B & ors v Marinovich [1999] NTSC 127

PARTIES:	B AND C AND D PTY LTD v LEONARD M. MARINOVICH
TITLE OF COURT:	SUPREME COURT OF THE NORTHERN TERRITORY
JURISDICTION:	SUPREME COURT OF THE NORTHERN TERRITORY EXERCISING TERRITORY JURISDICTION
FILE NO:	10 of 1999 (9903023)
DELIVERED:	22 November 1999
HEARING DATES:	1 - 11 November 1999
JUDGMENT OF:	RILEY J

CATCHWORDS:

Negligence – professional negligence – psychiatrist – breach of duty of care - duty to warn patient of material risk inherent in treatment.

Briggenshaw v Briggenshaw (1938) 60 CLR 336, referred to.
Rogers v Whitaker (1992) 175 CLR 479, followed.
Naxakis v Western General Hospital and Another (1999) 162 ALR 540, followed.

Negligence – professional negligence – psychiatrist – breach of duty of care – patient dependent on psychiatrist due to treatment – improper sexual

relationship with patient – claim for past gratuitous services – exemplary damages awarded.

Rosecrance v Rosecrance (1998) 8 NTLR 1, applied.
MBP (SA) Pty Ltd v Gogic (1991) 171 CLR 657, applied.
Uren v John Fairfax & Sons Limited (1965) 117 CLR 118, followed.
Lackersteen v Jones (1988) 92 FLR 6, followed.
XL Petroleum (NSW) Pty Ltd v Caltex Oil(Aust) Pty Ltd (1985) 155 CLR 4487, referred to.
Thompson v James & Co Pty Ltd (1992) Aust Torts Reports 81-153, referred to.
Hart v Herron (1996) Aust Torts Reports 81-395, referred to.
Backwell v AAA (1997) 1 VR 182, followed.
Griffiths v Kerkemeyer (1977) 139 CLR 161, applied.
Carrick v Commonwealth of Australia (1983) 2 Qd R 365, followed.

Negligence – professional negligence – psychiatrist – breach of duty of care – patient dependent on psychiatrist due to treatment – improper sexual relationship with patient – loss of consortium.

Toohey v Hollier (1955) 92 CLR 618, applied.

REPRESENTATION:

Counsel:

Plaintiff:	J. Tippett
Defendant:	No appearance

Solicitors:

Plaintiff:	Ward Keller
Defendant:	

Judgment category classification:	B
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IN THE SUPREME COURT
OF THE NORTHERN TERRITORY
OF AUSTRALIA
AT DARWIN

B & ors v Marinovich [1999] NTSC 127
No. 10 of 1999 (9903023)

BETWEEN:

B
First Plaintiff

C
Second Plaintiff

D PTY LTD
Third Plaintiff

AND:

LEONARD M. MARINOVICH
Defendant

CORAM: RILEY J

REASONS FOR JUDGMENT

(Delivered 22 November 1999)

[1] The defendant is a psychiatrist. From July 1995 until February 1997 the first plaintiff was the patient of the defendant. She claims loss and damage arising out of her treatment in the course of that relationship.

[2] The second plaintiff is the husband of the first plaintiff. The third plaintiff is a family company which conducted the drafting business in which the

second plaintiff was a draftsman and which employed the first plaintiff as a general assistant.

[3] When the trial commenced on 1 November 1999 there was no appearance by or on behalf of the defendant. At that time evidence had been placed before me indicating that the defendant had received legal advice and had the benefit of continuing legal representation at least until 25 October 1999. On 25 October 1999 I granted leave to the solicitors then acting for the defendant to file and serve a notice of ceasing to act on his behalf. The information provided to me made it clear that the defendant's case had been prepared and was ready to proceed on 1 November 1999. It was also clear that the defendant was aware of the date set for the commencement of the hearing but that he chose not to be present either by himself or by his legal representatives to defend the matter. For the reasons I gave on 1 November 1999 I directed that the trial should proceed in the absence of the defendant and that the defence that had been filed and delivered on his behalf should stand.

History of the First Plaintiff

[4] The first plaintiff was born in Western Australia on 27 November 1952. She gave evidence that between the ages of 5 years and 10 years she was sexually abused by an uncle. She did not complain about that abuse until 1986.

[5] She completed her schooling in Western Australia at the equivalent of year 10. She then worked as a typist, buyer, receptionist and personal assistant in Western Australia, New South Wales and Victoria.

[6] In June 1985 she moved to Darwin and worked for the Northern Territory Tourist Commission followed by employment in the office of a Government Minister. Thereafter she had short periods of employment as a marketing assistant and as a secretary/receptionist.

[7] The first plaintiff married the second plaintiff on 7 July 1989. Their child was born on 23 October 1989 and the first plaintiff assumed the role of primary care giver. The second plaintiff continued to operate the drafting business and the first plaintiff did some bookkeeping and other administrative work in that business.

