SUPREME COURT OF VICTORIA

COURT OF APPEAL

S APCI 2012 0250

LYNETTE PATTISON — Applicant

v

THE HERALD & WEEKLY TIMES LTD — Respondent

JUDGES	NETTLE, NEAVE and OSBORN JJA
WHERE HELD	MELBOURNE
DATE OF HEARING	17 May 2013
DATE OF JUDGMENT	23 May 2013
MEDIUM NEUTRAL CITATION	[2013] VSCA 121
JUDGMENT APPEALED FROM	[2012] VCC 2014 (Judge Misso)

ACCIDENT COMPENSATION – Serious injury – Emphysema contracted as result of passive inhalation of cigarette smoke – Cause of action accruing before, but incapacity not known until after, 12 November 1997 – When incapacity became known – Whether earlier diagnoses of chronic asthma and chronic bronchitis meant that incapacity resulting from emphysema became known before emphysema was diagnosed – *Barwon Spinners Pty Ltd v Podolaski* (2005) 14 VR 622; *Grech v Orica Australia Pty Ltd* (2006) 14 VR 602, applied; *Morris & Joan Rawlings Builders and Contractors v Rawlings* [2010] VSCA 306, considered – *Accident Compensation Act 1985* (Vic), ss 135A(4)(b), 135A(2B) and 135AC(b).

Appearances:	Counsel	Solicitors
For the Applicant	Mr A D B Ingram	Holding Redlich
For the Respondent	Mr S A O'Meara SC with Mr R Kumar	Wisewould Mahony

NETTLE JA
NEAVE JA
OSBORN JA:

1 This is an application for leave to appeal against an order made by a judge of the County Court under s 135A(4)(b) of the *Accident Compensation Act 1985* ('the Act'). The judge refused the applicant leave to bring proceedings for damages in respect of an injury which arose in the course of her employment with the respondent before 12 November 1997. The injury is emphysema which the applicant contracted as the result of her passive inhalation of cigarette smoke in the workplace between 1985 and 1990.

2 The judge refused leave to proceed because he found that the applicant had not made an application for a serious injury determination under s 135A(2B) of the Act within the time prescribed by s 135AC(b). Section 135AC(b) provides that proceedings for damages in respect of an injury which arose in the course of a worker's employment before 12 November 1997 must not be commenced:

> If the cause of action arose before 12 November 1997 and the incapacity arising from the injury was not known until after 12 November 1997, unless an application for a determination from the worker under section 135A(2B) has been made to the Authority or a self-insurer before the expiration of 3 years after the date the incapacity became known.

3 The application for a determination under s 135A(2B) was made on 24 December 2010 and so the relevant date for the purposes of s 135AC(b) was 24 December 2007. The judge held that:

> It appears to me that Dr Fisher's clinical notes demonstrate that the plaintiff [applicant] was labouring under major symptoms of an increasingly incapacitating chronic obstructive airways disease from 6 June 2000 onwards. It also appears to me that the severity of those symptoms were well-established before 24 December 2007. By 2007, the plaintiff's evidence is that her symptoms were well-established and only progressed a little at a time thereafter.
>
> I am satisfied on the medical evidence up to that time, and confirmed particularly by the evidence of Dr Sasse, Dr Burdon and Dr Trembath, that if the plaintiff had made an application for serious injury before 24 December 2007, that she would have succeeded, because all of the elements necessary to prove that she had suffered an injury which resulted in a long-term

impairment of the function of her lungs and long-term consequences were obviously present.[1]

The grounds of appeal

4 Although variously stated in the applicant's proposed grounds of appeal, the nub of the applicant's complaint is that the judge erred in his approach to the application of s 135AC(b) by failing properly to identify the compensable injury. In particular, the applicant contends that:

- The compensable injury is emphysema; the applicant was not diagnosed as suffering from emphysema until early in 2008; and, consequently, the applicant's incapacity arising from the compensable injury was not known until early 2008.

