note, it logically must follow that nothing of significance said during the appointment was absent from his notes. However, there were matters contained in his witness statement that were not included in those clinical notes and appeared after several years and many thousands of intervening consultations.

That is not in itself cause for criticism. The Defendant was, and remains, a busy GP. He estimated that he would have had 10,000 or more consultations between the single consultation he had with the Plaintiff on 23 August 2022 and the date he prepared his statement. One reason clinical notes are taken is so that vital patient information is recorded and not forgotten, which it otherwise would be owing to the high-volume nature of a family general practice.

The clinical note is almost entirely in the negative. It records few positive findings. Either the note is an incomplete record of a positive finding, or there was no positive finding to record and the diagnosis of haemorrhoids was made from the history the Defendant believed he had been given.

For those reasons, where there is disconformity between the clinical note and the Defendant's own statement or oral evidence, I will prefer the clinical note. I will only accept the Defendant's witness statement or oral testimony where it is consistent with the clinical notes.

There was nothing unusually memorable about this consultation. The Defendant's claim to recall this consultation, so many years later, with so many intervening consultations, stretches credulity. The consultation was for a haemorrhoid, which the expert evidence established is a common complaint. I found the Defendant's dogmatic rejection of the proposition that he was engaging in reconstruction to be hollow. That is not to say that he set out to mislead the Court. His reconstruction was from his usual practice, not a deliberately invented story.

Defendant's concessions of general principle

It is also important to note that the Defendant made certain concessions of principle during his cross-examination. The significance of those concessions turns on other factual findings I must make to resolve this matter. The Defendant's concessions are as follows:

a reported history of bleeding extending beyond one day would definitely have changed the Defendant's concerns and required consideration of a differential diagnosis other than haemorrhoids;

the question of "how long have you been bleeding for" is a fundamental question to ask a patient presenting with bleeding from the anus;

a history of blood for five or six months would be of concern, as would a history of needing to defecate with nothing passing;

bloating and constipation, taken together with bleeding and the urge to defecate, would be of concern. Investigation would require referral to a specialist with a view to colonoscopy, which is "the only way to really determine or exclude colorectal cancer". Such a referral would be made "pretty urgently"; and

it was "very, very important" for the Defendant, seeing the Plaintiff for the first time, to explore how long the symptoms had been going on.

Findings of fact in relation to the August 2022 Consultation

Duration of the Plaintiff's symptoms

The clinical notes taken by the Defendant contain the expression "1/7", which the Defendant stated meant that the Plaintiff had informed him that his symptoms had occurred for one day.

There is support for this from the Plaintiff himself. As I have already said, the Plaintiff said that he thought it could be a haemorrhoid.

I am not persuaded that the clinical note establishes that the symptoms from which the Plaintiff suffered were communicated as being for one day only. The clinical note is not written in such a way as to suggest that. The notation "1/7" appears once only, after the word "haemorrhoid". Read literally, the note records a one-day history of a haemorrhoid, which is what the Plaintiff conceded in cross-examination, and which he may himself have volunteered. I do not read it as recording a one-day history of bleeding, of painful defecation or of constipation.

Haemorrhoid history

While the Defendant's clinical notation indicates that the Plaintiff had a history of haemorrhoids, the Plaintiff denies providing any such history. The Plaintiff was asked about it on three occasions and firmly denied it each time. The Plaintiff submits that, absent an adverse credit finding, it should be accepted that the Defendant's note was incorrect. Despite a "thorough search" via subpoenas, the Plaintiff submits no clinical records of haemorrhoids have been found.

The Defendant maintained that the Plaintiff had informed him that he had had haemorrhoids previously. This was explored further in cross-examination:

Q. Did you ask him how long or when he'd had the previous haemorrhoids?

A. Yes.

Q. Do you recall what he said?

A. No. He was uncertain about the time.

Q. Do you remember that?

A. Yes. Otherwise, I would have put it in the notes.

The Plaintiff and the Defendant were sharply divided on this issue.

This conflict is difficult to resolve. Ultimately, I accept that there was some discussion of previous haemorrhoids between the Plaintiff and Defendant. It would otherwise be difficult to understand why the Defendant recorded "PH of haemorrhoids previously / never operated" in the clinical note. If the Plaintiff had informed the Defendant that he was uncertain about when he had haemorrhoids in the past, this could easily enough have been included in the clinical notes. It was not. It is possible that this was a miscommunication as well. I do not consider this specific issue to be of great overall significance.

Evidence concerning a digital rectal examination

The Defendant gave evidence that he offered to undertake a physical examination of the Plaintiff, including palpation of his abdomen and a digital rectal examination. However, he says, the Plaintiff was not keen to receive a digital rectal examination. When the Defendant was asked in cross-examination why the Plaintiff's declinature was not in the clinical notes, he replied, "it might not be on the notes, but I remember that I have offered him and he denied". The Defendant, during cross-examination, twice conceded that a declinature would ordinarily be recorded.

The Plaintiff had no recollection of any discussion about the need for a physical examination, about what such an examination would involve, and certainly no recollection of being offered one. The Plaintiff said that he had no problem with such an examination. Indeed, he said that he had anticipated it.

The Plaintiff's evidence is that, instead of being offered a digital examination, he was directed to lie on his side and pull his pants down, and the Defendant moved his right buttock "briefly" for a visual examination only.

It is open to me to find that the Defendant's recollection of his examination of the Plaintiff, contained in his statement, was based on his recitation of his standard practice rather than on any direct recollection. I do so find. I do not find that the Plaintiff declined a digital rectal examination. Rather, it was not raised by the Defendant. I consider the absence in the clinical note of any recording of a declinature by the Plaintiff to be determinative.

The reported protruding lump

There is no dispute that the Defendant did not perform a digital examination. The Defendant was cross-examined about what he was told by the Plaintiff as to his experience with the haemorrhoid when he went to the toilet.

The Defendant says that his visual examination revealed a haemorrhoid close to the anal verge. The haemorrhoid "looked like a bulging dilated vein". He says that he described it to the Plaintiff and drew its position on a handout. This was repeated during his cross-examination. The Plaintiff denied that the Defendant had described the haemorrhoid as looking like a bulging vein.

There is no record of a protruding lump in the Defendant's statement or the clinical note. The Plaintiff's evidence is that there was "nothing on the outside" and that he had checked repeatedly.

The Defendant's evidence is flatly inconsistent with his own statement. Where the Defendant explains why he did not perform a digital examination, he states that if the Plaintiff had reported suspecting a lump or growth, he would have regarded that as a strong indication of the need for a digital examination. The difficulty for the Defendant is that, according to his own oral evidence, the Plaintiff did report such a lump. On the terms of his own statement, the Defendant would have been obliged to perform a digital examination. He did not do so.

The Defendant's evidence on this matter, in addition to being contradictory and inconsistent, is also new. It has the character of a reconstruction, perhaps caused by the difficulty he encountered in that "haemorrhoid" is a diagnosis rather than a symptom. As he acknowledged, a diagnosis of external haemorrhoids requires some symptomatic foundation.

Urgency and tenesmus

In his statement, the Defendant recorded being told by the Plaintiff, "I feel slightly constipated, like I have the urge to go, but cannot". The clinical notes taken by the Defendant record only "slightly constipated". There is no record of any urge, of any failure to pass, or of the frequency of attempts. The Defendant accepted that a patient needing to defecate but failing to pass anything would be of concern, but disputed that this was tenesmus.

On the Defendant's own statement, the Plaintiff reported an urge to defecate which he could not satisfy. In his oral evidence, the Defendant interpreted his own note of "slightly constipated" as meaning the opposite: that the Plaintiff was attending the lavatory less frequently than usual, with harder stool. These are different matters. This bears on the adequacy of the record and raises a question as to whether the Defendant in fact appreciated the symptom that the Plaintiff says he described.

Length of the consultation

The Defendant testified that he considered the consultation was a "long consultation", that is, between 20 and 40 minutes. In his statement, he considered that the appointment length was approximately 39 minutes, commencing at 12.58 pm. The Defendant claimed to be confident of this because it was his usual practice to open the patient file only once the patient was present in the consulting room and the file was opened at 12.58 pm.

Counsel for the Plaintiff suggested to the Defendant that, because the practice receptionist accessed the file at 1.19 pm, and entries for "RX wizard" and "C prescriptions page" appear at about 1.34 to 1.36 pm, the consultation went for less than 20 minutes, that is, that it started at 1.19 pm and ended at 1.39 pm.

The Plaintiff sent messages to his wife at 1.02 pm and 1.08 pm, with the message recording the outcome of the consultation, set out at [55] above, sent at 1.39 pm. The Defendant had no recollection of the Plaintiff sending messages during the consultation. I add that the content of those messages does not read as that of a man who is in the middle of a consultation with a doctor.

Ultimately, this issue is not of great consequence. However, I am not persuaded that the consultation lasted for less than 20 minutes. Equally, I do not accept that the consultation commenced at 12.58 pm. Rather, I consider that it commenced some time after 1.08 pm and concluded at around 1.34 pm. In any event, I am satisfied that the consultation went for about 25 minutes.

Whether the Plaintiff was told to return the next day

This is, particularly in light of Professor Garne's evidence (discussed below), an important issue. In his statement, the Defendant stated that he said to the Plaintiff:

"Take this home and read through it. It explains the features of haemorrhoids, the treatment, and that bleeding may sometime be explained by some other condition. If your symptoms persist, come back and see me, or if you would prefer, your usual doctor, Dr Etemad. I would like to review you tomorrow. If you suffer a sudden onset of bleeding, severe constipation or pain, or sudden weight loss, go to the emergency department of your nearest hospital, which would be Campbelltown Hospital ED. Here is my card if you wish to see me."

The clinical note is consistent with that passage. Under the heading "review interval" appears the entry "review in 1 day". The words "follow up agreed" also appear in the clinical note. These entries are contemporaneous and unambiguous. They provide a strong documentary answer to the Plaintiff's evidence, which started as a positive denial that he was ever told to return the next day but gradually turned into a concession that he may have been told to do so if his symptoms persisted.