[8] On 28 April 1991 the first plaintiff suffered a miscarriage. In October 1991 she was admitted to the Cowdy Ward at Royal Darwin Hospital. She had been suffering from pains in her stomach that had not responded to medication and she had lost weight. She gave evidence that she was diagnosed with endogenous depression.

[9] The first plaintiff remained in Royal Darwin Hospital for some two to two and a half months. In the later stages of her admission she would go home for periods and then return to the hospital. She was treated with an anti-depressant drug, Prothiaden and she took that medication for approximately ten months.

[10] After her discharge she was treated as an outpatient at the Tamarind Centre. She also saw psychologists and a visiting psychiatrist.

[11] At that time she continued to work in the family business but her involvement was limited to updating records. She was also involved in the voluntary undertaking of delivering Meals on Wheels one day per week.

[12] The first plaintiff described her condition from 1991 until 1995 as follows:

> "Psychiatrically I thought I was fine but I still kept on having this stomach problem that nobody could find. Again it was off and on. I would get antibiotics and – antibiotics and I'd be okay for a couple of months and then I'd get the pains back again and it just went on, up and down for that sort of whole period."

[13] Her evidence was that ultimately it was determined that the cause of the stomach problem was a condition known as helicobacter. This was diagnosed in March 1995 and the condition was resolved by treatment with antibiotics.

[14] In July 1995 the first plaintiff was admitted to hospital with an ectopic pregnancy. She had surgery on 4 July 1995 and shortly thereafter suffered a "panic attack" which she described as:

> "I felt as if I'd lost control. I was shaky and my heart was going a hundred miles an hour and I was sweaty, I – I just lost control."

She was frightened and thought she was going to die.

[15] As a consequence of that event she was referred to the defendant. She saw the defendant whilst she was in hospital and he diagnosed her as having

post-natal depression. He prescribed a Benzodiazepine called Xanax and an anti-depressant named Aurorix.

[16] The first plaintiff says that on that occasion she asked the defendant whether the drugs were addictive and he assured her that she would not become addicted and that he had never had a patient who became addicted to medication prescribed by him. The first plaintiff also gave evidence of having asked the defendant on several occasions about becoming addicted to, and also about any side effects of, the drugs prescribed. She had read about side effects of nausea, constipation and headaches. The defendant informed her that the warnings were provided by the manufacturers to "protect themselves" and he continued to prescribe them.

[17] The prescribed drugs had an immediate effect. The first plaintiff described herself as feeling quite well and "almost my normal self". She saw the defendant nearly every day whilst she was in hospital. She was discharged on 14 July 1995 and she continued to see the defendant approximately once a week at his consulting rooms in Tiwi.

[18] In August 1995, despite her feeling well, the defendant increased the amount of Xanax that she was taking. She did not ask why the dosage was increased. The dosage was increased from a 0.5 milligram tablet three times a day to .75 of a milligram four times a day.

[19] The first plaintiff said that the diagnosis of post-natal depression was the only diagnosis of which she was informed by the defendant in the whole of

the time that she was under his care. The defendant did not alert her to any dangers of psychological or physical dependence associated with Xanax. The defendant simply prescribed the drugs and she took them in compliance with his directions.

[20] The first plaintiff said that in about September 1995 her social life began to decline. She felt tired and lacked energy. At that time she became aware that her mother had been diagnosed with terminal cancer and she enquired of the defendant whether she should have grief counselling. He advised her that this was unnecessary as she was suffering post-natal depression. He increased her intake of Xanax. In November 1995 her mother-in-law died. Her mother died in January 1996.

[21] On 12 November 1995 the first plaintiff attended at the Darwin Private Hospital suffering from what she described as "heart palpitations". The hospital contacted the defendant and she was given an increased dose of Xanax, together with some Mersyndol Forte. She was not admitted to hospital.

[22] After the death of her mother the first plaintiff said that she lacked energy and she was not taking much part in the life of her family or in work activities. She again asked the defendant about grief counselling and he advised that it was unnecessary.

[23] Throughout this period, and indeed until the cessation of her relationship with the defendant, the plaintiff took medication as prescribed by the

defendant. She did not self-medicate. She took all medicine in accordance with the directions of the defendant.

[24] In March 1996 the first plaintiff suffered another "panic attack". Her heart was "racing", her bowels were loose and she was nauseous. She thought she was going to die. She was admitted to Darwin Private Hospital on 13 March 1996 and was discharged on 20 March 1996. She saw the defendant there every day, except for Sunday. She was continued on Xanax and Aurorix.

[25] At about that time she was suffering menorrhagia and the defendant suggested that she should have a hysterectomy. She was referred to a gynaecologist, Dr Miller. Dr Miller performed the hysterectomy on 26 September 1996.

