Medico-Legal Society of New South Wales

Contact Sport: Watch your Head

Legal Exposures for Doctors of Concussion Injuries in Sport

Alan Sullivan QC
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Introduction

1. Tennis is not usually regarded as a contact sport. Unless, perhaps, Nick Kyrgios is playing. Imagine my surprise, therefore, when I awoke on Monday morning to the news that the Canadian tennis player, Emily Bouchard, had withdrawn from the US Open with a concussion injury she suffered in a "freak locker room fall".

2. This unusual incident highlights the pervasive occurrence of concussion injuries in all forms of sport. Concussion injuries are usually associated with "collision" sports such as the rugby codes, American football, ice hockey and the like. But they also frequently occur in virtually any sport where there is scope for accidental or deliberate contact with the head. Thus, concussion injuries are also part and parcel of more genteel sports such as basketball, netball, equestrian events, snow sports, cricket and the list could go on *ad infinitum*.

3. As Dr Shores has explained in his excellent presentation the incidence of concussion injuries in sport is surprisingly high.[1]

4. Moreover, unsurprisingly, skill level, age and gender do not seem to markedly impact upon the risk of suffering concussion injury in sport.

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[1] In addition to the statistics quoted by Dr Shores, these recent statistics emanating from the United States indicate the prevalence of concussion in sport. 3,800,000 concussions were reported in 2012. 33% of those concussions happened at practice. 47% of all reported sports concussions occurred during high school football. The number of sports concussions taking place per 100,000 athlete exposures in various sports were as follows: (a) Grid Iron – 64-77; (b) Boys Ice Hockey – 54; (c) Girls Soccer – 33; (d)Boys Lacrosse – 40-47; (e) Girls Lacrosse – 31-35; (f) Boys Soccer – 19-19.2; (g) Boys Wrestling – 22-24; (h) Girls Basketball – 18-21; (i) Girls Softball – 16; (j) Boys Basketball – 16-21; (k) Girls Field Hockey – 22-25; (l) Cheerleading – 11-14; (m) Girls Volleyball – 6-9; (n) Boys Baseball -4-5; (o) Girls Gymnastics – 7;
(Source: headcasecompany.com website as at 19 August 2015).

Amateur athletes are just as likely to suffer from concussion as elite ones, female participants are just as prone (perhaps even more so) than their male counterparts and children appear to be especially vulnerable.[2]

5. Indeed, the problem seems greater with children participating in sport than with older competitors. Awareness by athletes and participants in sport that they have suffered a concussive injury is not good. A survey conducted in the emergency department of a major Canadian hospital found that nearly 90% of the concussed patients had not recognised their injury.[3] In respect of children, it is generally accepted that fewer than 20% of concussed children are diagnosed with concussion with fewer again seeking medical attention.[4] Moreover there is a fear of deliberate under-reporting of conclusion by all athletes for fear of being stood down from games or letting down their teammates.[5]

6. So, concussion is a significant problem in virtually every sport where movement is involved. It is one of the most frequently occurring injuries. Not surprisingly, therefore, lawyers have become interested in finding ways to seek compensation for those who suffer from concussion whilst playing contact sports. This is particularly evident in the United States of America (**USA**).

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2 See the excellent article by Nick Rushworth of Brain Injury Australia entitled "*Concussion in Sport*" prepared for the Department of Families, Housing, Community Services and Indigenous Affairs in October 2012 at pp 4, 5, 32-35)

3 Rushworth *op cit*, at p 13.

4 Sports Medicine Australia "*Management of Concussion in Children*" extracted from concussioninsportproject.com.au website on 2 September 2015; also on 29 July 2015 ABC News reported on its website that Professor Gary Browne from Westmead Children's Hospital said that 6 children presented to Westmead every week with a concussion and that Westmead had found that for every one who presented at the hospital 15 went unrecognised. According to Gary Browne there is poor recognition of concussion "mostly at the grassroots sports level".

5 Rushworth, op cit, p 13; Gilbert and Partridge "*The need to tackle concussion in Australian football codes*" Med. J. Aust 196 (9) 561-563 at 561.