The clinical note satisfies me that the Defendant did tell the Plaintiff to return the next day if his symptoms persisted.

Findings

Based on the above, I make the following findings:

during the consultation, the Plaintiff informed the Defendant of the symptoms that he was experiencing, including rectal bleeding urgency without passing, bloating, abdominal pain and pain on defecation;

I reject the Plaintiff's evidence that he made no mention of a history of haemorrhoids. I prefer the clinical note. It would have been strange for the Defendant to record entries concerning a history of haemorrhoids if the Plaintiff had not said anything of that nature;

I do not accept that the Defendant actually identified, by visual examination, the existence of a haemorrhoid. It follows that I do not accept that the Defendant drew a diagram which recorded the haemorrhoid's location and provided a copy of that diagram to the Plaintiff. No such diagram appears in the clinical note;

I do not consider that the Plaintiff informed the Defendant that his symptoms of rectal bleeding or urgency were limited to one day. The shorthand notation "1/7" was recorded against the haemorrhoid only;

I find that the Defendant did not seek to probe the Plaintiff with questions concerning the history of his rectal bleeding or sense of urgency in order to determine whether the bleeding was long-standing or the urgency constituted tenesmus;

I find that the Defendant did not offer to perform a digital examination;

I find that the Defendant told the Plaintiff to return the next day if his symptoms persisted;

I consider that the consultation focused on the haemorrhoid to the exclusion of the other symptoms communicated by the Plaintiff to the Defendant. The Defendant functionally ignored those symptoms. This is consistent with the Plaintiff emerging from the consultation with prescriptions for haemorrhoid treatments and an informative pamphlet on haemorrhoids; and the consultation lasted for approximately 25 minutes.

The evidence of Dr Etemad

None of Dr Etemad's consultations with the Plaintiff before the August 2022 Consultation concerned the symptoms with which the Plaintiff presented to the Defendant.

The Plaintiff's 8 October 2023 consultation with Dr Etemad was pivotal. The Plaintiff attended for the purpose of obtaining another script for haemorrhoid cream. During that consultation, the following occurred:

Dr Etemad asked the Plaintiff who had prescribed the medication and whether he had seen a specialist;

before writing the script, Dr Etemad went back through the clinical records, including those of the 23 August 2022 consultation;

Dr Etemad took a full history. The Plaintiff reported to her that he had experienced 5–10 ccs of rectal bleeding a few times a week for around 12 months;

Dr Etemad recorded several negatives: no pain on defecation, blood on toilet paper only (i.e. not mixed with stool), no diarrhoea, no abdominal pain, no constipation, no family history of bowel cancer or inflammatory bowel disease, no weight loss, no night sweats;

Dr Etemad offered a differential diagnosis of internal haemorrhoid, polyp, inflammatory bowel disease and cancer; and

Dr Etemad referred the Plaintiff to Dr Hamilton.

Dr Etemad had reason to doubt the haemorrhoid diagnosis. The Plaintiff reported that no haemorrhoid was visible or otherwise apparent to him. However, a haemorrhoid that bled at such a high rate over such a long time should have been visible to the Plaintiff. That, together with the 12-month history of bleeding, led her to conclude that the Plaintiff should be reviewed by a specialist. Although Dr Etemad provided the Plaintiff with the haemorrhoid script he sought, it was for symptomatic relief only. She continued to prescribe the medication even after the Plaintiff was diagnosed with cancer.

In her oral evidence, Dr Etemad stated that, at the 8 October 2023 consultation, cancer was “the least likely diagnosis” given the Plaintiff’s age, family history and absence of alarming features. She added that this accorded with the relevant guidelines. However, Dr Etemad added that cancer “was definitely in the back of [her] mind” and was part of her reason for referring the Plaintiff to Dr Hamilton.

22 February 2024 consultation with Dr Etemad

As at 22 February 2024, the Plaintiff was still bleeding and had not made his appointment with Dr Hamilton. He had developed a new symptom, the sensation of pressure in his anal area. Dr Etemad’s evidence was that this new symptom made her consider cancer as likely, or at least one of the more probable diagnoses. She advised the Plaintiff to book with Dr Hamilton “ASAP” because a colonoscopy would be needed to determine the cause of the Plaintiff’s symptoms. She also encouraged the Plaintiff to contact her if he had trouble obtaining an appointment. She performed no rectal examination of any kind and made no diagnosis.

I pause to note that the Plaintiff contends that the Defendant ought to have referred him for a colonoscopy. During cross-examination, Dr Etemad confirmed that a GP cannot directly refer a patient for colonoscopy. Instead, a GP refers a patient to, relevantly, a colorectal surgeon or gastroenterologist who then completes the colonoscopy.

Dr Etemad chose Dr Hamilton because he had recently set himself up in the area and was likely to be available without an extended waiting period. The fact that Dr Hamilton worked in the public health system was also significant, as the Plaintiff was without private health insurance. Any colonoscopy would be booked with Campbelltown Hospital. Dr Etemad expected an appointment with Dr Hamilton would occur within two to four weeks of the October 2023 referral. She was certain that, unless Dr Hamilton was on leave, he would have been available for an appointment with the Plaintiff during that period.

The delay between an appointment with a specialist and a colonoscopy depends on how serious the specialist considers the patient’s presentation to be. The delay can be as short as a month, or, at Campbelltown Hospital, as long as 12 months. Dr Etemad recalled that Dr Hamilton considered the Plaintiff’s presentation to be serious. The estimated wait time was one month.

Dr Etemad gave evidence via audio-visual link. I found her to be a scrupulously honest witness who was attentive to the questions put to her. Dr Etemad did her best to assist the Court.

When presented with the Plaintiff’s history in October 2023, she did not accept the haemorrhoid diagnosis at face value. Although she did have an additional 12 months of reported history which was not available to the Defendant, her approach to the Plaintiff is a real-world benchmark.

The expert general practitioners

The Plaintiff's expert GP was Dr Dianne Chambers. The Defendant's was Professor Garne. Both provided separate reports and later produced a joint report after attending a conclave. They gave concurrent evidence at the hearing.

While I have considered their individual and joint reports, I found their oral evidence most enlightening. Although it sharpened their areas of disagreement, it showed their areas of agreement to an even greater extent.

The GP experts did not, in substance, disagree about the standard of care. Their differences stemmed from the assumptions they were each asked to make. The contest between these experts therefore turns on questions of fact.

Dr Chambers' opinion was that the Plaintiff's symptoms could not plausibly have arisen in a single day. Nor, in her opinion, could they be explained by haemorrhoids. Dr Chambers concluded that a reasonable practitioner would have probed the Plaintiff for further information.

Dr Chambers' evidence is that she would have asked detailed and open-ended questions, including "how long has this gone on?", "have you had anything like this before?", and additional questions regarding the duration of the urgency. Upon receiving that information, the Plaintiff should have been referred to a specialist.

Professor Garne's opinion was that the Defendant acted reasonably based on the history provided by the Plaintiff. Professor Garne accepted that the Plaintiff's symptoms called for inquiry as to their duration, that the urgency the Plaintiff described was tenesmus (which is not a feature of uncomplicated haemorrhoids), and that taking a longer history would have altered his approach.

Professor Garne said that he would have asked about the duration of the bleeding, the quantity and colour of the blood as well as the site, nature, severity and modifiers of the pain. He described these as "standard questions". He agreed that the urgency feature alone would require further inquiry into how long it had been present and that history-taking is a dialogue in which the medical practitioner explores what he is told.

None of these matters were recorded in the Defendant's clinical note. Professor Garne's answer to that absence was that they may not have been recorded, but, nevertheless, "I'm assuming [the Defendant] would have asked". The basis for that assumption is unclear. In any event, I have already found that the Defendant did not ask further questions.

The following propositions were accepted by both GP experts:

if a haemorrhoid had been seen by the Defendant, it should have been recorded;

the account given by the Plaintiff called for further inquiry from the Defendant, including as to duration;

urgency of the kind described by the Plaintiff is tenesmus, which is not a feature of uncomplicated haemorrhoids;

patients often self-diagnose. A doctor taking a history should look beyond any self-diagnosis; and a 39-year-old man was generally low-risk in 2022 and rectal bleeding can be caused by many things other than cancer.

Whether a haemorrhoid was visualised

The experts were divided as to whether the Defendant actually saw a haemorrhoid. Professor Garne stated that the Plaintiff had an obvious external haemorrhoid which was at least grade 3. Because of that external haemorrhoid and the reported one-day duration of the symptoms, Professor Garne did not consider that a referral to a specialist was required on the day of the consultation.

My findings preclude Professor Garne's opinion that everything was pointing towards the Plaintiff suffering a grade 3 haemorrhoid. Professor Garne twice acknowledged that the finding was not in the notes. He concluded that the Defendant should have recorded such an observation but did not. In this regard, I prefer Dr Chambers' inferential argument: a note which meticulously records itemised negatives on inspection cannot sensibly be read as having omitted a single positive finding of a grade 3 haemorrhoid.

It should further be noted that:

Dr Hamilton advised the Plaintiff there was no evidence of haemorrhoids at the colonoscopy and both Professor Garne and Dr Chambers considered it unlikely that a grade 3 haemorrhoid would disappear within 18 months;

Dr Sethi considered that such a haemorrhoid was probably never there to begin with and was misdiagnosed; and

Associate Professor Ho and Dr Sethi agreed that haemorrhoids alone would not explain faecal urgency and Dr Chambers endorsed this position during the hearing.

The expert GP evidence provides further support for my earlier finding that the Defendant did not see a haemorrhoid. While the colonoscopy found that the Plaintiff had cancer, the results were "otherwise normal". When asked whether it was likely that a prolapsed grade 3 haemorrhoid could effectively disappear within 18 months, Professor Garne said "[n]ot necessarily" if the Plaintiff stopped doing physical activity. However, the Plaintiff continued to both work as a personal trainer and play OzTag up until he was diagnosed with cancer. There is no suggestion in the evidence that he ceased physical activity.