- The judge erred by identifying the compensable injury in terms of the generic description, 'chronic obstructive airway disease'; wrongly proceeding on the basis that both asthma and bronchitis are species of chronic obstructive airway disease; and so erroneously concluding that, because the applicant was diagnosed in June 2000 as suffering from asthma and bronchitis, her incapacity arising from the compensable injury was known before 24 December 2007.

- The judge's reasons are inadequate in that they do not condescend to an explanation of why the judge concluded that the several different respiratory conditions of asthma, bronchitis and emphysema were identified by a single diagnosis of chronic obstructive airway disease.

- The judge erred in finding that, prior to 24 December 2007, the applicant would have succeeded in a serious injury application because 'all of the elements necessary to prove that she had suffered an injury which resulted in long-term impairment of the function of her lungs and long-term consequences were obviously present'.

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1 Reasons, [59]-[60] (citations omitted).

The judge's reasoning

5 Before turning to the applicant's specific criticisms of the judge's reasoning, it is convenient to say something more general about his Honour's approach. As appears from what is set out above, his Honour proceeded by steps as follows:

a) first, although the applicant was not diagnosed as suffering from emphysema until January 2008, it was obvious from about 2000 onwards that she was suffering from 'major symptoms of an increasingly incapacitating chronic obstructive airways disease'; hence

b) secondly, if she 'had made an application for serious injury before 24 December 2007 … she would have succeeded', because 'all of the elements necessary to prove that she had suffered an injury which resulted in a long-term impairment of the function of her lungs and long-term consequences were obviously present'; and, therefore

c) thirdly, it follows that the applicant did not make an application for a determination under section 135A(2B) to the Authority or a self-insurer before the expiration of 3 years after the date the incapacity became known.

With respect, we agree with the first and second steps but not with the third.

6 Plainly enough, the applicant knew before 24 December 2007 that she was 'labouring under major symptoms of an increasingly incapacitating lung disorder'. She also knew, because she was so advised by her specialist consultant respiratory physician, Dr Sasse, that, in his opinion, the lung disorder was chronic asthma. She knew, too, that, in the opinion of her general practitioner, Dr Fisher, her chronic asthma was 'related to' her passive inhalation of cigarette smoke while working for the respondent. She also accepted in cross-examination that, as at 2006, she had:

> some idea that the abnormalities in your lung function test were the result of the cigarette smoke that you had been exposed to in your workplace?

7 Where we disagree with the judge, however, is that, in our view on the evidence before his Honour, emphysema was shown to be a disease so different in kind and consequences from either chronic asthma or chronic bronchitis that, until the applicant was diagnosed as suffering from emphysema, neither the injury nor the nature and scale of the consequent long-term impairment of her lung function were facts which were known.

The diagnosis of the applicant's condition

8 The applicant was first diagnosed by her general practitioner, Dr Fisher, in 2006 as possibly suffering from cigarette smoke induced emphysema. Dr Fisher based that diagnosis, in part, on the results of spirometric lung function testing of the applicant carried out in January 2006. Those tests showed inter alia that the applicant's carbon monoxide diffusing capacity (DLCO ml/min/mm Hg STPD) was 72 per cent of predicted capacity for a woman of her age and stature, and thus was 'mildly impaired'. As the judge found, however, Dr Fisher's 2006 diagnosis was in effect only a tentative diagnosis which Dr Fisher did not disclose to the applicant and which was almost immediately supplanted as a result of Dr Fisher referring the applicant to a consultant respiratory physician, Dr Sasse, for further diagnosis. Dr Sasse diagnosed the applicant as suffering from chronic asthma and, as Dr Fisher said in evidence, he deferred to Dr Sasse's diagnosis because Dr Sasse was a specialist. Consequently, between 2006 and January 2008, the applicant believed that she was suffering from chronic asthma as a result of the passive inhalation of cigarette smoke while working for the respondent and that the chronic asthma was productive of the impairment of lung function which she was then experiencing.