Concussion Litigation in the United States of America

7. Concussion lawsuits are becoming big business in the USA. There are even websites to which one can subscribe to keep up with the developments in such litigation.[6] There have been at least three highly publicized recent pieces of litigation in the USA, two involving American football and one involving soccer. The two involving American football have been settled, or are in the course of settling, whilst the case involving soccer was dismissed.

NFL Class Action – In re: National Football League Players' Concussion Injury Litigation (MDL 23223) – United States District Court for the Eastern District of Pennsylvania

8. In 2012, more than 3,000 former grid iron players engaged in class action lawsuits against the National Football League (**NFL**) in the USA which were later consolidated. The lawsuits generally alleged that the NFL either knew, or should have known of the long-term neurological consequence of repeated concussions, including the "phenomenon" of chronic traumatic encephalopathy (**CTE**), depression, dementia, Alzheimer's Disease etc. Despite such knowledge it was alleged the NFL withheld that knowledge and indeed, for publicity purposes, sensationalised the big hits in the game.[7]

9. It has been reported that a settlement of this consolidated class action has recently been approved without admissions by US District Court Judge Anita Brody with a settlement that could cost the NFL $1 billion over 65 years.[8]

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6 E.g., nflconcussionlitigation.com.

7 Rushworth, op cit, p 9; see also Anderson "*The Latest Wave*" 23 June 2015 published on nflconcussion.com website as at 7 September 2015. CTE is a degenerative brain disease caused by repeated head trauma and characterized by the neural disposition of injury-related tau proteins. CTE produces symptoms similar to those of early on-set dementia, along with behavioural and cognitive impairment. It can only be definitively diagnosed port-mortem – see Gilbert and Partridge, op cit at p 561.

8 "*The Knock Out Blow: How Australia is tackling concussion and neck injuries*" extracted from the sportslawyer.com.au website on 19 August 2015.

10. However, it has also been reported that a number of former NFL players have appealed against this settlement citing that the plan unfairly excluded players who have yet to be diagnosed with CTE. The players opposing the settlement argue that the plan overlooks a potential 19,000 players who are likely to develop neurological diseases but have yet to be diagnosed with any. In a novel argument, the lawyer for the opposing players complained:

> "It is the height of hypocrisy for the parties to defend the settlement that offers nothing for CTE to the vast majority of class members by arguing that those claims could not prevail at trial **because the science is too new**". (emphasis added)[9]

11. The reference in the passage quoted above to the fact "the science is too new" is significant. It is significant that the NFL class action settled before a judge could determine liability or, perhaps, more accurately **causation.**

12. Because literally and metaphorically, the jury still appears to be out as to whether recurrent or cumulative concussive or sub-concussive episodes can lead to degenerative brain conditions such as CTE.[10]

The NCAA Class Action

13. In 2011, Adrian Arrington commenced a class action on behalf of US College footballers against the National Collegiate Athletic Association (**NCAA**) in respect of concussive injuries. Arrington who was a former captain of the East Illinois University football team claimed in his 2011 lawsuit that he was

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9 Joseph Hanna, "*More ex-NFL players oppose the concussion settlement*" reported on the Concussion Policy and the Law website (concussionpolicyandthelaw.com) as at 19 August 2015.

10 The highly respected and frequently cited *2012 Zurich Consensus Statement on Concussion in Sport* delivered at the 4th International Conference on Concussion in Sport held in Zurich in November 2012 stated this: "*Clinicians need to be mindful of the potential for long-term problems in the management of all athletes. However, it was agreed that ... CTE represents a distinct tauopathy with an unknown incidence in athletic populations. It was further agreed that a cause and effect relationship has not yet been demonstrated between CTE and concussions or exposures in contact sports. At present the interpretation of causation in the modern CTE case studies should proceed cautiously. It was also recognised that it is important to address the fears of parents/athletes from media pressure related to the possibility of CTE.*" However some argue that the NFL has created "junk science" to obfuscate the truth and engineer the settlement – see, e.g. Anderson, op cit p 3 of 23. Even more balanced reporters suggest there may be a link which requires thorough and urgent investigation – see Gilbert and Partridge op cit, at p 561, 562.

forced to stop playing football because of the numerous and repeated concussions he suffered during his college playing days. Arrington claimed that the five concussions set forth in his complaint as well as other head injuries sustained playing college football resulted in serious medical issues including memory loss, seizures and headaches, all of which cut short his football career.