Professor Garne's own statement that patients under 40 presenting with rectal bleeding warrant referral for further investigation where there is a family history or the presence of other symptoms is consistent with my findings. Professor Garne accepted that urgency is one such "other symptom". Based upon Professor Garne's criteria, and without recourse to Dr Chambers' material at all, referral for investigation was indicated notwithstanding the Plaintiff's age.

The consequence of my finding that the Defendant did not see a haemorrhoid is that the two opinions of the GP experts effectively converge. This was confirmed by Professor Garne, who stated, "I agree with Dr Chambers if we assume the assumptions that she has been given". I prefer the evidence and conclusions of Dr Chambers to those of Professor Garne principally because I am satisfied that the assumptions made by Dr Chambers, which informs her view that the Defendant conducted himself below the appropriate standard of care, are made out.

Duty of care

There are several categories of relationships in which the law recognises that a duty of care exists. A plaintiff is generally able to establish the existence of a duty of care if the relationship at issue falls within one of those categories: *St Paul's College Ltd v Allan* [2026] NSWCA 22 at [42] (Kirk JA, Payne JA and Price AJA agreeing). The parties here agree that the Defendant, being a medical professional, owed the Plaintiff a duty of care.

The duty of care owed by a medical practitioner is to exercise reasonable care and skill in the provision of treatment and professional advice. That duty extends to, relevantly, the examination, diagnosis and treatment of the patient: *Rogers v Whitaker* (1992) 175 CLR 479; [1992] HCA 58 (Whitaker) at 483 [5]. The standard of care required in this case is that of the ordinary skilled person exercising and professing to have that skill: *Whitaker* at 487 [12].

Section 50: The standard of care and peer professional opinion

In answer to the claim, the Defendant relies on s 50 of the CLA in respect of "all material aspects" of the Defendant's management and care of the Plaintiff. As the provision contains a different standard of care against which an alleged breach of duty is to be assessed, it ought to be considered before turning to breach and causation: *Dean v Pope* (2022) 110 NSWLR 398; [2022] NSWCA 260 at [258], [260] and [273]–[274].

That provision is as follows:

50 Standard of care for professionals

- (1) A person practising a profession ("a professional") does not incur a liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice.

- (2) However, peer professional opinion cannot be relied on for the purposes of this section if the court considers that the opinion is irrational.
- (3) The fact that there are differing peer professional opinions widely accepted in Australia concerning a matter does not prevent any one or more (or all) of those opinions being relied on for the purposes of this section.
- (4) Peer professional opinion does not have to be universally accepted to be considered widely accepted.

The Defendant particularised his s 50 plea as follows:

“(a) The Defendant relies on the expert opinion of [Professor] Garne, general practitioner, who considered... that in relation to the consultation on 23 August 2022, the Defendant:

- (i) acted reasonably in his assessment, history taking and examination of the Plaintiff;
- (ii) acted reasonably in diagnosing the Plaintiff with haemorrhoids given the age of the Plaintiff in August 2022 (39 years), the lack of family history of colorectal cancer, his previous history of haemorrhoids, the short duration of his symptoms of pain on defecation, the complaints of mild constipation and the fact that the Defendant visualised a prolapsing haemorrhoid;
- (iii) acted reasonably in all the advice he gave to the Plaintiff regarding the short and long-term management of his condition and the risks involved with his presentation;
- (iv) acted reasonably in not providing a referral for a colonoscopy to the Plaintiff given the history with which the Plaintiff presented and the findings on physical examination;
- (v) acted reasonably in not performing a digital rectal examination noting that the Plaintiff’s complaints of pain on defecation together with the finding on examination of a visible haemorrhoid were contraindications;
- (vi) acted reasonably in not performing a digital rectal examination without consent;
- (vii) acted reasonably in advising the Plaintiff to return the next day for a follow-up.”

By virtue of those particulars the Defendant claims he incurs no liability to the Plaintiff in negligence.

Applicable principles

Section 50 of the CLA operates as a defence in so far as it is a complete answer to a negligence claim under the CLA. Subject to the rationality requirement in subsection (2), the applicable standard of care is a matter for medical judgment, not the Court: *Dobler v Halverson* (2007) 70 NSWLR 151; [2007] NSWCA 335 at 166 [59] (Giles JA).

The Defendant bears the onus of establishing the preconditions in s 50 of the CLA. Those preconditions are, first, that the Defendant was practising in a profession and, secondly, that he was doing so in a manner that was widely accepted in Australia by peer professional opinion as competent professional practice.

Section 50(2): Rationality

The Plaintiff in this matter has not suggested that any peer professional opinion on which the Defendant relies is irrational for the purposes of s 50(2) of the CLA. I add that the fact that the parties' competing experts disagree does not cause any problems in this regard, as the peer professional opinion in question need only be widely, not universally, accepted: s 50(4) of the CLA.

Determination

Where s 50 of the CLA is made out, it supplants the analysis otherwise required by s 5B and there is no reason to require the evaluation of the professional's conduct against two separate standards: *South-Western Sydney Local Health District v Gould* (2018) 97 NSWLR 513; [2018] NSWCA 69 (Gould) at 539, 540 [127], [129] (Leeming JA, Basten and Meagher JJA agreeing). If those preconditions are not established, then ss 5B and 5C are to be applied: Gould at 539 [123].

While the Defendant submitted that Professor Garne's evidence was sufficient to establish that the Defendant's care of the Plaintiff met the standard of care of his peer practitioners and so satisfied the preconditions of s 50 of the CLA, I have found that his evidence was founded on incorrect assumptions. Accordingly, no peer professional opinion supports the Defendant's conduct at the August 2022 Consultation. The s 50 "defence" has not been made out. I will next consider s 5B of the CLA.

Breach of duty

Section 5B of the CLA provides as follows:

5B General principles

- (1) A person is not negligent in failing to take precautions against a risk of harm unless—
 - (a) the risk was foreseeable (that is, it is a risk of which the person knew or ought to have known), and
 - (b) the risk was not insignificant, and
 - (c) in the circumstances, a reasonable person in the person's position would have taken those precautions.
- (2) In determining whether a reasonable person would have taken precautions against a risk of harm, the court is to consider the following (amongst other relevant things)—
 - (a) the probability that the harm would occur if care were not taken,

- (b) the likely seriousness of the harm,
- (c) the burden of taking precautions to avoid the risk of harm,
- (d) the social utility of the activity that creates the risk of harm.

The risk of harm: identification and characterisation

Liability for negligence is dependent upon identification of the risk of harm against which a defendant is said to have failed to exercise reasonable care and skill: *Uniting Church in Australia Property Trust (NSW) v Miller; Miller v Lithgow City Council* [2015] NSWCA 320 at [101] (Leeming JA, Basten and Simpson JJA agreeing).

The risk of harm identified in the Amended Statement of Claim is as follows:

“The risk of harm to the Plaintiff was a delay in diagnosis of his rectal cancer. This delay leading to the progression of the staging of his cancer, requirement for more extensive treatment and loss of life expectancy.”

The Plaintiff must therefore prove that the Defendant failed to provide the requisite standard of care to the Plaintiff at the August 2022 Consultation, that the failure led to a delay in diagnosis, the length of that delay, that the delay occasioned more extensive treatment, that the Plaintiff’s life expectancy has been reduced, and the amount of that reduction.

The Defendant submits that the Plaintiff cannot establish a material failure to provide an acceptable standard of care to the Plaintiff.

Sections 5B(1)(a) and (b): Foreseeability and significance

The Plaintiff must satisfy me that the Defendant, at the consultation on 23 August 2022, either knew of the pleaded risk or ought to have known it: *Bencic v State of New South Wales* [2010] NSWSC 1039 at [90]–[92] (Garling J).

The term “not insignificant” for the purposes of s 5B(1)(b) of the CLA has been held to be more demanding than the common law test of the risk being real and not far-fetched or fanciful, but “not by very much”: *Lederer Group Pty Ltd v Hodson* [2024] NSWCA 303 at [195] (Ward P, Leeming JA and Basten AJA agreeing).

As to proof, the decision of *West v Government Insurance Office of NSW* (1981) 148 CLR 62; [1981] HCA 38, which predates the CLA, illustrates the Plaintiff’s task in satisfying the Court. The Court observed at [9] the following:

“It is well to recall what was said by Dixon C.J. in Jones v. Dunkel [1959] HCA 8; (1959) 101 CLR 298, at pp 304-305 where he said:

‘In an action of negligence for death or personal injuries the plaintiff must fail unless he offers evidence supporting some positive inference implying negligence and it must be an inference which arises as an affirmative conclusion from the circumstances proved in evidence and one which they establish to the reasonable satisfaction of a judicial mind.’

His Honour went on to say that the law ‘does not authorise a court to choose between guesses, where the possibilities are not unlimited, on the ground that one guess seems more likely than another or the others. The facts proved must form a reasonable basis for a definite conclusion affirmatively drawn of the truth of which the tribunal of fact may reasonably be satisfied’ and see also *T.N.T. Management Pty. Ltd. v. Brooks* (1979) 53 ALJR 267, at p 269 per Gibbs J. (at p66)”

In *Derrick v Cheung* [2001] HCA 48 at [13], the Court held:

“Few occurrences in human affairs, in retrospect, can be seen to have been, in absolute terms, inevitable. Different conduct on the part of those involved in them almost always would have produced a different result. But the possibility of a different result is not the issue and does not represent the proper test for negligence. That test remains whether the plaintiff has proved that the defendant, who owed a duty of care, has not acted in accordance with reasonable care.”

In considering foreseeability, the Court must have regard to the context in which a risk, or risks, were assessed: *Rosenberg v Percival* (2001) 205 CLR 434; [2001] HCA 18 at 441–442 [16] (Gleeson CJ). It is especially important to apply the proper standards of objectivity and impartiality where, as here, the consequences of alleged negligence are said to be devastating: *Trustees of the Roman Catholic Church for the Archdiocese of Sydney v Kondrajian* [2001] NSWCA 308 at [64].