9 By January 2008, the applicant's symptoms had so much worsened that Dr Fisher referred the applicant for a second round of spirometric lung function testing. It revealed that, in the two years elapsed since the last round of testing, the applicant's carbon monoxide diffusing capacity had declined from the 'moderate' degree of impairment represented by a capacity of 72 per cent of predicted capacity for a woman of her age and stature to a 'significant' degree of impairment

represented by a capacity of 67 per cent of predicted capacity for a woman of her age and stature. Such a significant decline in so relatively short a period of time led Dr Fisher confidently to conclude that the applicant was in fact suffering emphysema as a result of passive smoking in the workplace; and, in or about January 2008, he advised her of that conclusion and that, because she had emphysema, she should expect that her symptoms would get progressively worse over time. Hence, from that time, the applicant was aware that she was suffering from emphysema as a result of her passive inhalation of cigarette smoke in the work place and that the emphysema was productive of symptoms which would continue to worsen.

When the incapacity became known

10 Although the judge accepted that it was not until 2008 the applicant learned that she had emphysema, his Honour considered that, because she was diagnosed in 2006 as suffering from chronic asthma, she knew from that time that she was suffering from 'chronic obstructive airways disease'; and, hence knew from that time of facts sufficient from which it was objectively possible to discern that she had suffered the serious injury which was the subject of her claim. As his Honour reasoned:

> The fact that the plaintiff did not have knowledge of the actual clinical process which caused or contributed to the diagnosis of chronic obstructive airways disease is not to the point. For example, if a worker suffered an injury to his lower back which might be due to a muscular or musculo-ligamentous or facet joint dysfunction or dysfunction of some other structure, it does not detract from a diagnosis that the worker suffered an injury to structures in the lower back resulting in an impairment of the function of the lower back which is long-term and which has consequences which are long-term. I do not accept that, in every case, it is necessary for the actual clinical process which caused or contributed to the injury to be identified when there is a sufficient clinical picture enabling a generic diagnosis to be made. In my experience, the latter is very commonplace in serious injury applications, and in damages trials where the impairment might not be capable of a precise diagnosis or where there is disagreement about the precise diagnosis, yet there is agreement that the worker suffered an injury described rather more generically.[2]

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[2] Reasons, [57].

11 With respect, we disagree with that part of his Honour's analysis. While it is true that a generic diagnosis (as opposed to the precise identification of clinical processes) may sometimes provide a sufficient clinical picture to start time running against a worker's claim, it is inevitably a question of fact and degree and, in this case, the diagnosis of chronic asthma in 2006 was in terms of fact and degree so far removed from the diagnosis of emphysema in 2008 that the 2006 diagnosis was in our view clearly insufficient to start time running.

12 As was explained in *Barwon Spinners Pty Ltd v Podolak*,[3] and reiterated in Ashley JA's explication of relevant principle in *Grech v Orica Australia Pty Ltd*,[4] 'injury' in the relevant sense is ordinarily understood to mean 'some physiological change to a body part'. Accordingly, 'serious injury' means a permanent serious physiological change to a body part which probably will not mend or repair,[5] where the seriousness of the injury is to be assessed by reference to the seriousness of the impairment of which it is productive.[6] So, if a worker knows that as a result of employment he or she has suffered some physiological change to a body part which is unlikely to mend or repair, and which is productive of a permanent serious impairment or loss of bodily function, the worker probably knows enough to start time running against a claim even though the worker may not be aware of the identity or mechanism of the disease in question or may be mistaken as to its identity or mechanism .

13 In this case, as the judge found, the applicant knew by about June 2006 that she was suffering from a physiological change to her respiratory system; which had been caused or exacerbated by her passive inhalation of cigarette smoke while working for the respondent; which might not mend or repair; and which was likely to remain productive of very substantial disabling consequences. Perhaps, therefore, as the judge said, the applicant's state of knowledge following the 2006 diagnosis

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3 (2005) 14 VR 622, 629 [9]-[10] (Phillips JA for the Court).

4 (2006) 14 VR 602.