14. The plaintiffs in the NCAA concussion case claimed that the organisation knew about but disregarded information concerning the long-term effects of concussions and other forms of head trauma on athletes, and that the NCAA ignored studies involving the link between the frequency and severity of concussions and certain types of sport. The case was settled for a reported $75 million. But on 10 June 2014 Arrington sought to fire his attorney claiming he had never approved that settlement.[11]

15. Once more this litigation appears to have resolved or be likely to resolve, without a determination of the important causation issues.

Mehr v FIFA

16. On 27 August 2014, seven amateur soccer players commenced an action against FIFA and other US defendants associated with the control of soccer in the USA seeking to force FIFA and other governing bodies to change the sport's rules, including limiting the number of headers allowed, in order to reduce the risk of concussions and other head injuries.[12]

17. On 16 July 2015 Chief Judge Phyllis Hamilton of the United States District Court for the Northern District of California dismissed the plaintiffs' claim. Her Honour said that the plaintiffs could not use the courts to change FIFA's

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11 Giller, *"The NCAA and its insurers are fighting over coverage for concussions lawsuits"* 17 August 2015 reported on concussionpolicyandthelaw.com website as at 19 August 2015.

12 Boucher *"Concussions rears its ugly head again"* in Touchline, Issue 21, August 2015 at p 2.

"laws of the game", noting that it was their decision to play soccer. Her Honour observed that it was part of the law of the United States (as, indeed, it is part of the law of Australia) that those participate in a sporting activity that poses an inherent risk of injury generally assume the risk that they may be injured whilst so doing. It will come as no surprise that FIFA welcomed this court decision.[13]

Are Legal Claims for Concussion Injuries (or their consequences) viable in Australia?

18. Given the spate of legal activity in the USA it is tempting to predict that "copycat" lawsuits in Australia will follow. Indeed, they have been threatened or predicted.[14] However, there are a number of significant threshold problems which potential plaintiffs will need to overcome if they are to be successful in any such lawsuits.

Threshold Issues for Plaintiffs to Overcome

19. The major threshold issue for a potential plaintiff to overcome in Australia is that the overwhelming majority of concussion injuries completely resolve within 7-10 days of the incident causing the concussion. Of the remaining 10-20% (usually involving children or adolescents) the symptoms and consequences of the concussion, if properly treated, resolve, generally, within a couple of months.[15]

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[13] See Media Release on FIFA website on 17 July 2015 "*FIFA welcomes US Court's decision on concussion lawsuit*"; in light of the decision of the High Court of Australia in Agar v Hyde (2000) 201 CLR 552, a similar result would have been likely in Australia.

[14] See, e.g. Barrett "*Lawyer keen to act for NRL players on NFL-style concussion lawsuits*", Sydney Morning Herald, 10 November 2014.

[15] As stated in the *2012 Zurich Consensus Statement on Concussion in Sport* Statement at pp 2, 4:
"The majority (80-90%) of concussions resolve in the short (7-10 day) period, although the recovery timeframe may be longer in children and adolescents...
...
Persistent symptoms (more than 10 days) are generally reported in 10-15% of concussions. In general, symptoms are not specific to concussion and it is important to consider other pathologies. Cases of concussion in sport where clinical recovery

20. Given the transient nature and very short duration of most concussion injuries, the fact that many, if not the majority, occur in respect of child athletes or amateur athletes with no loss of earning capacity and the legal costs involved it is extremely problematic as to whether pursuing such action, even as a class action, would be financially viable in Australia. When one adds the risk of losing on the ground of common law or statutory voluntary assumption of risk and the very difficult and expensive to prove causation issues, it is easy to see why no litigation has yet commenced in Australia.[16]

21. In addition to the common law exclusion of liability in respect of voluntary assumption of inherent risks in a sport, in New South Wales, and other States which have similar legislation, the provisions of Part 1A Division 5 of the *Civil Liability Act 2002* (NSW) (**CLA**) pose significant difficulties for any plaintiff seeking to bring an action for damages in respect of a concussion injury he or she has suffered especially where that plaintiff was participating in a "dangerous" sport or has been given a risk warning.