Sections 5B(1)(c) and (2): The response of a reasonable person

The question with respect to s 5B(1)(c) of the CLA is whether a reasonable person in the Defendant’s position would have taken the precautions pleaded by the Plaintiff. Those pleaded precautions are set out in full below.

Subsections 5B(2)(a)–(d) contain mandatory considerations to be borne in mind in determining that question. However, as the words “amongst other relevant things” in the subsection show, those considerations are not exhaustive: *Venues NSW v Kane* [2023] NSWCA 192 at [62] (Leeming JA, Adamson JA and Simpson AJA agreeing).

Section 5C of the CLA provides as follows:

5C Other principles

In proceedings relating to liability for negligence—

- (a) the burden of taking precautions to avoid a risk of harm includes the burden of taking precautions to avoid similar risks of harm for which the person may be responsible, and
- (b) the fact that a risk of harm could have been avoided by doing something in a different way does not of itself give rise to or affect liability for the way in which the thing was done, and

- (c) the subsequent taking of action that would (had the action been taken earlier) have avoided a risk of harm does not of itself give rise to or affect liability in respect of the risk and does not of itself constitute an admission of liability in connection with the risk.

The pleaded precautions

The Plaintiff claims that a reasonable and competent person in the Defendant's position would have taken the following precautions at the August 2022 Consultation:

performed a comprehensive assessment in view of the Plaintiff presenting with a new symptom;
considered that rectal bleeding can be the first warning of other bowel disease such as cancer;
followed the standard diagnostic route, history taking, examination and investigation;
taken a history of the bleeding and its frequency or persistence;
properly considered and investigated the cause of the pain;
considered blood at the end of defecation significant and a red flag;
informed the Plaintiff that the history he gave was not consistent with a diagnosis of simple haemorrhoids;
not made a diagnosis of haemorrhoids when it was not indicated;
referred the Plaintiff for a proctoscopy, sigmoidoscopy or colonoscopy;
advised the Plaintiff that one of those tests should be performed on a semi-urgent basis; and
set a follow-up on the relevant medical software.

Beyond the date of the consultation, the particulars of precautions that a reasonable and competent person in the Defendant's position would have taken are:

informed the Plaintiff that rectal bleeding can be the first sign of bowel cancer;
ensured that necessary tests were performed in a timely fashion;
not caused a delay in diagnosis;
not caused perforation;
not caused recurrent disease;
treated the Plaintiff with due care and skill; and
treated the Plaintiff with a reasonable standard of care.

Findings on the particulars of negligence

Dr Chambers evidence satisfies me that the Defendant was negligent at the August 2022 Consultation. Not only do I prefer Dr Chambers' evidence, I observe the following:

the Defendant conceded that an enquiry as to how long a patient had been experiencing rectal bleeding was a fundamental question to ask. I find no evidence to support a finding that this was asked. I find that it was not asked;

the Defendant also accepted that bloating and constipation, taken together with bleeding and an urge to defecate, would be of concern (noting the contradictory nature of constipation versus tenesmus);

there is nothing to indicate that anything other than a haemorrhoid was discussed at the August 2022 Consultation. The other concerning symptoms were either ignored even though they had no connection with the presentation of a haemorrhoid;

both expert GPs agreed that the account given by the Plaintiff called for further enquiry from the Defendant; and

urgency is not a feature of haemorrhoids.

For those reasons, I find that the Defendant failed to take the particulars set forth at [168]–[169] above.

I find that the risk of harm was that a serious cause of the Plaintiff's symptoms, including colorectal cancer, would not be diagnosed and that the delay in diagnosis would delay treatment.

That risk was foreseeable. The Defendant knew, or ought to have known of the risk. His concessions at [93] above and the pamphlet he handed the Plaintiff show as much.

The risk of harm to the Plaintiff in failing properly to probe the Plaintiff's symptoms and, thereafter, to refer him for specialist consultation, was foreseeable, not insignificant, and was a precaution that the Defendant should have taken. Although the oncology experts agreed that cancer is found only in around 10% of patients investigated for rectal bleeding (and the Plaintiff was 39), rectal bleeding along with tenesmus required investigation.

As to s 5B(2) of the CLA, I find that the probability of harm, while low, was real and grave. The burden of precautions was slight, as the Defendant need only have asked additional questions and, upon receiving the answers, written a referral letter. The matters in s 5C of the CLA do not affect my conclusions.

In arriving at this conclusion, I have not merely accepted the evidence of Dr Chambers, but also the propositions accepted by the GP experts at [138] above.

The expert oncologists

The Plaintiff's expert oncologist was Associate Professor Pendlebury. The Defendant's was Professor Clarke. Associate Professor Pendlebury provided three reports, while Professor Clarke produced a single report. They later produced a joint report after attending a conclave. They gave concurrent evidence at the hearing.

The academic literature

The Plaintiff tendered several articles to which Associate Professor Pendlebury had referred in her reports. Those articles were not discussed at great length, indeed there was minimal discussion of them at all, nor were submissions devoted to them. Having considered each of the articles in question, I note that they do not address the same legal issues. Some go to breach, others causation. Moreover, they do not share similar subject matter. One article, "Rate of growth of untreated colorectal tumours" (2020) 4 (6) BJS 1200 is directed towards the consequences of delay in diagnosis. Another, "Diagnostic Yield of Colonoscopy by Presenting Symptom" (2008) 43 Scandinavian Journal of Gastroenterology 356 concerns the presentation of symptoms and the circumstances in which a colonoscopy would be undertaken. Some of them are derived from small sample sizes, while others are not current owing to rapid developments in treatment over the last five years.

The articles are of little assistance. I have instead placed greater weight on the opinions expressed by Professor Clarke and Associate Professor Pendlebury in their reports and oral evidence.

Professor Clarke considered the Plaintiff's cancer to be slow growing and that it was stage 3 at all possible times, even at the time of the August 2022 Consultation. The Plaintiff submits that Professor Clarke provided no published growth rates to counter the publications upon which Associate Professor Pendlebury relied. When asked, during cross-examination, about the absence of cited literature concerning his opinions, Professor Clarke referred to an article "in [his] bag", which article was produced. The Plaintiff submitted that the article in question is confined to a study of advanced mucinous colorectal cancers. The Plaintiff, who submits that he did not have such a cancer as at the August 2022 Consultation, argues that the article is largely irrelevant. The Plaintiff concedes that the article may be relevant in so far as it relates to the Plaintiff's life expectancy. However, he maintains that it is irrelevant with respect to the expected growth rate of the Plaintiff's cancer. This article is discussed further below.

Discussion of Associate Professor Pendlebury's qualifications

In his report, Professor Clarke raised a question concerning Associate Professor Pendlebury's qualifications to give evidence about the cancer from which the Plaintiff suffers. Professor Clarke expressed surprise that Associate Professor Pendlebury offered opinions on what he described as a highly specialised area outside of their expertise. He questioned whether they had attended a colorectal multidisciplinary team or managed a patient with a mucinous rectal tumour. He

characterised Associate Professor Pendlebury as a breast cancer specialist and said that her comments were, of necessity, based on generic published information not supplemented by their own clinical experience. I note that Professor Clarke did not repeat that criticism during his oral evidence, nor was he asked, during cross-examination, whether he maintained it.

Associate Professor Pendlebury is a radiation oncologist who received her first consultant appointment in 1992. She spent approximately 10 years as a junior staff specialist at Royal Prince Alfred Hospital and had an academic association with the University of Sydney. Since 2005, she has been director of the Radiation Oncology Department at St Vincent's Hospital, Sydney and has an academic association with the University of New South Wales. For the past 10 years, she has been the Director of Radiation Oncology for the Tamworth Section of Hunter New England Health.

Associate Professor Pendlebury described her Tamworth practice as a large general oncology practice. She is effectively the sole practitioner covering a vast region which extends from the town of Scone in the Upper Hunter region to the Queensland border. Some of her patients come from Armidale, others from southern Queensland. At any given time, Associate Professor Pendlebury is treating two or three colorectal cancers. She treats over 100 cases of such cancers annually and has been published in Surgical Clinics of North America on anal cancer.

During the hearing, Associate Professor Pendlebury gave evidence that she runs a multidisciplinary team which liaises with the Royal Prince Alfred Hospital for complex cases. She has been an active member of colorectal multidisciplinary teams since 2005.

To my mind, Associate Professor Pendlebury's evidence that she treats over 100 cases of colorectal cancer annually is determinative. In that light, I consider Professor Clarke's criticisms to be unjustified and, further, that Associate Professor Pendlebury eloquently answered Professor Clarke's attack on her qualifications.

Areas of agreement

The expert oncologists agreed, or at least did not meaningfully disagree, on a number of matters. Those are as follows.

The biology of mucinous rectal cancer

Mucinous rectal cancers are an uncommon subtype. Professor Clarke stated that they make up approximately 10% of colorectal cancers. Associate Professor Pendlebury broadly agreed that the subtype is uncommon.

Mucinous rectal cancers respond less well to neoadjuvant chemotherapy and chemoradiotherapy than non-mucinous adenocarcinomas. Professor Clarke attributed this to paucicellularity: while most cytotoxic therapies are directed towards dividing cells, this subtype has fewer of those cells. Rather than metastasising, it generally recurs. The expert oncologists agreed that this is inherent to the biology of the cancer rather than a function of its "bulk" at presentation.

Diagnosis, pathology and staging as at May 2024

The expert oncologists agreed that the Plaintiff is suffering from primary rectal carcinoma, adenocarcinoma of the rectum, mucinous adenocarcinoma with signet ring cells present on biopsy. Signet ring cells are present but constitute less than 50% of the tumour such that it is not considered to be a signet ring cell carcinoma. It occupies the intermediate category of mucinous carcinoma with some signet ring cells.

They also agreed that the clinical stage of the cancer upon diagnosis in May 2024 was cT3N1M0, stage 3B. Surgical pathology after neoadjuvant therapy was ypT3 ypN2a. Four of eleven nodes were involved with margins of 6 mm distal and 0.8 mm radial. Lymphovascular invasion was present at the time of diagnosis. Further, the tumour responded poorly to neoadjuvant therapy. The February 2025 MRI showed poor response to chemoradiotherapy and there was a large volume of residual carcinoma at the point of resection.