5 Ibid 632 [18]-[19].

6 *Georgopoulos v Silaforts Painting Pty Ltd* [2012] VSCA 179, [58]-[59].

would have constituted a sufficient appreciation of an injury comprised of chronic asthma and chronic bronchitis suffered as the result of her passive inhalation of cigarette smoke while working for the respondent to start time running against a claim against the respondent in respect of *that injury*.[7]

14 What the applicant did not know, however, and would not learn until she was diagnosed with emphysema in 2008, was that, in addition to the chronic asthma or chronic bronchitis or more probably a mixture of both with which she had been diagnosed in 2006, she was also suffering from a further and significantly different physiological change to her respiratory system consisting of the progressive destruction of the tissue of her lungs, which would not only not mend or repair but progressively worsen with consequent increasingly intense symptoms and degree of impairment.

Confusing asthma with chronic obstructive airway disease

15 Counsel for the respondent argued below and repeated before us that, although emphysema may be a physiological disorder of different kind to chronic asthma and chronic bronchitis, the symptoms of each (which he said were apparent to the applicant from 2006, if not from the time of ceasing to work in 1990) were in all respects so similar that the three disorders were properly to be regarded as but different manifestations of the one generic disorder of 'chronic obstructive airways disease'. It followed, in counsel's submission, that the applicant knew from at least 2006 that she had suffered a serious injury of the kind which was the subject of her claim.

16 Evidently, the judge accepted that argument. His Honour said that:

> It was after the second lung function test [in January 2008] that Dr Fisher altered his diagnosis, but on my analysis of all of the evidence, he did not suggest that the generic term of chronic obstructive airways disease was not an appropriate clinical diagnosis.
>
> The clinical term 'chronic obstructive airways disease' was favoured by Dr Burdon and Dr Trembath as a generic clinical term. Both Dr Burdon and

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7 Emphasis added.

> Dr Trembath discussed a number of possible/probable diagnoses, being asthma, bronchitis and emphysema, but they did so in the context of one or other or all of those as causes or contributors to the clinical processes contributing to the clinical diagnosis of chronic obstructive airways disease.
>
> The way in which the case was developed by Mr Ingram is that it was not until a diagnosis of emphysema was made that the plaintiff acquired the relevant knowledge. I reject that proposition. Firstly, it ignores the clinical diagnosis of chronic obstructive airways disease, and ignores the fact that the thrust of the diagnoses made by Dr Sasse, Dr Burdon and Dr Trembath include an attempt to determine the clinical process which caused or contributed to the diagnosis of chronic obstructive airways disease. Secondly, Mr Ingram criticised Dr Sasse's diagnosis of asthma, submitting that it was inconsistent with the balance of the medical evidence. Dr Fisher's evidence is that the plaintiff probably had asthma. Dr Burdon and Dr Trembath have not excluded asthma as being part of the plaintiff's clinical picture. Dr Trembath confirms that asthma is a relevant diagnosis, whereas Dr Burdon is of the opinion that the plaintiff suffers from chronic bronchitis rather than asthma.[8]
>
> …
>
> … the [applicant] subjectively knew [therefore] of facts at the relevant time before 24 December 2007 which, when viewed objectively at that time, means that she was suffering from the relevant incapacity before that date.[9]

17 With respect, however, we think that the argument is misplaced. It is true that Dr Fisher did not say that asthma was not chronic obstructive airway disease. But what is more to the point is that he did not ever suggest that asthma and chronic obstructive airway disease were the same things. Indeed, to the contrary, he several times said in substance that he regarded each as standing in marked contradistinction to the other. For example:

> To what extent did asthma camouflage or disguise any other condition that may have been present, for example, early emphysema, or - - - ? --- Well, the chronic asthma I treated her for was disguising the emphysema and COPD.[10]
>
> …
>
> Yes. But did you have any suspicion at all in those years [before 2008]? --- No
>
> …
>
> No, I didn't I just thought it was chronic asthma.

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8 Reasons, [54]-[56] (citations omitted).

9 Reasons, [63].

10 The terms 'COPD' or 'Chronic Obstructive Pulmonary Disease' and 'COAD' or 'Chronic Obstructive Airway Disease' were used interchangeably throughout the evidence.

For what period of time did you have that thought pattern, that this is chronic asthma that I'm treating? --- Until the second lung function test in [January 2008].

…

Yes. So before this time nothing about emphysema or COPD, that's the first time - - - ? --- That's the first, well, clinical entry, yes.