[26] Prior to making her decision to have a hysterectomy Dr Miller had provided the first plaintiff with a number of options. She discussed those with the defendant and, after discussion, he suggested that the hysterectomy would be the most appropriate option. She said in her evidence before this Court that she relied upon the advice of the defendant. However it is clear that she also had the advice of an appropriately qualified specialist in Dr Miller. She did not discuss the matter with her husband. Again the defendant visited her each day in hospital.

[27] The first plaintiff said that at this time she lost concentration. She could no longer concentrate on a book. She just sat in front of the television and otherwise did nothing. The efforts of the second plaintiff to discuss matters

with her were rebuffed. She always defended the defendant in conversations with her husband.

[28] In October 1996 she had contact from a man I shall call X with whom she had had a relationship many years before. X came to Darwin and saw the first plaintiff. They discussed a business venture and they spent time together. She realised she still had feelings for X and this caused her confusion. She sought advice from the defendant who told her that she was able to "love two people". She told her husband of her feelings for X and he was angry. She saw the defendant each day whilst X was in Darwin. X left Darwin about 17 October 1996.

[29] Shortly thereafter the defendant, in the course of treatment, offered her a massage and indicated that he was appropriately qualified to provide the massage. He showed her the relevant certificate. That massage took place on 25 October 1996 at the defendant's rooms. At the time of the massage the first plaintiff was naked but covered by a towel. The defendant wore shorts and a T-shirt, having changed from trousers and a business shirt. The defendant's wife was present in the reception area. The massage took place in the kitchen area at the other end of the building. The massage was successful and there is no allegation of any impropriety on the part of the defendant on that occasion.

[30] By this time the relationship between the first plaintiff, the defendant and Mrs Marinovich had developed into a social relationship. The first plaintiff

attended at Toastmasters with the defendant and his wife on a few occasions. Mrs Marinovich visited the first plaintiff in hospital and was supportive of her.

[31] The contact between the first plaintiff and the defendant gradually assumed a greater degree of intimacy. The defendant began to "hug" the first plaintiff at the conclusion of their many sessions. He told her she "felt nice" and that she had "beautiful skin". He paid her numerous compliments of that kind.

[32] A further massage took place on 20 November 1996. The first plaintiff said that on this occasion the defendant seemed to massage "further into my groin area and on the tops of my breasts". She did not do anything about that.

[33] The first plaintiff said that she paid $200 for each of the massages but that the service was recorded as a psychiatric consultation to enable her to recover the payments from a health fund.

[34] The first plaintiff advised the defendant that X was returning to Darwin. The defendant informed the first plaintiff that her husband was not affectionate, that she "probably needed a bit more love than [her husband] was giving you" and that he would provide her with "an alibi" if she wanted to see X.

[35] On 27 November 1996 the defendant provided the first plaintiff with a third massage which he described as a “special massage” and “a warm up for X”. On this occasion the massage went beyond the previous limits and at the conclusion the defendant had unprotected sexual intercourse with the first plaintiff. The defendant initiated all of the sexual conduct, including the sexual intercourse. The first plaintiff merely complied with his wishes.

[36] Whilst she did not express objection to the defendant’s conduct, she said that, following the sexual intercourse and upon leaving the premises, she drove a couple of kilometres down the road and then stopped. She was shaking and crying for about ten minutes. She was confused. She felt “terrible”. There were no further massages after that.

[37] Then, on 6 December 1996, the first plaintiff met X and she had sexual intercourse with him. She determined for herself that that had been the wrong thing to do and she had no further contact with X.

[38] The first plaintiff continued to see the defendant professionally and she informed him of the relationship with X. She was advised: “You don’t have to tell your husband everything. It’s our secret.”

[39] Thereafter, in December 1996, the first plaintiff suffered from a constant pain “like a cramp” in her stomach. She could not eat. She felt nauseous. She suffered headaches and was shaking and crying “all the time”. Her bowel functions went from one extreme to another. She had been losing

weight since about March 1996. By December 1996 she had dropped from 72 kilos to about 60 kilos.

[40] She was admitted to the Darwin Private Hospital on 13 December 1996 suffering from a further "panic attack". She remained there until discharge on 24 December 1996. The defendant saw her every day until he went on holidays to New Zealand on about 17 December 1996. He provided her with the number of his mobile telephone which she rang on at least two occasions.

[41] On 10 January 1997 the plaintiff was readmitted to Darwin Private Hospital. She was continuing to suffer pain, shaking and headaches and she was frightened. The defendant, who had returned from his vacation, readmitted her.

[42] She was referred to Mr Campbell who in turn referred her to a gastroenterologist in Adelaide, Dr Williams. From 2 February 1997 until 15 February 1997 she was an inpatient at Vales Private Hospital, Adelaide. It seems that, whilst there, she was not advised to alter her medication.