22. Section 5L of the CLA is in these terms:

> **"5L No liability for harm suffered from obvious risks of dangerous recreation activities**
>
> (1) a person (the defendant) is not liable in negligence for harm suffered by another person (the plaintiff) as a result of the

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falls outside the expected window (ie 10 days) should be managed in a multi-disciplinary manner by health care providers with experience in sports-related concussion."

See also Bleiberg & Ors *"Duration of cognitive impairment after sports concussion"* being an article in Neurosurgery, June 2014 pp 1073-1080.

16 The leading Australian case on the legal consequences of participating in a sport where there is an obvious risk of danger is *Agar v Hyde* (2000) 201 CLR 552. In that case, Gleeson CJ said this at [15]:

"People who pursue recreational activities regarded as sports often do so in hazardous circumstances; the element of danger may add to the enjoyment of the activity. Accepting risk, sometimes a high degree of risk, is part of many sports. A great deal of public and private effort, and funding, is devoted to providing facilities for people to engage in individual team sports. This reflects a view, not merely of the importance of individual autonomy, but also the public benefit of sport."

See also *Woods v Multi-Sport Holdings Pty Limited* (2002) 208 CLR 460 and, generally, Section 5L of the *Civil Liability Act 2002* (NSW) and its counterparts in other States.

materialisation of an obvious risk of a dangerous recreational activity engaged in by the plaintiff.

(2) this section applies whether or not the plaintiff was aware of the risk."

23. Section 5M of the CLA reads as follows:

> **"5M No Duty of Care for Recreational Activity Where Risk Warning**
>
> (1) a person (the defendant) does not owe a duty of care to another person who engaged in a recreational activity (the plaintiff) to take care in respect of a risk of the activity if the risk was the subject of risk warning to the plaintiff.
>
> (2) ...
>
> (3) for the purposes of sub-section (1) and (2) a risk warning to a person in relation to a recreation activity is a warning that is given in a manner that is reasonably likely to result in people being warned of the risk of before engaging in the recreational activity. The defendant is not required to establish the person perceived to understood the warning or was incapable of receiving or understanding the warning."

24. Importantly, s.5N of the CLA also provides that it is lawful to exclude liability in a contract for breach of an express or implied warranty that recreation services will be rendered with reasonable care and skill.

25. It would take far longer than it is now available to discuss the effect and limitations of these statutory provisions. But they do provide a significant fetter to any attempt to bring an action for damages for mere concussion in Australia especially in relation to a sport or recreational activity where such an injury is a well-known common incident of playing the game.

26. However, as the controversial case of *McCracken v Melbourne Storm Rugby League Football Club* establishes[17], the provisions of the CLA including those referred to above will not apply where the injury in question was the result of an intentional act done with an intention to cause injury (because of the

[17] [2005] NSWSC 107 .

provisions of s.3B of the CLA). In McCracken's case, a professional rugby league footballer was injured as a result of a "spear" tackle and Hulme J found that there was an intention to "lift" or "spear" the player into the ground and an intention to "injure" the player albeit not as seriously as he was in fact injured. Hulme J thus found that the provisions of the CLA did not apply in that particular case.

27. Just as a player at, common law, does not assume the risk of deliberate foul play[18] , the statutory exclusion of liability under the CLA is also inapplicable in respect of intentional conduct. Thus, in the rugby codes, a deliberate head high tackle, shoulder charge or punch, which is clearly forbidden by the rules, would result in the inapplicability of Part 1A Division 5 of the CLA. Moreover neither the common law exclusion nor that Part of the CLA has any application to the potential claims against doctors which are discussed below because negligent medical diagnosis, advice or treatment is not an "obvious" or "inherent" risk of playing the game.

Two Possible Areas of Legal Liability

28. Leaving aside the area of intentional conduct or foul play which results in a concussion injury, there are at least two further areas of potential liability in respect of concussion injuries. They are:

    (a) The situation where a person who has, or might have, suffered a concussion injury is permitted to continue to play in the game or resume play prematurely before his or her symptoms have resolved fully thereby exposing that person to a greater risk of a second, much more significant injury ("Premature Return to Play"); and

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[18] See, e.g. *McNamara v Duncan* (1971) 26 ALR 584.

(b) The situation where a player with a history of concussion injuries is permitted to continue his/her playing career with a possible risk of thereby increasing the prospects of permanent brain damage ("Cumulative Episodes").