…

You knew she had had bronchitis over the years, before that entry did you ever associate that bronchitis with the COPD and the emphysema? --- At the time I didn't, but I did then, on 3 July '08, because that's what – you could work it out then.

Is that the first time you made that link? --- Yes. I was just linking it with asthma before that.

…

In terms of determining the cause of those symptoms, there is often an overlap as you have previously described? --- Yes.

As to whether they're due to asthma, whether they're due to chronic obstructive airways disease? --- Yes.

Or whether they're due to more discrete types of conditions, such as emphysema? --- Yes.

Your view was, was it not, that until the lung function test carried out in 2006 and 2008 that her symptoms were due to asthma? --- Yes.

…

Whether she be suffering from asthma or Chronic Obstructive Airways Disease, or perhaps some mix of the two, you would attribute the symptoms as being referrable to her exposure to passive smoking in the course of her employment that she has described to you? --- Well, the cigarette smoke wouldn't have done asthma any good, you see, I thought – I thought she had emphysema and I though it was attributed to the cigarettes from her work, but the cigarettes would have also triggered asthma – acute asthma attacks on a background of chronic asthma.

…

This conclusion is – just tell me whether you agree or disagree, this is Dr Sasse, writing July 2010, p.24, 'Asthma is a multi-factorial disorder and Lynette is allergic of rye grass (allergy testing result attached), but occupational exposure to cigarette smoke is very likely to have been a significant precipitating factor in her asthma'? --- Well, I have to accept that, what he says.

Would you agree with that? --- Yes, I have to accept that.

18 It is also true that Dr Burdon and Dr Trembath used the description 'chronic obstructive airways disease' as a generic clinical term and that they essayed a number of possible/probable diagnoses of the applicant's condition, being chronic asthma, chronic bronchitis and emphysema. But, with respect, they did not suggest that asthma, chronic or otherwise, was a possible contributor to the clinical diagnosis of 'chronic obstructive airways disease'. To the contrary, like Dr Fisher, they identified chronic obstructive airways disease, whether constituted of bronchitis or of a mixture of emphysema and bronchitis, as standing in contrast to chronic asthma.

19 For example, in his report dated 6 December 2010, Dr Burdon said:

> I am of the opinion that Ms Pattison suffers from mild chronic airways disease predominantly of the mixed emphysematous and chronic bronchitic types. I note that Dr Tony Sasse in his report dated 15th July, 2010 opines that Ms Pattison suffers from asthma. I would not agree with this opinion but do agree there is a small degree of reversibility in her airways obstruction, particularly the small airway level. This is entirely consistent with chronic airways disease.

20 Similarly, in his report of 15 October 2012, Dr Trembath, although reaching a different conclusion as to whether the applicant was suffering from both chronic asthma and chronic obstructive airways disease, drew a clear distinction between chronic asthma and chronic obstructive airways disease, as follows:

> In my opinion, the worker still suffers from asthma, and chronic bronchitis. On the basis of the reduced gas transfer, at 61% predicted, emphysema is, on balance, also a likely diagnosis.
>
> …
>
> Spiriva is being prescribed for her respiratory condition. While this is typically recommended for individuals with chronic obstructive airways disease, which may include emphysema, it is quite a common practice for respiratory specialists to prescribe Spiriva to assist with the symptoms of asthma. In the case of Ms. Pattison, the indications for Spiriva would either be related to underlying asthma or chronic obstructive bronchitis. Such a prescription would be entirely appropriate.
>
> *… In his report of 20 April 2012, Dr Burdon indicates that 'In my opinion, Ms. Pattison suffers from mild chronic airways disease of the mixed emphysematous and chronic bronchitis types'. Could you indicate what you understand Dr Burdon to mean by his opinion?*

> His diagnosis of chronic bronchitis is on the basis of the chronic productive cough. He includes emphysema on the basis of the reduced gas transfer. I think that this is quite a reasonable diagnosis to formulate.[11]

21 To essentially the same effect, at least as to the distinction between chronic asthma and COPD, Dr Edwards stated in his report of 27 August 2012 that:

> I can confirm that Spiriva was prescribed for her from January 2008 when Dr Fisher diagnosed her COPD condition. Prior to that, she had been seen mainly as an asthma case with exacerbation of infection from time to time.
>
> In summary, this unfortunate woman has clearly suffered from a chronic lung condition since at least the year 2000 and if we were to go back in time through her paper records, I suspect it would indicate and even earlier history of chest and lung disease. *However, it also seems that COPD only bec[a]me a significant element since January 2008*.[12]

22 Most importantly, however, to treat emphysema as if it were essentially the same injury as chronic asthma was to overlook the apparently critical difference in ætiology and symptomatology as between emphysema and chronic asthma or chronic bronchitis that, because emphysema alone is destructive of lung tissue, emphysema alone is productive of an irreversibly worsening reduction in lung gas transfer capacity. As Dr Fisher explained in the course of his evidence in chief:

> You knew she had had bronchitis over the years, before that entry [January 2008] did you ever associate that bronchitis with the COPD and the emphysema? - - - At the time I didn't, but I did then, on 3 July '08, because that's what – you could work it out then.
>
> Is that the first time you make that link? - - - Yes. I was just linking it with the asthma before that.

23 Similarly, in cross-examination:

> Could I then take you to the following page, it should be the test done on 7 January 2008: - - - Yes.
>
> That was also from the Regional Respiratory Service, at Traralgon? - - - Yes.
>
> On 7 January 2008? - - - That's right, the same technician.
>
> A comment 'Normal spirometric values with no further significant acute bronchodilator response demonstrated.' Correct? - - - That just – yes, that just means she wasn't having an asthma attack at the time.

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11 The emphasis is original.

12 Emphasis added.

So it's certainly a similar comment to that made in the first report? - - - Yes.

Then it says, 'carbon monoxide diffusing capacity remains, sig. impaired.'? - - - Significantly impaired, yes.

Remains significantly impaired? - - - Well, she only – from me, she only had lung function tests in January '06, and January '08, so I just then thought there was a deterioration from between those two dates and I thought she had emphysema.

But you said before you were relying on the comment of the technician? - - - Yes.

And the technician's comment is that the carbon monoxide diffusing capacity, remains significantly impaired? - - - Yes.

Yes? - - - Yes.

That would suggest there has been little change, would it not? - - - Well, what he said – mildly impaired, but the same person said mildly impaired on 20 January '06, and significantly impaired on 7 January '08.

24 And, in re-examination:

Just to make sure we have specifically concentrated on my question, I am asking from what you saw from that second lung function test in January 2008 onwards, in terms of the progression or otherwise of her lung condition, what did you see? What you have just described, is that what you saw during that period? - - - It would be a slow deterioration due to recurrent – the recurrent chest infections would cause a slow deterioration in her emphysema.

25 To the same effect, the applicant said in her evidence:

In terms of the stability of your condition what do you say as to that? - - - He [Dr Fisher] said it would – that my emphysema would get worse as I got older.

26 The respondent did not call any of the other doctors for cross-examination. Nonetheless, like Dr Fisher, Dr Burdon concluded in his report of 20 April 2012 that, on the basis of a reduced diffusing capacity of 67 per cent, the applicant was suffering from emphysema; and, similarly, as has been seen, it was on the basis of a further reduction in gas diffusion capacity to 61 per cent of predicted capacity by 15 October 2012 that Dr Trembath ultimately concluded that, on balance, emphysema was a likely diagnosis.

27 Finally, as to the contrast in terms of irreversibility of impairment between asthma and emphysema, it is to be noted that, as at 15 July 2010, Dr Sasse was still of

opinion that the applicant was suffering from chronic asthma and not emphysema. In that respect, his diagnosis ill-accorded with the balance of medical opinion constituted of Dr Fisher, Dr Burdon, Dr Trembath and Dr Edwards, and it was not accepted. But importantly for present purposes, because Dr Sasse considered that the applicant was suffering only from chronic asthma, he concluded that 'her prognosis [was] excellent.' His evidence as to the likely consequences of chronic asthma was thus the only evidence on that point and there was nothing to suggest, contrary to his opinion that, if the applicant were suffering only from chronic asthma, her condition might not improve. In contrast, as has been noted, it was clear on the balance of medical opinion that the applicant was suffering from emphysema and clear on the evidence, and not disputed that, because she was suffering from emphysema, her prognosis was irreversible and bound to worsen.