Natural history and presence of the cancer

The cancer developed over a long period. Associate Professor Pendlebury estimated it to be between 6 and 10 years from the first abnormality, while Professor Clarke considered it to be between 5 and 8 years. It is uncontroversial that the cancer started as a polyp.

Definition of “locally advanced”

Associate Professor Pendlebury defined “locally advanced” cancers of this subtype as those that have perforated the bowel wall and/or involve lymph nodes. Associate Professor Pendlebury considered that the cancer would be described as “locally advanced” if it were T2 or T3, so long as nodes were involved. She regarded nodal involvement as significant. In this case, the cancer’s invasion of surrounding blood vessels in 2024 placed it within her definition of locally advanced. Professor Clarke accepted this definition as “pretty reasonable”, and noted that a large tumour with suspicious nodes would be regarded as locally advanced because of the preference for neoadjuvant therapy and the desire to avoid a permanent stoma.

Present condition

There is no dispute that the current state of the Plaintiff’s cancer is important in order to determine the nature, type and growth of the tumour at the time of the August 2022 Consultation. The Plaintiff’s disease is now stage 4 and is incurable. The Plaintiff’s permanent stoma is attributable to the recurrence of the cancer.

The expert oncologists’ disagreement

There are two key areas of disagreement between the oncology experts. The first is the stage of the Plaintiff’s cancer as at the August 2022 Consultation. The second is whether the outcome would have been different if the cancer had been diagnosed earlier than it was in May 2024. The first disagreement bears on the second.

The Plaintiff's tumour as at August 2022

In Associate Professor Pendlebury's opinion, the cancer would have been T2N0M0 stage 1 (i.e. present and invasive but not locally advanced) as at the time of the August 2022 Consultation. Professor Clarke's opinion is that the cancer was locally advanced (i.e. stage 3) at all possible time points, including August 2022.

If Associate Professor Pendlebury is correct that the cancer was significantly smaller, surgical treatment would likely have been sufficient. Ordinarily, neither radiotherapy, chemotherapy nor a stoma would have been necessary. In Professor Clarke's opinion, if he is correct that the cancer was at stage 3, the Plaintiff would have undergone the same treatment as was actually administered, namely, total neoadjuvant therapy with chemotherapy then chemoradiation before resection.

The concrete difference between their positions is whether, as at the August 2022 Consultation, the tumour had penetrated the bowel wall and/or involved regional lymph nodes. Associate Professor Pendlebury says neither. Professor Clarke says at least one, and probably both. They take different paths in arriving at their conclusions.

Both expert oncologists reason forwards and backwards from the available data, though they do not seem to agree on which sets of data are most valuable. Associate Professor Pendlebury reasons forwards from the negative examination findings and the interval during which the Plaintiff did not present to his doctor and backwards from population growth and delay data. Professor Clarke reasons forwards from the Plaintiff's symptomatology as at the August 2022 Consultation and backwards from the tumour's observed behaviour since diagnosis.

In her analysis, Associate Professor Pendlebury proceeded on the assumption that a rectal examination had been performed and revealed nothing. That error was corrected during cross-examination, when Mr Hutchings asked Associate Professor Pendlebury to proceed on the assumption that no internal examination had been performed. That change did not cause Associate Professor Pendlebury to change her opinion.

Associate Professor Pendlebury considers that, with diagnosis in 2022 or early 2023, the colostomy before commencing chemoradiotherapy would not have been required. Professor Clarke was more tentative. In his opinion, earlier diagnosis would only have probably reduced the likelihood of a permanent stoma.

Associate Professor Pendlebury considers that the cancer progressed to stage 3B by February 2023, though it would have been less "bulky" than when it was diagnosed in May 2024. By February 2023, treatment would have been total neoadjuvant therapy followed by surgery, but without a defunctioning colostomy before treatment and with a temporary diverting ileostomy at the time of surgery.

Professor Clarke considers that, by February 2023, the cancer would have been locally advanced, with significant local adenopathy and the same histology as was found upon diagnosis. He considers that it would have required the same treatment regime as was eventually administered.

Whilst the oncology experts seemingly agree that, by February 2023, the cancer had advanced, the dispute, as at that date, reduces to outcome: had the cancer been diagnosed in February 2023, would the cancer have perforated the bowel wall, would it have recurred, and would the Plaintiff have a temporary, rather than permanent, stoma.

Resolving the difference between these two highly experienced experts, each of whom I found to be a model witness, is a difficult and nuanced exercise.

Associate Professor Pendlebury's reasons for her opinion that the cancer was stage 1 as at the August 2022 Consultation are as follows:

the Plaintiff did not raise his symptoms with a GP for over a year after the August 2022 Consultation. Associate Professor Pendlebury would expect that a locally advanced cancer would produce constant symptoms over that time. It did not;

rectal bleeding is the most common indication for colonoscopy, and cancer is found in fewer than 10% of such cases. The Plaintiff's symptoms did not equate to a locally advanced cancer;

the mean interval for progression from T2 to T3 and T4 is in the order of 485 days. Working backwards from May 2024 places the cancer at T2 in August 2022;

only 4 of 11 nodes were involved even at the time of surgery in 2025. The risk of nodal involvement for a T2 high-grade cancer with lymphovascular invasion is 41.5%. On the balance of probabilities the nodes were not involved;

30 to 40% of mucinous carcinomas with signet ring cells present at stages 1 or 2, compared with under 10% for pure signet ring carcinoma. Nodal involvement is 50% in the former, and 75% in the latter. Early-stage presentation was accordingly a real possibility here; and

Professor Clarke's suggestion that the cancer was always stage 3 is nonsensical. It must have progressed from an earlier stage.

Professor Clarke's reasons for concluding that the Plaintiff's cancer was, as of the August 2022 Consultation, stage 3, are as follows:

tenesmus is an indicator of locally advanced disease. In his experience, it is uncommon for chronic tenesmus to be present in early rectal cancer. Since the Plaintiff had tenesmus in around September 2021, it is unlikely that the cancer was in an early stage;

the Plaintiff's need to sit on a ring cushion indicated whilst driving that the tumour was pressing on local nerves. Professor Clarke maintained this view even after it was pointed out to him that the Plaintiff first started using the ring cushion in September 2023, over a year after the August 2022 Consultation. He maintained that his conclusion was nevertheless supported by the continuing tenesmus and preceding 12 months of rectal bleeding;

Professor Clarke suspected that the Plaintiff did not mention his bowel issues at medical appointments or seek further advice because he was frightened by the symptoms. In this regard, Professor Clarke relied on the Plaintiff's text exchanges with Mrs Peterkin and on the history taken by Professor Fox (whose evidence is relevant to quantum, which I will not address in this judgment); and

the nodes were large both on MRI and at resection. Given the cancer's slow growth since diagnosis, they would already have been involved in August 2022.

Would an earlier diagnosis have led to a better outcome?

The Plaintiff maintains that, had the existing tumour been diagnosed shortly after the 23 August 2022 consultation, it would have been considerably smaller and could have been managed in a way that would have produced a better clinical outcome. The Defendant argues that, had he discovered the tumour during the consultation, it would have made no difference because the tumour was likely already large and would not have been receptive to treatment that would have led to a clinically better outcome.

Associate Professor Pendlebury's opinion is biological and clinical. Her reasoning is distilled as follows:

mucinous rectal cancers are generally high grade, meaning (relevantly) that the cancer's cells divide rapidly. The pathologist reported the tumour as poorly differentiated and high grade;

the post-operative course demonstrates that point. Surgery occurred in February 2025 and the tumour was found to have recurred by December 2025. The Plaintiff's cancer recurred at the anastomosis (the exact location where the ileostomy was reversed), which Associate Professor Pendlebury regarded as uncommon;

the Plaintiff suffered acute obstruction of his ureter within months of definitive surgery and required ureteric stenting weeks thereafter. Associate Professor Pendlebury considered that this is not the behaviour of an indolent disease;

the cancer recurring in the pelvis and peritoneum reflects the pattern of the subtype, not slow growth. Associate Professor Pendlebury observed that patients with mucinous cancers frequently die of bowel obstruction and intra-abdominal misadventure rather than metastatic disease. The absence of distant spread does not make the rapid recurrence within the abdomen any less significant;

increase in tumour volume is not one cancer cell secreting ever more mucin. Rather, the increased volume of mucin implies a commensurate increase in the volume of the cancer producing it; and

the tumour's failure to respond is due to the absence of an effective drug and also the efficacy of the tumour's resistance mechanisms, not slow cell division.

Professor Clarke considered that the tumour is indolent, or "low grade". I distil his reasoning as follows:

the Plaintiff remains alive even though the tumour has largely failed to respond to any treatment. The Plaintiff has lived well beyond the 14-month median survival time for mucin-secreting colorectal cancer;

a mucinous mass may be largely fluid,

"a bag full of liquid with cancer cells on the rim". The apparent volume of a mucinous mass may reflect mucin accumulation rather than cell division. A biopsy would show fewer cancer cells undergoing mitosis;

both chemotherapy and radiotherapy target cells which divide. The tumour's failure to respond to treatment is evidence that only a relatively small percentage of its cells are dividing;

aggressive colorectal cancers spread to the liver, lung, bone or brain. The Plaintiff's cancer has not;

during the conclave, Professor Clarke added that tumour growth, particularly in mucinous tumours, is Gompertzian, meaning that it slows down as the tumour becomes larger; and

a rapidly growing cancer causes problems over the course of months, whereas the Plaintiff's has caused problems over months to years.