29. In view of the composition of the audience tonight and time limitations, in discussing each of these topics, I leave aside the potential liability of governing bodies, employers, clubs, coaches, fellow players or the like in respect of these two scenarios.

30. Rather, I shall focus on the potential liability of a medical practitioner who needs to diagnose, advise and/or to treat a player in either of the scenarios referred to.

Premature Return to Play

31. A doctor may be called upon to assess the condition of a player on the field of play during the game or shortly after the game has concluded where the player exhibits signs of disorientation, grogginess, unsteadiness or the like, but before the player in question is permitted to continue playing in that game or before the player is allowed to play in another game.[19]

32. Although this is outside my field of expertise, it appears from what I have read that it is imperative that in either situation the doctor form a diagnosis of whether the athlete in question has suffered from concussion. It has been said that concussion is considered to be amongst the most complex injuries in sports medicine to diagnose, assess and manage.[20] It appears that the reason for the importance of making an early, accurate diagnosis of concussion is what is sometimes called "Second Impact Syndrome".

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19 This is the recommendation of the *2012 Zurich Consensus Statement on Concussion in Sport* at p 2 which has been adopted in all major Australian football codes.

20 See the *2012 Zurich Consensus Statement on Concussion in Sport* at p 6.

33. Dr Ralph Richards, Senior Research Consultant, NSIC Clearing House Australian Sports Commission has opined:

> "It is recognised that most concussions get better in 7 to 10 days. However, ignoring concussion signs and symptoms or not recognising them, can result in potential catastrophic consequences. Acute brain swelling, traditionally referred to as "Second Impact Syndrome" is usually fatal. Prolonged symptoms, recurrent concussion, learning difficulties, personality problems have also been reported."[21]

34. Likewise it has been asserted that recent NFL and NCAA concussion experiences have "crystallised" that athletes who return to the field of play and risk further trauma prior to fully recovering from a concussion are significantly more likely to receive permanent brain damage.[22] On the headcasecompany.com website under the heading "Childhood Concussions: Sports-related head injuries during play" it is stated:

> "If your child returns to sport or activities too quickly he or she risks head injury complications. Once a young athlete has sustained a concussion, he or she has a higher risk of sustaining another concussion. A second blow to the head while the first concussion is still healing can result in additional long-term injury, or even permanent brain damage."

35. Assuming the validity, from a medical perspective, of such potential consequences flowing from a second head injury following a premature return to play, in my opinion, a doctor assessing a person presenting with possible symptoms of concussion owes a duty of care to endeavour to form a reasonable and accurate diagnosis of concussion and to give appropriate advice as to management of the condition and proper warning as to the risks of returning to play too early. Clearly, if the possible medical consequences

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21 Richards *"Sports Concussion and Head Trauma"* 31 July 2015 as published on the secure.aus.sport.gov.au/clearinghouseandknowledge website as at 19 August 2015. It appears that Second Impact Syndrome is even more of a problem with young athletes such as children – see Gilbert and Partridge, op cit at 562.

22 *"The Knockout Blow: How Australia is tackling concussion and neck injuries"* published on the sportslawyer.com.au website as at 19 August 2015.

are as great as stated, a doctor should err on the side of caution when making such a diagnosis, advising on management and giving the appropriate warnings.[23]

36. However, doctors, especially those associated with sporting clubs or in treating players associated with such clubs, are often on the horns of a dilemna when undertaking such a role. One only has to remember the spectacle of Sam Burgess in the 2014 NRL Grand Final suffering a severe early head knock, apparently staggering around afterwards, reporting after the game he had no memory of the match and yet playing a "blinder" resulting in him being awarded the Clive Churchill Medal for best player in the Grand Final.