[43] Upon her return to Darwin she had a discussion with the defendant who was informed that Dr Williams had said her condition was "probably psychosomatic". The defendant rejected that proposition. However he did stop the Xanax and transferred the first plaintiff to Valium. She suffered another "panic attack" and was admitted to hospital on 18 February 1997. The defendant then took her off Valium and put her back on Xanax. Apart

from that occasion her medication remained the same throughout the whole of the period of her treatment by the defendant, ie she was taking Xanax and Aurorix in accordance with the directions of the defendant

[44] It was during that period in hospital that the first plaintiff came under the care of the defendant for the last time. Arrangements were made for her to fly to Sydney to stay with her sister and she did so. Whilst in Sydney she was seen by people from Crisis Line. She said that, at that time, she had with her Xanax, Aurorix, Rohypnol, Temazapam, Frisium, Prepulsid, Pepcidine, and Mersyndol Forte.

[45] When she arrived in Sydney her weight was down to 58 kilos and she described herself as being "an absolute mess". She had constant pain, she was not eating, she had headaches and she could not sleep. The only medication she was taking was that directed by the defendant. The sister of the first plaintiff, Linda Foulkes, gave evidence that the first plaintiff was, at this time, "basically like skin and bone". She said her sister was scared to be on her own, she would sit in the corner and stare at people and she cried "all the time".

[46] As a result of the call to Crisis Line the first plaintiff was taken to Central Sydney Area Health Service. She came under the care of Dr Burrows who reduced her intake of Xanax and Aurorix. She was having bad panic attacks and she went through what she described as a "withdrawal" at St John of God's Drug and Alcohol Unit in Burwood in Sydney.

[47] At St John of God Hospital she was under the care of treating psychiatrist Dr Selwyn Smith. She was admitted to the Hospital on 12 March 1997 and discharged on 15 April 1997. She underwent an intensive withdrawal program. Xanax was replaced with Valium and the Aurorix was simply removed. She did not continue to take any of the other drugs which had been prescribed at various times by the defendant, being Rohypnol, Frisium, Temazapam and Mersyndol Forte.

[48] She finally came off the Valium altogether during the course of her treatment at the Hospital.

[49] It is clear that during the course of the withdrawal the first plaintiff had a very difficult time. She had panic attacks, she suffered nausea, on occasions she would undergo uncontrollable rocking, ie moving her body to and fro. She was unable to sleep. She was unable to remain in one place and, on one occasion, she believed that she was dead. She suffered a crippling pain, she could not eat and she was very frightened.

[50] I have been provided with a report from Dr Selwyn Smith regarding the admission of the first plaintiff to the St John of God Hospital. He noted that on admission she was "in a most agitated and depressed state". She experienced considerable difficulty in withdrawing from the Benzodiazepines and she "demonstrated a marked degree of depression and agitation and pain focused behaviour" including "cramping behaviour".

[51] By the time of her discharge from hospital her sister described her as being "improved considerably" but that she was "still not in a good way". She was eating more and was more positive in her attitude. Upon her discharge from hospital Dr Smith prescribed Rivotril. She returned to Darwin where she saw Dr Anita Green who took her off Rivotril over a period of two weeks. At that point she still felt "pretty lousy" and she was down to 53 kilos in weight. When the first plaintiff was provided with Rivotril it had an immediate effect. The pain ceased and she calmed down. She started eating and exercising and gradually got better. After the Rivotril was withdrawn she was placed on an anti-depressant named Aropax.

[52] The first plaintiff continued to improve over a period of time and by August 1997 was able to start work at Aquascene. She continues to be employed by Aquascene. By the time she had returned to work she described her family life as "excellent". However she said she needed to put on weight.

[53] She gradually reduced her intake of Aropax and by January 1998 had ceased to use Aropax altogether.

[54] Earlier in 1997 the first plaintiff made a complaint to the Medical Board of the Northern Territory regarding the conduct of the defendant. She also engaged the services of solicitors.

[55] Thereafter she was involved in the preparation of material for the Medical Board. She made a detailed statement and medical experts examined her for the purposes of the hearing. She was required to relive the history of this

matter in those processes. In addition she participated in a hearing before the Board in the course of which she was subjected to lengthy and combative cross-examination. Of course she also had to prepare for the hearing before this Court.

[56] The matter was eventually heard by the Medical Board in the middle of 1999. The hearing before this Court commenced on 1 November 1999.

[57] Further, in July 1998, the brother of the first plaintiff died.

[58] All of these matters placed additional pressure on the first plaintiff and increased her anxiety. Following the death of her brother she suffered a further panic attack in what she described as a "relapse". Her general practitioner, Dr Green, prescribed Aropax and she has remained on that drug pending the finalisation of the hearings before the Medical Board and this Court. With the assistance of Aropax she has been able to cope with the various and difficult situations which have been presented to her. This is in marked contrast to her ability to cope in 1996 and early 1997.