In attempting to grapple with the size of the tumour as at the date of the Plaintiff's consultation with the Defendant, Associate Professor Pendlebury consulted published doubling times for primary colorectal cancer. The most rapidly growing such cancers double in size every 100 days, while the slowest double every 1,000 days. As Associate Professor Pendlebury regards the Plaintiff's tumour as a high-grade cancer, a fairly rapid doubling time of 211 days was adopted. Using the May 2024 dimensions (6 cm in length with a 15 mm depth of invasion), she worked backwards. She approached the question on the basis of a mean doubling time of 211 days, T stage progression in 78% of patients over a 150-day delay, and a mean time to progression from T2 to T3/T4 of 485 days. She considered that the rate of locally advanced disease at colonoscopy rises from approximately 0.6% at under six months to 1.2% at 10 to 12 months and 2.1% beyond 12 months. During her examination in Court, she referred to the medical literature on doubling times across a range of cancers, distinguishing the subclinical growth phase, the detectable and potentially alterable phase, and the late phase.

I note that, although Associate Professor Pendlebury initially stated that the delay between the August 2022 Consultation and diagnosis was 411 days, this was caused by an arithmetical error. The delay was in fact 644 days.

Professor Clarke disagreed with Associate Professor Pendlebury's conclusions. He emphasised that radiological doubling time measures two-dimensional size, which may not reflect what is happening at the cellular level. For this reason, he preferred the individual's natural history to a population model, saying that such a history means "[y]ou don't need estimated doubling times, you've got the person and you're seeing how it changes". He stated that applying the medical literature to an individual whose natural history is known "becomes a little bit irrelevant". In his opinion, if the tumour were doubling at the rate proposed by Associate Professor Pendlebury and were unresponsive to treatment, it would by now be "huge".

Professor Clarke did, however, accept that if there was a breach in the tumour while it was being surgically removed, cancer cells could spill into the abdomen and lead to local recurrence.

Findings

Each of these experts presents compelling arguments. For the following reasons, I prefer the opinion of Associate Professor Pendlebury.

First, there is force in Associate Professor Pendlebury's observation that the symptoms were not raised with the GP again for over a year after the August 2022 Consultation. Although Professor Clarke suspected that the Plaintiff, frightened by his symptoms, was being a "tough guy" and only intermittently reaching out, I do not consider that the evidence supports that suspicion. The Plaintiff's symptoms as at August 2022 were sufficient for him to consider it necessary urgently to consult a doctor. I see no reason why the Plaintiff would not have done so again if those symptoms had been recurring to the same extent. The Plaintiff's attendance at seven medical appointments for other ailments between the August 2022 Consultation and the 8 October 2023 consultation with Dr Etemad does not bespeak a man attempting to be a "tough guy". He had every opportunity of raising these matters in the subsequent visits to doctors.

Secondly, the Plaintiff started using the ring cushion about a year after the August 2022 Consultation. Professor Clarke's theory that the cancer was stage 3 at both times does not account for the change in symptoms which necessitated that cushion in September 2023.

Thirdly, I find Associate Professor Pendlebury's analysis of the involvement of nodes compelling. I do not consider that Professor Clarke undermined that analysis.

Finally, I struggle to see how Associate Professor Pendlebury could be wrong in arguing that it is nonsensical to suggest that the cancer was stage 3 at all relevant time points.

Accordingly, I prefer and accept Associate Professor Pendlebury's evidence that, at the August 2022 Consultation, the cancer was present and invasive but not locally advanced.

Causation

Loss is the gist of an action in negligence. A cause of action only crystallises if the breach of the duty of care caused loss: *Tabet v Gett* (2010) 240 CLR 537; [2010] HCA 12 (*Tabet*) at 577 [109] (*Kiefel J*).

The general principles with respect to causation are set out in s 5D of the CLA, which provides as follows:

5D General principles

- (1) A determination that negligence caused particular harm comprises the following elements—
 - (a) that the negligence was a necessary condition of the occurrence of the harm (“factual causation”), and
 - (b) that it is appropriate for the scope of the negligent person’s liability to extend to the harm so caused (“scope of liability”).
- (2) In determining in an exceptional case, in accordance with established principles, whether negligence that cannot be established as a necessary condition of the occurrence of harm should be accepted as establishing factual causation, the court is to consider (amongst other relevant things) whether or not and why responsibility for the harm should be imposed on the negligent party.
- (3) If it is relevant to the determination of factual causation to determine what the person who suffered harm would have done if the negligent person had not been negligent—
 - (a) the matter is to be determined subjectively in the light of all relevant circumstances, subject to paragraph (b), and
 - (b) any statement made by the person after suffering the harm about what he or she would have done is inadmissible except to the extent (if any) that the statement is against his or her interest.
- (4) For the purpose of determining the scope of liability, the court is to consider (amongst other relevant things) whether or not and why responsibility for the harm should be imposed on the negligent party.

Factual causation under s 5D(1)(a) is an application of the “but for” test, meaning that the Plaintiff must establish, on the balance of probabilities, that the harm which occurred would not have occurred without the Defendant’s negligence: *Wallace v Kam* (2013) 250 CLR 375; [2013] HCA 19 at 383 [16]; *Strong v Woolworths Ltd* (2012) 246 CLR 182; [2012] HCA 5 at 190 [18]. The Plaintiff must show that it is more probable than not that the harm would have been prevented or lessened if the Defendant had taken reasonable care. It is not sufficient for the Plaintiff to show that there might have been a different outcome if the Defendant had taken different steps: *Adeels Palace Pty Ltd v Moubarak* (2009) 239 CLR 420; [2009] HCA 48 at 442 [50], [53].

The Plaintiff must prove that the breach caused loss: s 5E of the CLA. It must be proved on the balance of probabilities: Tabet at 578 [111]. To succeed in proving that the breach caused loss, the Plaintiff must establish the relevant counterfactual: *Gates v City Mutual Life Assurance Society Ltd* (1986) 160 CLR 1 at [13].

The Defendant claims that the Plaintiff cannot establish that counterfactual as he cannot point to the likely course of events that would have occurred if the Defendant had adopted a different course. This, on the Defendant's case, goes as far as the Plaintiff being unable to establish what would have been discovered by any colonoscopy performed shortly after the August 2022 Consultation.

Stage of disease at the counterfactual dates

Associate Professor Pendlebury considered it to be “more likely than not” that earlier diagnosis of the cancer would have prevented the tumour perforating the bowel wall and later recurring. Based on her calculations, the cancer would have been stage 1. The delay of 644 days between the August 2022 Consultation and the cancer's diagnosis is longer than the mean time for cancers to progress from that stage to stages 3 and 4.

The Plaintiff submits that, because of this, but for the Defendant's negligence, the cancer would have been discovered in the latter months of 2022. At that time, Associate Professor Pendlebury opines, the Plaintiff would have had surgery (such surgery for stage 1 disease being effective) and an approximately 80% chance of 10-year survival.

Section 5D(3): What the Plaintiff would have done

Since the enactment of s 5D(3)(b) of the CLA, a plaintiff's hypothetical evidence of what they would have done if the allegedly negligent person had not been negligent has been rendered largely inadmissible. Such evidence, even from an honest witness, is not reliable. In *Chappel v Hart* (1998) 195 CLR 232; [1998] HCA 55 at [33], McHugh J said the following:

“Human nature being what it is, most plaintiffs will genuinely believe that, if he or she had been given an option that would or might have avoided the injury, the option would have been taken.”

However, the question is still to be determined “in the light of all relevant circumstances”: s 5D(3)(a) of the CLA.

The Plaintiff points out that the Defendant conceded that if the Plaintiff had reported bloating, constipation, bleeding and urgency, he would have considered a differential diagnosis, including colorectal cancer. The Plaintiff submits that those symptoms, and their duration, would have been provided if the Defendant had asked him additional questions. Upon receiving them, the Plaintiff submits, the Defendant would have referred him to a specialist. The Plaintiff submits that Dr Hamilton's referral for a colonoscopy is what caused him to take his symptoms seriously.

The Defendant contends that the Plaintiff has failed to establish that a specialist was available for him to see and, even if one were available, it cannot be demonstrated that he would have acted on the referral.

He further argues that speculation about how the Plaintiff would have responded to an earlier diagnosis is unnecessary. He did not act on Dr Etemad's referral to Dr Hamilton in October 2023. The Plaintiff's own evidence, the Defendant submits, was that he had been exhausted and close to burning out until he commenced employment at Fairfield City Council in March 2024. This led him to defer his health concerns. It was only in February 2024, the second time he saw Dr Etemad, that he acted on the referral, and then only after Dr Etemad had urged him, as her notes record, to contact Dr Hamilton "ASAP".

An additional issue is the time between seeing a specialist and the colonoscopy procedure. Associate Professor Ho's evidence was that COVID-19 affected Campbelltown Hospital, as it did "many hospitals in the west and southwest of Sydney". This caused a significant backlog and a patient in the Plaintiff's position would have waited approximately 18 months before a colonoscopy.

The Defendant claims that Associate Professor Ho's evidence is determinative.

The Plaintiff submits that, even if Dr Hamilton would not have performed the colonoscopy within a month in late 2022 (as it may not have appeared sufficiently serious for such an expedited procedure), Mrs Peterkin would not have tolerated a substantial delay. While Mrs Peterkin did not see any need urgently to investigate the Plaintiff's symptoms until the appointment with Dr Hamilton, after that appointment, she canvassed obtaining a colonoscopy sooner than the one-month period Dr Hamilton could accommodate. The Defendant points out that this means the colonoscopy would have been performed after February 2023, by which time the oncology experts agreed the tumour would have progressed to T3.

I consider these issues in detail below.

Loss of life expectancy

Oncology evidence on life expectancy

Having found that the Defendant failed properly to investigate, take a history and refer the Plaintiff in August 2022, I must consider whether that failure had a causative effect on the Plaintiff's life expectancy.

Two counterfactual dates were used in the instructions provided to the oncology experts: September 2022 and February 2023. Which date applies depends on findings of factual causation as to, first, whether the Plaintiff would have acted on a referral and, secondly, how soon a colonoscopy would have followed.