37. I am not in any way disputing the medical assessment of the doctor who determined that Mr Burgess was fit to continue playing. However, it is such episodes which highlight the dilemma facing such doctors. That dilemma was graphically reported by Dr John Orchard, now the head doctor for Cricket Australia, but previously a doctor associated with a Rugby League club in these terms:

> "I am about to start working in my 15th season as a professional NRL team doctor but do so feeling as uneasy as I ever have at any stage of working in sports medicine... Because the NRL has just brought in a rule that if a doctor assesses a player as having had a concussion (irrespective of whether he has been deemed to have recovered) then the player must not be allowed to return to play in that game... The problem is that the NRL haven't really properly defined concussion (which doesn't distinguish them too badly as even the consensus panels struggle to give a good definition) and more importantly, haven't defined a severity cut-off... I am either going to be put one of the three following positions very soon, none of which makes me comfortable: (1) That I am going to be pulling players out of the game who I have been comfortable letting continue for many years, and possibly hurting

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[23] c.f. the rather sarcastic "admiration" expressed by Rushworth, op cit, p 19 for club doctors who are confidently able to diagnose no concussion whilst taking into account the paramount interest of the players' health; See, also, *Rogers v Whitaker* (1992) 175 CLR 479.

> our team's chances of winning games (2) That I am going to turn a blind eye and go out of my way to not examine or assess a player who looks as though he is fit to continue (3) that I am going to re-name something I used to call "mild transient concussion" something different like "traumatic migraine" so the player can be allowed to continue, even though deep down I think that the player has probably had a very mild concussion and has quickly recovered. I have just gone over my stats for the past 14 years to look at how many concussions I have recorded and how they were managed. I have overseen about 10,000 player games and recorded approximately 250 concussions (about 1 in every 40 player games). I would also expect that maybe every second incident that could count as a concussion I wouldn't even see/record (that is a player wouldn't necessarily report symptoms to me). Of the 250 I did record about 100 (less than half) left the field on the day, with 68 coming off for good and the other 32 being allowed to return to game at some stage with a careful eye being kept on them by me and the on-field trainers. I am not aware of any of these players coming to long-term harm as a result of the concussions they have suffered."[24]

38. As a result of the potential conflict of interest and duty between doctors associated with sporting teams who have to diagnose potential concussion injuries, there has been a call for such assessments to be made by independent medical practitioners[25] but, as far as I am aware, such calls, to date, have largely gone unheeded.

39. However, if there is persuasive medical evidence to establish the potential long-term consequences of much more serious damage following a second head knock on a return to play and if causation is established then this is an obvious area of legal risk for medical practitioners.

40. Further legal risks for the doctor attend his /her management of the player diagnosed with concussion. Everyone seems to now agree that he or she

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[24] Quoted in Rushworth, op cit, at p 18. It has been anecdotally reported in the SMH article by Barrett, op cit, that some club doctors had fears about future legal action and left the sport.

[25] E.g. Gilbert and Partridge, op cit, at 561-562.

should take no further part in the game in question but when should he or she resume playing? There are arguments for and against a fixed period.[26]

41. Moreover, even at amateur level or in connection with children playing sport obviously there are the same or greater risk factors involved for medical practitioners when they first are asked to diagnose someone who could be suffering concussion as a result of a sports-related activity.

Cumulative concussive or sub-concussive episodes

42. Once more, Dr Shores is in a much better position to offer an opinion on this topic than I am from a medical perspective. I will only venture tentative views based on what I have read.

43. The inherent premise of the grid iron litigation in the USA was that the repeated or cumulative effects of concussive or sub-concussive injuries was likely to result in permanent brain damage such as CTE, depression, dementia, Alzheimer's Disease or other long term mental health issues. The analogy was with boxing. On the other hand, the authoritative 2012 Zurich Consensus Statement on Concussion in Sport (albeit commissioned by four leading sporting governing bodies) is much more sceptical. It is worth quoting the relevant portion of that statement:[27]

> "It was agreed that CTE represents a distinct tauopathy with an unknown incidence in athletic populations. It was further agreed that CTE was not related to concussions alone or simply exposure to contact sports. At present there are no published epidemiological, cohort or prospective studies relating to modern CTE. Owing to the nature of the case reports and pathological case series that have been published, it is not possible to determine the causality or risk factors with any certainty. As such, the

[26] See, e.g. Gilbert and Partridge, op cit, pp 561-563; Rushworth, op cit, pp 42-44.