[59] The evidence of the first plaintiff was that the whole of her history, including the episodes of sexual abuse as a child, had been provided to the defendant at a very early stage in the relationship. Indeed, in his defence, the defendant admitted that the first plaintiff had given him a history of having been sexually abused by an uncle between the ages of 5 and 10 years.

The Evidence of the Second Plaintiff

[60] The second plaintiff also gave evidence as to the history of the matter. His evidence was consistent with, and supportive of, that given by the first plaintiff. He said that from around Christmas 1996 his attitude became one of questioning the drug regime upon which his wife relied. He obtained the details of the drugs from bottles and packets in the house. He read the manufacturer's warnings and he conducted research on the Internet. When he tried to raise the subject of these warnings and the information he had discovered with the first plaintiff she would respond by observing that she had faith in the defendant. It soon became clear to the second plaintiff that this was not a welcome topic of discussion and he retreated from raising it.

[61] As time went on the second plaintiff said that the first plaintiff became totally focused upon herself. She was focused upon her physical and mental condition. She seemed more depressed. Nothing she ate agreed with her. She lost significant amounts of weight and was always tired and lacking in enthusiasm. They had no social life. There were consequent strains in the marriage and the second plaintiff said his wife seemed to grow more independent from him. She had talked of suicide.

[62] Eventually the first plaintiff was sent to Sydney. The second plaintiff indicated that, at that time, his attitude had become one of "you're going in there and you can't come home until you're off these drugs that you're on." In agreeing to assist his wife to travel to Sydney the second plaintiff did so

to assist her "to get away from her doctor". He told her "you have to come home free of drugs".

[63] Whilst she was in Sydney she informed him by telephone of the sexual relationship she had with the defendant. It was after that that the first and second plaintiffs sought legal advice.

[64] The first plaintiff returned from Sydney in mid-April 1997. At that time she was very weak. However she got noticeably better as time went on.

Findings of Fact

[65] In making findings of fact in this matter I bear in mind that the defendant did not appear. The only information I have regarding his case is that which appears in the defence. The evidence of the first plaintiff and her witnesses was not tested by cross-examination. I am aware that the allegations made by the first plaintiff against the defendant are serious and my findings may have repercussions beyond the scope of these proceedings.

[66] In proceeding to evaluate the evidence I have borne in mind the observations of Dixon J in *Briggenshaw v Briggenshaw* (1938) 60 CLR 336 at 361-362 where he observed that the nature of the issue necessarily affects the process by which reasonable satisfaction is attained.

[67] I listened carefully to the evidence of the first plaintiff. She did her best to recount the history. She did not shy away from dealing with issues which were obviously painful for her to recount and which gave rise to feelings of

guilt and embarrassment on her part. In general terms I accept her evidence and I note that in many respects it receives support from the other witnesses called and from the medical evidence tendered.

[68] I find that the first plaintiff was the patient of the defendant between July 1995 and February 1997. In that time the defendant prescribed the drugs on the dates and in the quantities summarised in Exhibit P13. The first plaintiff took those drugs in accordance with the direction of the defendant.

[69] I find that the defendant did not inform the first plaintiff of the side effects and the dangers associated with the regime he prescribed. He was dismissive of the warnings provided by the manufacturers of the drugs and he did not permit the first plaintiff to provide an informed consent to the course of treatment which took place. He did not provide her with any alternative regime for her consideration.

[70] I find that the defendant allowed the first plaintiff to develop an inappropriate dependency upon him and that he took advantage of that situation. He massaged her on three occasions and on the third occasion he had sexual intercourse with her. I accept the evidence of the first plaintiff in her description of these events.

The Medical Evidence

Dr Jonathon Phillips

[71] Dr Jonathon Phillips, a consultant psychiatrist and the current President of the Royal Australian and New Zealand College of Psychiatrists, gave evidence by video link. In addition he provided two reports which became Exhibits P3 and P4.

[72] In his evidence Dr Phillips discussed the impact that sexual assault of a child has on the individual as he or she matures. He noted that in the usual case psychological defences of suppression or repression push the unwanted memories away. He went on to say:

> "But these psychological defences are hardly sufficient to banish the memory forever and the memory, the powerful, destructive, painful, child-like memory can be reinvigorated by a sexual event in adult life. It is more likely to be reinvigorated if the sexual event is not within the safe confines of a marriage or a steady relationship. So on those grounds, the actions of Dr Marinovich as I understand them, in leading his patient to the point where he could have intercourse with her was likely to expose those powerful and destructive child-like memories which this lady undoubtedly had been trying to push away for many years."