I will deal with those two matters first. The question of how soon after a referral the Plaintiff would have had a colonoscopy involves intertwined questions of fact and expert opinion. The question of fact is whether the Plaintiff would have proactively followed up on the referral upon being provided with it. If he had, the further question is how long it would have taken him to obtain a colonoscopy. That question is the subject of competing expert opinions from Dr Sethi (for the Plaintiff) and Associate Professor Ho (for the Defendant).

Whether the Plaintiff would have acted upon a referral

The task of determining when, in the counterfactual scenario, the Plaintiff would have had a colonoscopy following his consultation with the Defendant in August 2022 draws parasitically on what in fact occurred when he did receive such a referral in October 2023. That is the most reliable predictor of the Plaintiff's conduct. It is for this reason I reject the September 2022 date provided to the oncology experts.

On 8 October 2023, the Plaintiff saw Dr Etemad and reported rectal bleeding several times a week without pain on defecation. Dr Etemad is said to have observed a "small haemorrhoid" and referred him to Dr Hamilton "for an opinion and management of rectal bleeding ([haemorrhoid]?)".

Despite obtaining this referral, the Plaintiff did not act upon it. He cited a range of competing priorities which led him to deprioritise his own health in favour of other stressors.

The Defendant points out that the Plaintiff did not report his abdominal symptoms when attending medical appointments between the August 2022 Consultation and his October 2023 consultation with Dr Etemad. Indeed, he submits, the Plaintiff did not even report those symptoms to his wife in that period.

On 22 February 2024, the Plaintiff again consulted Dr Etemad. During that consultation, Dr Etemad advised the Plaintiff to see Dr Hamilton as soon as possible, telling him that a colonoscopy was needed to rule out polyps, cancer or haemorrhoids, and gave him a second referral. The practice records show that the referral was printed again on 7 March 2024, seemingly at the Plaintiff's request.

Dr Etemad's evidence was that she chose Dr Hamilton because he was new to the area, was likely to be available without a long waiting list, and worked in the public system, which mattered because the Plaintiff had no private health insurance. For that reason, Dr Etemad expected an appointment within two to four weeks of the October 2023 referral, with a colonoscopy to follow in about a month if the specialist regarded the case as serious, or in up to 12 months at Campbelltown Hospital if not.

The evidence establishes that the Plaintiff first attended Dr Hamilton on 7 March 2024. On that date, the Plaintiff consented to a colonoscopy, with or without banding of haemorrhoids. Dr Hamilton's referral is dated 7 March 2024 and recommends admission on 8 March at category A (i.e. within 30 days). After an assessment by the director of surgery, the Plaintiff was downgraded

to category B. That decision included the note “no critical symptoms in a 40-year-old”. A letter of 2 May 2024 reveals that Dr Hamilton asked for an earlier listing, citing pencil-shaped stools, PR pain disturbing sleep and persistent tenesmus. The case was restored to category A, and the colonoscopy followed 13 days later.

At a further consultation with Dr Etemad on 8 May 2024, the Plaintiff reported that he was still bleeding and that his symptoms were unchanged, but that he had scheduled an appointment with Dr Hamilton. On 15 May 2024, the Plaintiff attended Dr Hamilton at Campbelltown Hospital. A digital examination revealed a hard mass 10 cm from the anal verge, and the colonoscopy found a 6 cm mass.

The reasons why the Plaintiff did not act upon the referral provided to him in October 2023, which I have touched upon above, were, unsurprisingly, explored during his cross-examination. He acknowledged that he had not prioritised his health, but had placed his wife, their daughter and his father ahead of it. His father’s business difficulties and mental health were a particular source of stress. He did not accept that the Defendant’s diagnosis gave him “confidence” not to pursue the matter for 18 months.

Reading between the lines, I infer that when the Plaintiff saw Dr Hamilton on 7 March 2024, he had lost his referral and contacted Dr Etemad’s practice to obtain a copy of it to provide to Dr Hamilton’s reception staff.

Based upon the Plaintiff’s actual conduct, there is no reason for me to assume that, had he received a referral from the Defendant on 23 August 2022, he would have acted upon it immediately. In addition, I must engage in some degree of speculation as to, (a) whether any such referral would have been made to Dr Hamilton or to some other specialist (it is unclear whether Dr Hamilton worked at Campbelltown Hospital in August 2022), and (b) whether the same stressors that caused the delay from October 2023 were in existence in August 2022.

Three distinct periods emerge from the actual delays:

8 October 2023 to 22 February 2024, which involved around 137 days of inaction by the Plaintiff;

22 February 2024 to around 7 March 2024, a two-week period between the second referral and the Plaintiff seeing Dr Hamilton; and

7 March 2024 to 15 May 2024, a delay of 69 days attributable to the hospital downgrading the Plaintiff’s category.

Applying these delays to the period following the Plaintiff’s consultation with the Defendant, I prefer the February 2023 counterfactual to the November 2022 counterfactual. I do so for the following reasons:

if the Defendant properly interrogated the Plaintiff during this consultation, I find that the Plaintiff would have communicated his lengthy period of rectal bleeding and tenesmus. That is not because of his evidence of how he would have acted, but because of his readiness to make concessions in cross-examination and the fact that he was forthcoming with Dr Etemad when she asked questions at the 8 October 2023 consultation. I consider that the seriousness of the disclosed symptoms would have given rise to an immediate referral to a colorectal specialist; and had the Defendant advised the Plaintiff that those symptoms required he immediately attend a specialist, and adding delays (a) for the Plaintiff's dilatory conduct, (b) the delay in obtaining a specialist appointment and (c) the delay in obtaining a colonoscopy in the public health system, I find that the Plaintiff would probably have undergone a colonoscopy and been diagnosed with colorectal cancer by about February 2023.

That is also in line with the delay that occurred between 8 October 2023 and 15 May 2024, accounting for 69 days of delay caused by the hospital downgrading the Plaintiff's category, which I accept cannot be attributed to the Plaintiff. I find that had the Defendant properly probed the Plaintiff and, by that questioning, extracted the long-standing symptoms, there is no reason to believe that the Defendant would not have impressed upon the Plaintiff the need for him to see a specialist, replete with a suitably authored referral. I also accept that Mrs Peterkin would have encouraged him to make the appointment without delay.

There was no evidence presented to the Court that the same factors which delayed the Plaintiff from acting on his referral in October 2023 were present in August 2022, and I cannot conclude they were.

Diagnosis in February 2023

There is a stark difference between the opinions of Associate Professor Pendlebury and Professor Clarke as to whether a diagnosis in February 2023 (as opposed to May 2024) would have made a tangible (or any) difference to the Plaintiff's life expectancy.

Professor Clarke maintained that, as at August 2022, the Plaintiff's cancer was already at stage 3, that total neoadjuvant therapy would not have worked very well, and that even a diagnosis at that time would have left the Plaintiff "in the same circumstance as he is now, albeit with an earlier diagnosis". Professor Clarke considered that an earlier diagnosis would have made the Plaintiff "appear to live longer", but with the same outcome. During the concurrent expert evidence, Professor Clarke stated that "this cancer was always going to behave badly".

As at February 2023, Professor Clarke's opinion is that the cancer would have been locally advanced (stage 3) with the same histology, albeit "probably a bit smaller", and would have required the same treatment, and that the Plaintiff's life expectancy would have been no different.

Associate Professor Pendlebury's opinion is that, on a diagnosis in February 2023, the cancer would have been categorised as cT3N1M0, stage 3B. Treatment would have been total neoadjuvant therapy followed by surgery, without a pre-treatment colostomy and with a temporary ileostomy. The 10-year survival rate would have been 46%, which she equated to a median survival of the order of nine years from February 2023. Perforation of the bowel "would likely not have occurred", and she would have expected recurrence, with distant metastatic disease, at about the five-to-six-year mark.

The experts' opinions as to the Plaintiff's present prognosis broadly converge. Professor Clarke described the median survival for mucin-secreting colorectal cancer by reference to an article entitled "Mucinous histology" (2009) 100 British Journal of Cancer. If that article states a median for advanced (stage 4) disease, its natural starting point is the onset of stage 4. On the evidence, that occurred in about December 2025. Measured from that date, the Plaintiff is some 10 months into, rather than beyond, the median. On any basis, the experts consider that the Plaintiff's death is likely to occur between mid-2027 and September 2027.

I find that, if diagnosed in about February 2023, the cancer would have been stage 3B. The Plaintiff would have received neoadjuvant therapy followed by resection.

Evidence concerning the time for the Plaintiff to obtain a colonoscopy

As the Defendant conceded that the Plaintiff's full symptoms and history, if disclosed, would require referral "pretty urgently" to a specialist, I find that the Defendant would have referred the Plaintiff to a colorectal surgeon or gastroenterologist by a letter recording the Plaintiff's symptoms. Such a referral would have been categorised as category B (discussed below).

Each party called evidence from a gastroenterologist as to the time it would have taken for the Plaintiff to obtain a colonoscopy after referral. There was a significant disparity between the estimates of Dr Sethi, for the Plaintiff, and Associate Professor Ho, for the Defendant.

Both specialists agreed that the category they would ascribe to a patient, in terms of priority, depended upon the nature of the referral. That stands to reason. Patients classed as category A are to be seen within 30 days, category B within 90 days, and category C within 365 days. Those categories are also referred to as categories 1, 2 and 3. Both gastroenterologists put the referral at category B. Associate Professor Ho said that the NSW outpatient guidelines would classify a referral framed as haemorrhoids (for a patient aged 39 or under, without a positive faecal occult blood test, presenting with rectal bleeding and a change of bowel habit) as category C, but that in his own practice he classified rectal bleeding as category B. However, even with six months of bleeding, Associate Professor Ho would go no higher than category B.

Dr Sethi would likewise have classified the Plaintiff as category B. If the GP's referral had indicated a concern about cancer, he would have seen the patient within 30 days (category A) and expedited the colonoscopy. Dr Sethi stated that specialists in the public system are guided by the GP's referral, with category A patients to be seen within 30 days, category B within 90 days and category C (the same as category 3) within 365 days.