28 It follows, as we see it, that it was not until January 2008 that the applicant knew of facts sufficient from which objectively to discern that, in addition to chronic asthma or chronic bronchitis or both, she had also been caused to suffer a further and significantly different physiological change to her respiratory system, in the form of emphysema, which was productive of different and irreversible disabling consequences of profoundly greater order than might be caused by asthma or bronchitis. Hence, the applicant did not know until January 2008 of facts which, objectively discerned, disclosed that she had suffered the serious injury which was the subject of her claim. While she may well have decided not to initiate proceedings in respect of her chronic asthma because she was informed that her prognosis for recovery was 'excellent' by Dr Sasse, once she was informed of the more serious diagnosis of emphysema, she commenced these proceedings.

More than one serious

29 As was noticed earlier in these reasons, it may be that, if the applicant had made an application for serious injury before 24 December 2007, she would have succeeded because 'all of the elements necessary to prove that she had suffered an

injury which resulted in a long-term impairment of the function of her lungs and long-term consequences were obviously present'.

30 On the evidence, she was diagnosed in 2006 as suffering from chronic lung disorder the result of her passive inhalation of cigarette smoke in the course of employment with the respondent, which was productive inter alia of shortness of breath, coughing and blood stained sputum. Arguably, therefore, it was apparent to the applicant from about June 2006 that she was suffering from a chronic, severely diminished lung function, which arose as the result of her subjection to cigarette smoke during her employment with the respondent, and that it was productive of a permanent serious impairment.

31 So to conclude, however, was hardly obvious. Indeed, for most of the hearing before the judge below, the respondent maintained the stance that the applicant was not suffering from emphysema – rather, only chronic asthma and chronic bronchitis – and that the disabling consequences of chronic asthma and chronic bronchitis were insufficient to qualify as serious injury. As it appears from the transcript, it was only very late in the hearing, after it emerged in evidence from Dr Trembath's second report and Dr Edward's report that the diagnosis of emphysema was effectively unassailable, that the respondent changed tack to its present course of contending that it really does not matter whether the applicant is suffering from emphysema or only from chronic asthma and bronchitis – since, by reason of the diagnosis of chronic asthma in 2006, applicant knew from at least 2006 that she was suffering from a disabling lung disorder which was sufficient to start time running against her claim.

32 Be all that as it may, the point at which we really part company with the judge is not so much with whether there was enough known to the applicant from 2006 to establish the elements of a successful serious injury claim as with whether emphysema is to be perceived as an essentially different and profoundly more serious injury than chronic asthma or chronic bronchitis. For the reasons already expressed, we think that it is. It follows that, even assuming without deciding that

there were enough known in 2006 to reveal the existence of a serious injury, what was revealed in 2008 was sufficient to reveal a second and different serious injury.

33 It is trite that a single misadventure in the course of employment may be productive of more than one serious injury. For example, an automotive spray-painter might suffer industrial dermatitis the result of exposure to high-end hydrocarbons or isocyanates so serious and disabling as to amount to serious injury and yet later learn, after his symptoms have become worse, that in addition to dermatitis he has also contracted chronic skin cancer. There being two separate serious injuries the result of employment, it may well be that each would be a separate compensable injury. Similarly, to take an example with which counsel for the respondent readily agreed in the course of argument, the fact that a worker has once been diagnosed as suffering from chronic bronchitis productive of serious long term impairment the result of employment would not for a moment stand in the way of the conclusion that, if the worker were later diagnosed as also suffering from lung cancer as a result of employment, the cancer should be regarded as a further serious injury.