[73] Dr Phillips observed that the first plaintiff appeared to have a degree of dependence upon the defendant. He said that in some cases of psychiatric treatment this is an inevitable occurrence. However it is a "fundamental goal" of the therapist to promote the patient's autonomy with consequent optimal coping strategies and that is the "expected and required end point of

therapy". He noted that dependency is contrary to the notion of autonomy and contrary to the process of recovery.

[74] It was the view of Dr Phillips that the conduct of the defendant in this matter amounted to the encouragement of a dependent relationship followed by an abuse of the trust found in that relationship.

[75] There can be little doubt that a sexual relationship between a psychiatrist and his patient is inappropriate both from an ethical and a treatment point of view. In this case the first plaintiff admitted having a sexual relationship with a former boyfriend at about the same time as sexual intercourse occurred with her psychiatrist. Dr Phillips acknowledged that the act of intercourse with the boyfriend "was also an issue which propelled (the first plaintiff) towards her – her then breakdown, if you could call it that". He identified the connection between the two acts occurring in close proximity, one to the other, as increasing the destructive power of each in relation to the first plaintiff. He went on to say:

> "I would say clearly the intercourse with Dr Marinovich, in that he was not a person in his role as her treating psychiatrist, with whom she could have any sexual contact. She'd broken more boundaries, more barriers and more – and had committed more ethical problems by being, as it were, induced into that relationship, or that intercourse, than with an ex-boyfriend."

[76] The relationship was one which was more destructive of her sense of self leading to "intra-psychic instability in the sense of loss of self esteem and

loss of certainty, and loss of direction", and was more damaging to the plaintiff than her single act of intercourse with an ex-boyfriend.

[77] In relation to the physical aspects of the condition of the first plaintiff Dr Phillips noted that she had a giardia infection on one occasion and on other occasions she had a helicobacter infection. He observed that these organisms could have led to some of her symptoms. However it was his view that the greater part of her unexplained gastro-intestinal symptoms were psycho-physiological in nature and associated with either her depression or her problems with Xanax withdrawal.

[78] Dr Phillips was of the view that the correct diagnosis of the first plaintiff was not a post-natal depressive disorder as found by the defendant but, rather, was a depressive disorder. This observation was made by other experts in reports received into evidence. My understanding is that the incorrect diagnosis would not have led to any real difference in terms of the appropriate treatment.

[79] Dr Phillips was critical of the drug regime that had been settled upon and pursued by the defendant over the period that he was treating the first plaintiff. The details of that regime are fully set out in the schedule which became Exhibit P13. His criticism was not so much of the choice of drug but rather the fact that Xanax, a Benzodiazepine tranquilliser, was used over what he described as "a very excessive period bringing with it quite significant dangers to the patient." The problem with the use of Xanax in

the circumstances of this matter is that it is a drug which induces habituation (ie psychological habit formation) and addiction (ie physiological tolerance of the drug). Whilst it is an efficient short-term tranquilliser, it is not a drug which should be used for the long-term management of a patient. Because it is a short acting drug there is, as a consequence, a rapid withdrawal experience.

[80] The evidence of Dr Phillips was that the daily average dose of Xanax prescribed by the defendant was close to being excessive. However the real problem was that, because of the protracted use of the drug, "[the first plaintiff] was inevitably going to become psychologically habituated to the drug, physiologically dependent on the drug and to suffer repeated withdrawal experiences when she wasn't taking the drug". He described the factors relevant to Xanax not being used in the longer term as follows:

> "There are a number of factors. Firstly, the drug of itself is habit forming and addictive. Second, it is a short acting drug, therefore, however, there is a rapid withdrawal experience when the metabolite is no longer within the brain which causes a withdrawal syndrome which leads to the patient to want to take more of the same drug. Thirdly, it has no secondary metabolite and therefore, the withdrawal is even more abrupt."

[81] It was the view of Dr Phillips that the nature of the drug should have been explained to the first plaintiff in order that she might provide her informed consent to using that form of treatment, and also so that she could be aware of, and alert to, problems which might flow from the use of the drug. He described the symptoms of withdrawal in the following terms:

> "The patient becomes tense, becomes anxious, agitated. There's a sense of – of doom or uncertainty and there are the physical concomitants of anxiety such as sweating, acceleration of heart rate, emote or restlessness, churning of the stomach, even passage of frequent stools or frequent urination."

[82] I note that these are symptoms which were described by the first plaintiff at various times in the course of her evidence. Indeed Dr Phillips noted that the first plaintiff had symptoms of that type "many, many times". Her symptoms he said went beyond that and she had on four occasions "full blown panic syndrome". Three of those occurrences he thought were likely to be associated with withdrawal from Xanax.

[83] The doctor acknowledged that there could have been a case made for the use of Xanax, but only "transiently" and in lower dosage.