Dr Sethi's evidence was that the wait for a category 2 referral in August 2022 would be "usually within the 90 day[s] ... around 60 to 70 days on average", and for category 3 "around 5 to 6 months", in the public system. He described a wait of 18 to 24 months as a "doomsday", "hyperbolic" scenario. He practised at Ingleburn, near Campbelltown, but ceased practising there in about January 2022, and there was only a "slight" post-COVID backlog in his district.

Associate Professor Ho's evidence was that the wait for a category 2 procedure at Campbelltown in 2022 was 18 months, because of the COVID-19 backlog. He stated that the current category 2 wait is 476 days. He runs the only public general gastroenterology clinic at Campbelltown.

Set against these opinions is the Plaintiff's actual pathway in 2024, which was substantially quicker than the wait identified by Associate Professor Ho and consistent, to a much greater degree, with the evidence of Dr Sethi. Admittedly, Dr Sethi did not practise at Campbelltown, but nearby, and it could readily be accepted that by late 2023 the COVID-19 backlog may have attenuated. What remains unexplained is Associate Professor Ho's evidence that the category 2 wait for a colonoscopy in 2026 is 476 days. It is difficult to understand how the Plaintiff obtained a colonoscopy far more quickly than Associate Professor Ho's estimate would suggest.

I am not prepared to disregard the circumstances and time frame in which the Plaintiff obtained a colonoscopy after his initial consultation with Dr Hamilton on 7 March 2024. But for the recategorisation, there is no reason to believe that the Plaintiff would not have received his colonoscopy in April 2024 rather than May 2024. For this reason, I prefer the evidence of Dr Sethi and adopt his estimate of 60 to 70 days in the public system.

A diagnosis some months later than February 2023 would not change the stage. Whether it would change the risk of perforation depends on bulk, which I address below.

Life expectancy if diagnosis had occurred in early 2023

As already stated, if a diagnosis had occurred in February 2023 or shortly thereafter, both experts agree that the cancer would have been stage 3. At that point, Associate Professor Pendlebury estimates that the Plaintiff would have had a 46% chance of 10-year survival. The difference between her median survival of about nine years from February 2023 and her present prognosis rests on the proposition that the early recurrence was caused by a perforation during the February 2025 operation, which would not have occurred at an operation in 2023.

That, in turn, depends on a finding that there was such a perforation during the February 2025 operation. Neither expert was involved in the operation or has direct knowledge of it, and the surgeon who performed the operation, Dr Hamilton, did not give evidence.

The operation on 20 February 2025 began laparoscopically and was converted to a laparotomy. It comprised a reversal of the colostomy, an ultra-low anterior resection and a loop ileostomy. Dr Hamilton performed the operation with four assistants. The Plaintiff was discharged on 28 February 2025. The hospital nursing records “uncomplicated surgery”.

On 11 March 2025, Associate Professor Santos reported on the resection specimen. His report states that “[t]here is a small defect in the specimen distally. The defect is iatrogenic in nature.” The report also notes that “[t]here is a disrupted area in the specimen ... The mucosa and the wall of this area contains malignant cells and mucinous material. The disrupted area happened intra-operatively.”

Associate Professor Pendlebury’s evidence was that perforation is an established risk of rectal cancer surgery (less than 10% in the modern era), and that the risk of early pelvic recurrence following perforation is about 9% where radiotherapy has been delivered. Perforation reduces five-year survival from about 67% to about 41%. Associate Professor Pendlebury considered it more likely than not that the perforation caused the pelvic recurrence, because tumour was present at the site of the perforation, and that it contributed significantly to the early pelvic relapse. By contrast, she considered that a perforation would have been less likely following a February 2023 diagnosis, because the tumour would have been less bulky.

Professor Clarke had not considered the surgical report before giving evidence, but he accepted that “it sounds like it was a tough operation because of fibrosis and things, so it’s possible that there was a breach”. He agreed that, if there was a breach, cells could spill and, despite washout, could cause local recurrence. His substantive view nevertheless remained that the recurrence reflected the tumour’s local avidity.

The evidence as to whether the bowel was perforated during the February 2025 operation points in both directions. I am satisfied, however, on the basis of the pathologist’s report, which was made from the specimen itself, that a perforation occurred. Although the pathologist asked the surgeons to “please correlate” his opinion that the defect was iatrogenic, the surgeons do not appear to have done so.

On balance, I accept the pathologist’s opinion, taken together with the evidence of Associate Professor Pendlebury and Professor Clarke’s acceptance that, in a tough operation, it is possible that a breach occurred.

I can only take that perforation into account if I am satisfied that the delay in the operation, from about February or March 2023 to February 2025, increased the risk of the bowel breach that occurred. The delay otherwise merely changed the date of an operation that would have happened anyway, and the risk of the breach would have been the same on either date. If that were the case, the delay did not in fact increase the risk of harm. Here, Associate Professor Pendlebury’s opinion that a perforation probably would not have occurred at an operation in 2023 is significant.

As with the evidence as to whether a perforation occurred, the evidence as to an increased risk points in both directions. Associate Professor Pendlebury bases her opinion that a less bulky tumour would probably not have been perforated on literature associating perforation with more advanced tumours. That literature connects perforation risk to advancing T-stage, but the tumour would have been T3 on both dates, so her opinion ultimately comes down to bulk alone. I am satisfied that Associate Professor Pendlebury's opinion is uncontradicted by any contrary expert opinion on this point, and that it accords with the more general proposition that large tumours carry greater operative risk.

I am satisfied that the harm would have been less likely to occur had the operation occurred in the first quarter of 2023

Conclusion

I conclude that the Defendant's negligent failure investigate, take a history and refer the Plaintiff in August 2022 has foreshortened the Plaintiff's life expectancy from about February 2032 (nine years from February 2023) to about mid-2027. That reduction is 4.75 years.

Sections 5D(1)(b) and (4): Scope of liability

Determination of the scope of liability under s 5D(1)(b) rests on whether it is appropriate for the Defendant's liability to extend to the harm caused: *AA v The Trustees of the Roman Catholic Church for the Diocese of Maitland-Newcastle* (2026) 100 ALJR 170; [2026] HCA 2 at 209 [143] (Gageler CJ, Jagot and Beech-Jones JJ).

For the Plaintiff to succeed, the evidence would need to establish that, had the Defendant taken the pleaded precautions set out at [167]–[168] above, he would have received an earlier diagnosis, that the earlier diagnosis would have led to him starting treatment earlier and that starting treatment earlier would have prevented the Plaintiff from suffering at least some of the consequences of his illness.

The harm the Plaintiff has suffered is precisely the kind that the pleaded precautions are intended to guard against. Had the Defendant taken those precautions, the Plaintiff would have been diagnosed in February 2023, that diagnosis would have led to him starting treatment earlier, and earlier treatment would have prevented him from suffering at least some of the consequences of his illness.

Contributory negligence

The Defendant claims that, if negligence is ultimately found against him, the Plaintiff was contributorily negligent. I will return to the particulars of that plea below.

The pleaded particulars

The pleaded particulars of that alleged contributory negligence are as follows:

“(a) The Plaintiff has contributed to his own loss by failing to:

- (i) investigate his symptoms earlier following the consultation on 23 August 2022;
- (ii) return for a follow-up appointment with a general practitioner as advised by the Defendant during the consultation on 23 August 2022;
- (iii) make an appointment to see a medical practitioner during the period from 23 August [2022] until 8 October 2023 with respect to complaints of ongoing rectal bleeding and pain on urgency;
- (iv) not disclose [sic] any complaints of ongoing rectal bleeding and pain on urgency when he had consultations with medical practitioners at the centre on 2 November 2022, 4 November 2022, 6 June 2023, 9 June 2023, 23 August 2023, 24 August 2023 and 28 August 2023;
- (v) act on his referral to Dr Hamilton, colorectal surgeon provided to him by Dr Samira Etemad on 8 October 2023, in a timely manner;
- (vi) only making an appointment [sic] to see Dr Hamilton after being provided with a second referral from Dr Etemad on 22 February 2024.”

Section 5R: The standard of care

Section 5R of the CLA provides as follows:

5R Standard of contributory negligence

- (1) The principles that are applicable in determining whether a person has been negligent also apply in determining whether the person who suffered harm has been contributorily negligent in failing to take precautions against the risk of that harm.
- (2) For that purpose—
 - (a) the standard of care required of the person who suffered harm is that of a reasonable person in the position of that person, and
 - (b) the matter is to be determined on the basis of what that person knew or ought to have known at the time.

The Defendant bears the onus of proving that the Plaintiff’s actions amount to negligence for the purpose of s 5R: *Joslyn v Berryman* (2003) 214 CLR 552; [2003] HCA 34 (*Joslyn*) at [18]. The question is whether, in the conduct giving rise to the present situation, the Plaintiff exercised reasonable care for his own safety: *T and X Company Pty Ltd v Chivas* [2014] NSWCA 235 at [4] (*Beazley P*). The test of contributory negligence is objective and independent of the idiosyncrasies of the person whose conduct is in question: *Joslyn* at [32].

I find that the Plaintiff, in failing to see a doctor in the months before the August 2022 Consultation, failing to have regard to the informative pamphlet provided by the Defendant, failing to failing to mention his gradually worsening symptoms at the consultations between August 2022 and October 2023 and delaying making an appointment with Dr Hamilton for 137 days after the October 2023 consultation, failed to take reasonable care for his own health.

Those failures contributed to the delay in diagnosis from February 2023 to May 2024. I find that the Plaintiff was contributorily negligent.

Orders

I make the following orders:

The Defendant is liable to the Plaintiff in negligence, and the Plaintiff was contributorily negligent.

The parties are to send to my chambers, by 13 October 2026, competing submissions on damages, apportionment and costs. Such submissions are to be no more than 10 pages, in size 12 font, with 1.5 spacing between each line and with margins of no less than 2.54 cm on all sides of the page.

Should the parties consider it necessary, they are to contact my chambers by 5pm on 3 October 2026 for the purpose of having the matter listed for hearing on damages.

Costs are reserved.

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Decision last updated:

29 September 2026

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Prepared on 23 October 2026 · Esheria