34 Ultimately, as we have said, it is a question of fact and degree as to whether two or more disorders are sufficiently similar or dissimilar in terms of physiological mechanism and consequent impairment of physical function as to be regarded as the same or separate injures. It goes without saying, therefore, that some cases will be clearer than others. At one end of the spectrum, there are cases like those instanced by the judge of a worker who suffers an injury to his lower back which might be due to a muscular or musculo-ligamentous or facet joint dysfunction. The fact that it is not immediately clear which of the two or more possible malfunctions is responsible may not be enough to stop time running against the claim. At the other end, there are cases of the kind to which we have referred of a worker who is diagnosed as suffering from chronic asthma or chronic bronchitis and is later diagnosed as also suffering from lung cancer. No doubt this case lies somewhere between them. Even so, it seems to us that it lies very much closer to the asthama/bronchitis cancer dichotomy than to that of the aggravated facet joint. Unquestionably, asthma and

bronchitis are one thing and, as Drs Fisher, Edwards, Burdon and Trembath all considered, and as the respondent initially argued, emphysema is quite another.

Rawlings' case

35 Finally, it is necessary to say something about this court's decision in *Morris & Joan Rawlings Builders and Contractors v Rawlings,*[13] to which the judge referred in the course of his reasoning. *Rawlings* involved psychiatric injury and consequently consideration of the issue that, because of the law's limitation of compensable mental problems to conditions which psychiatric medicine classifies as psychiatric injury, it is often if not always the case that a worker may not appreciate that psychiatric symptoms from which he or she may suffer rise to the level of serious injury until and unless he or she is diagnosed as suffering from such a condition. On the facts of that case, it was found that, although the applicant had suffered for years from significant symptoms later attributed to a psychiatric condition, it was not until he was finally diagnosed as suffering from that condition that he was capable of knowing that he had a compensable injury of the kind which was diagnosed.

36 In this case, the judge observed that:

> What the Court of Appeal observed [in *Rawlings*] is immediately distinguishable from the [applicant's] position. The [applicant's] position is rather more like the physical injury cases which the Court of Appeal referred to; that is, that her deteriorating lung condition was, to a large extent, obvious, and again, I refer to Dr Fisher's clinical notes and the opinions of Dr Sasse, Dr Burdon and Dr Trembath. I can well understand that the difficulty in determining whether a worker has a mental or behavioural disturbance or disorder is very different from a physical injury for reasons which the Court of Appeal commented upon.[14]

37 With respect, that is correct as far as it goes but it requires some qualification. Ultimately, as the judge observed, *Rawlings* turned on the difference between psychiatric injury and physiological injury. At base, however, *Rawlings,* like this case, was to do with the reasoning to be applied when a court is faced with a worker suffering from a disease, be it mental or physical, of which the existence and

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13 [2010] VSCA 306.

14 Reasons, [62].

consequences were only ever capable of being revealed by expert diagnosis. In such a case, as *Rawlings* showed, it is only when and if the worker is so diagnosed that it can be said that facts are known sufficient from which objectively to discern that the worker has suffered a compensable injury. Psychiatric injuries provide graphic examples of the phenomenon because the recognition of their existence is beyond the ken of most lay people. But they are certainly not the only examples, as this case this amply demonstrates.

38 In short, because of problems or uncertainty in the diagnosis of the applicant's condition, it was not known until early 2008 that she was suffering from emphysema and thus that she knew that she had sustained a physiological change to her respiratory system profoundly different in nature and consequences to the disorders of asthma and bronchitis which had previously been detected. In effect, up until that point, it was open to conclude that her condition, although serious, might yet remit or at least hold steady. Once emphysema was diagnosed, however, it was known that the disease could only go in one direction, for the worse, with significant and increasing reduction in her breathing capacity. Then and then only were there facts known sufficient from which objectively to discern that she had sustained a serious injury comprised of emphysema in addition to any which may have been comprised of her asthma or bronchitis.

Conclusion and orders

39 It follows that the application for leave to appeal should be allowed. Since it was agreed that the application for leave to appeal should be treated as the hearing of the appeal, it also follows that the appeal should be treated as instituted and heard instanter and allowed. We shall set aside the order the subject of appeal and, in lieu of it, order that the applicant have leave to bring proceedings for damages in respect of an injury, namely, the contraction of emphysema, which arose in the course of her employment with the respondent before 12 November 1997.

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