[84] Dr Phillips put forward an alternative proposal for treatment. He suggested the first plaintiff should have been treated with one well respected anti-depressant agent eg the drug Aurorix which the defendant in fact prescribed. He then said a Benzodiazepine tranquilliser would be used in the short term and that "it would not have been inappropriate to use Xanax". This would then have been supplemented by appropriate counselling and other non drug related therapy, including education and training in relation to relaxation techniques.

[85] If the Benzodiazepine tranquilliser did not have the effect sought in the short term then it would be necessary to consider using a longer acting

Benzodiazepine tranquilliser. If that was not effective then a beta blocking agent such as Inderal may be used.

[86] If the regime suggested by Dr Phillips had been adopted it was his view that the first plaintiff would have shown substantial improvement within a couple of months. It was also his view that, had she been properly treated when first seen by the defendant, she would have been able to cope with the subsequent set-backs with, "no more than the anticipated pain that each and every one of us would experience".

Dr Carolyn Quadrio

[87] I received a psychiatric report from Dr Quadrio who is a consultant psychiatrist. In her view the diagnosis of post-natal depression made by the defendant was incorrect but he was correct in assessing the first plaintiff as being depressed. She expressed the opinion that the prescription of Xanax, a Benzodiazepine, would be an appropriate medication for the treatment of the panic attacks suffered by the first plaintiff. She observed that psychiatrists are aware of the danger of dependency with Benzodiazepines and that they should not be used in the long term.

[88] She expressed the view that "both the dose and the duration of Benzodiazepine prescribed were at the high end of the acceptable limit but not so much as to be judged bad practice." She also observed that the doses were not "seriously excessive and at most this might attract some mild criticism from his peers". This does not seem to sit comfortably with her

other observation that it is "very well known that Benzodiazepines are highly addictive and that withdrawal phenomenon are common on cessation." Nor does it coincide with the evidence of Dr Phillips, Dr Seidler and Mr Alderman regarding the duration of the treatment.

[89] In relation to the massages and the occurrence of sexual intercourse Dr Quadrio observed that these were highly inappropriate. She said:

> "It is also well known that patients with a history of childhood sexual abuse are particularly vulnerable to any inappropriate touching in therapy and psychiatrists are educated about the dangers of this. Dr Marinovich was aware of the patient's history and should have been absolutely clear in providing firm limits on any inappropriate behaviour or any behaviour that might run a risk of being interpreted in that way."

[90] Dr Quadrio went on to conclude as follows:

> "[The first plaintiff] was seriously traumatised by the sexualisation of the therapy. In effect any benefit she might have derived from Dr Marinovich in the past was entirely negated by this. She is slowly making a recovery from the effects of this trauma and I would expect that over another two years she will make a reasonable recovery. It is likely, however, that her capacity for trusting a professional, especially a male, will be permanently affected."

Dr Raymond Seidler

[91] Dr Seidler is a General Practitioner with a special interest in the field of drug and alcohol medicine. He has a practice in Kings Cross in Sydney and approximately one half of his patients are drug dependent on various substances.

[92] Dr Seidler advised that the use of Alprazolam or Xanax is "for short term symptomatic treatment of anxiety, including the treatment of anxious patients with some symptoms of depression." He agreed with the warning contained in the MIMS Annual that a physician should periodically reassess the usefulness of the drug for each patient. The drug should be prescribed for the shortest possible duration and at the lowest effective dose.

[93] Dr Seidler considered the whole of the relationship between the defendant and the first plaintiff and expressed the following conclusion:

> "In reviewing Dr Marinovich's treatment of [the first plaintiff], I believe that there was an excessive and prolonged prescription of Alprazolam to this woman at doses close to or above the therapeutic standard for the use of this drug. I further believe that the duration for which this patient was prescribed Alprazolam was excessive. I do not believe that Dr Marinovich made frequent or appropriate attempts to withdraw this patient in an in-patient setting, despite requests from the patient and the patient's spouse to do this. Upon reviewing the clinical information provided I conclude that the diagnosis of post-partum depression was not an appropriate one under the circumstances and that the correct diagnosis was made when the patient was transferred for detoxification to Sydney, namely she was suffering from a major depressive episode with panic disorder. The long term use of Alprazolam in patients suffering from a chronic depressive illness is inappropriate and ill-advised. More especially in patients who have suffered sexual abuse in childhood, as this patient population is more vulnerable to the effects of Benzodiazepines, the medication and the relief it provides them from their on-going stress. The use of a short acting medication such as Alprazolam in this case was contra-indicated I believe and the difficulty which [the first plaintiff] had in withdrawing is a clear indication of her dependence on this medication."

Mr Christopher Alderman

[94] I received two reports from Mr Alderman who is a consulting clinical pharmacist. Those reports provided detailed information regarding the pharmacological and clinical profiles of the various drugs prescribed for the first plaintiff by the defendant during the period July 1995 to March 1997.