[27] At p 8.

speculation that repeated concussion or sub-concussive impacts cause CTE remains unproven. The extent to which age-related changes, psychiatric or mental health illness, alcohol/drug use or co-existing medical or dementia illnesses contribute to this process is largely unaccounted for in the published literature. At present, the interpretation of causation in the modern CTE case studies should proceed cautiously. It was also recognised that it is important to address the fears of parents/athletes from media pressure related to the possibility of CTE."[28]

44. Whilst causation remains a "hot" issue it would be imprudent, in my opinion, for a doctor to rely upon causation, or lack thereof, as a means to defending his or her conduct in respect of failing to diagnose or properly advise or manage the treatment of an athlete who has been the subject of repeated episodes of concussion. The risk of long-term permanent brain damage as a result of repeated concussions or the cumulative effect of them is not far-fetched or fanciful. It is thus, in legal terms, foreseeable and, in my view, a doctor's duty of care would extend to advising of that risk in appropriate cases.

45. Given the apparent fact that many athletes (especially young ones) are unaware of the symptoms of concussion let alone whether they have suffered concussive episodes in the past (or worse still are unwilling to volunteer a history of concussion) it would appear to me vital that a doctor when seeing a patient for the first time in respect of a possible concussion injury takes as detailed a history as possible of past events/incidents which have either been diagnosed as episodes of concussion and/or, even if undiagnosed or unreported, which manifest symptoms associated with

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[28] c.f., however, Gilbert and Partridge, op cit, at p 561; Rushworth, op cit, at pp 3, 26-31.

concussion. To protect himself or herself, I think a doctor has to be as much a detective as a clinician.

46. If a doctor, having taken such a history, forms the view that the athlete in question has suffered from a number of episodes of concussion then a real question arises as to the content of the doctor's duty of care to advise as to the athlete's future participation in the sport.

47. As stated by Mr Nick Rushworth:[29]

> "Despite the increasing body of literature on this topic, debate still surrounds the question of how many concussions are enough to recommend ending the player's career. Some research suggests that the magic number may be three concussions in a career. Brain Injury Australia notes that the 14 year survey of 155 concussions in one NRL team... included 23 players who suffered a second concussion, two players who sustained a third, and one a fourth during the same season. Moreover, up to six concussions for the same player were recorded during the survey period. Of the 94 concussions recorded by one AFL team over ten seasons... 17 players were concussed twice in the one season, three players three times."

48. A doctor has an unenviable role in giving such advice, potentially bringing to an end a professional athlete's highly lucrative playing career. That doctor may, if he or she gets the prognosis wrong, and the advice to retire is accepted by the player, arguably expose himself or herself to an action for damages by the player!

49. Hopefully, as medical science evolves and more becomes known of the cumulative effects of concussion, the task for the doctor will become easier.

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[29] Rushworth, op cit, pp 27-28; Also, last year, Liam Fulton, a well-known NRL Rugby League player with the Wests Tigers, retired midway through the season, presumably on medical advice, after coming from the field four times in six games because of concussion.

In the meantime, the doctor may have to take comfort in provisions such as s.50 of the CLA which reintroduced a modified "Bolam" principle in New South Wales (and in other jurisdictions in Australia with similar legislation). Thus, if the doctor can demonstrate that he/she advised in a manner that was widely accepted in Australia by peer professional opinion as competent professional practice at the relevant time, then there will be no liability in negligence.

Conclusion

50. Given the rapid resolution of symptoms and problems following the vast majority of concussive injuries, the lack, therefore, of likely significant financial damage associated with such injuries, and the common law and statute law limitations on liability relating to involvement in sports with obvious risks, the cost / benefit analysis of bringing a lawsuit in Australia in respect of such injuries will generally result in few, if any, proceedings being brought notwithstanding the North American experience.

51. However, in at least two areas, so far as doctors are concerned, there is a potential area for concern. The first area involves the diagnosis and management of a possible concussive injury where there is a pressure that the athlete continue to play in the game or return to play too quickly subsequently.

52. The second, and potentially most significant, field of exposure is the diagnosis management and advice to be given to athletes and players who have reported, or should have reported, repeated episodes of concussion in their sporting activities.

53. In each of these two scenarios, although causation of the ultimate injury may be hotly in dispute, prudence would dictate that a doctor, in order to avoid

possible legal claims and to discharge his or her duty of care to the patient, err on the side of caution in the diagnosis of patients and the management and advice given to them in such circumstances irrespective of competing or conflicting pressures.

54. Otherwise, concussion injuries may well become as much as a headache for doctors as they are for their patients.

Alan Sullivan QC

9 September 2015