[95] Xanax is a brand name for the drug, Alprazolam, which is a drug belonging to the Benzodiazepine class. As with all Benzodiazepines it has the potential to cause physiological dependence and withdrawal symptoms. The withdrawal effects commonly last for between one and six weeks but may persist for up to six months after discontinuation of the drug. Those symptoms include both physical and psychiatric components.

[96] Mr Alderman expressed the view that in all cases the patient should be informed and involved in the decision making process where Benzodiazepines are involved and that the patient should be made aware that Benzodiazepines are associated with the risk of dependence. It is not surprising that this view is supported by the literature to which Mr Alderman referred.

[97] Mr Alderman reviewed the regime of medication undertaken by the first plaintiff. He concluded that the dosage of Alprazolam (Xanax) prescribed for the first plaintiff at no time exceeded reasonable daily limits. He noted that there was a trend to increased daily dosing. At the commencement of treatment the dosage was 1.5 milligrams daily. Dosage escalation was

observed by him to have occurred within one month and within three months the daily dosage was more than double the initial dosage. Mr Alderman also recorded that the total duration of continuous treatment with Xanax was in the order of seventeen months. That, he said, was in excess of reasonable limits. The fact that the duration of the therapy was in excess of reasonable limits was confirmed by reference to product information and relevant practice guidelines. Reasonable medical and psychiatric practice would have been to explore alternative treatment options such as the use of Selective Serotonin Re-uptake Inhibitors (SSRI).

[98] It was his view that it was probable and predictable that the first plaintiff would have become physically and or psychologically dependent upon Alprazolam (Xanax) during the relevant time period.

[99] Mr Alderman said that the nature of the interaction between the first plaintiff and the defendant would have been substantially influenced by the provision of therapy by the defendant both in the form of psychological therapy and drug therapy.

[100] It was the opinion of Mr Alderman that the first plaintiff was dependent upon Benzodiazepines in both physiological and psychological terms. He went on to say:

> "In terms of the physical effects of the dependency upon [the first plaintiff] during the acute phase, very little lasting damage is likely. Although Benzodiazepines withdrawal reactions may include very serious physical sequelae such as seizures or disturbances in cardiac rhythm, these effects are only apparent on discontinuation of the

> drug. The potential psychological effects of such dependence are complex, and may have ramifications beyond the scope of [the first plaintiff] herself, reflected in her social and occupational functioning."

[101] He then said that after the withdrawal from Benzodiazepines became complete it would be unlikely that any significant enduring physical adverse effect would remain. However, there is always a risk of relapse.

[102] Mr Alderman was critical of the defendant for failing to attempt to wean the first plaintiff off the treatment during the course of a long-term Benzodiazepine treatment. He observed that "seventeen months of continuous Alprazolam treatment, with no apparent attempt to taper, represents a duration of treatment in excess of reasonable limits outlined in relevant practice guidelines".

The Law

[103] For the first plaintiff to succeed in her action in negligence she must demonstrate the existence of a duty of care owed to her by the defendant and that there has been a breach of that duty by the defendant which has caused damage to her. In this case the fact that the first plaintiff and the defendant were in a doctor/patient relationship provides the necessary relationship of proximity to establish the existence of a duty of care owed by the defendant to her.

[104] Amongst the duties owed by a medical practitioner to his or her patient is a duty to warn the patient of a material risk inherent in a proposed treatment,

Rogers v Whitaker (1992) 175 CLR 479 at 490. The risk that requires a warning is one that is real and foreseeable and not one that is "far fetched or fanciful". In the circumstances of the present matter the interest shown by the first plaintiff in the risk that the taking of the drugs prescribed may lead to some form of addiction was, in itself, a sufficient basis to require an appropriate warning from the defendant. The evidence of the plaintiff was that if she had been given the appropriate warning and if she had been provided with an alternative she would not have proceeded with the regime proposed by the defendant.

[105] The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. The standard of reasonable care and skill required is that of the ordinary skilled person exercising and professing to have that special skill: *Rogers v Whitaker* (supra) at 483 and 487; *Naxakis v Western General Hospital and Another* (1999) 162 ALR 540 at 545. In this case the skill required is that of a psychiatrist. It is a matter for the Court to determine whether or not the conduct conforms to the standard of reasonable care demanded by the law. It is not a matter to be resolved on the basis of expert medical evidence alone.

Liability in Negligence.

[106] In the circumstances of the matter I find that the defendant owed the first plaintiff a duty of care. I find that he breached that duty of care and, as a result, the first plaintiff suffered damage.

[107] In my opinion the defendant was negligent in implementing and continuing a regime in which the first plaintiff undertook seventeen months of continuous Alprazolam treatment. That period was considerably in excess of the reasonable limits outlined in the relevant practice guidelines and in the product information and was excessive according to the evidence of Dr Phillips, Dr Seidler and Mr Alderman.

[108] Dr Quadrio expressed the view that the duration of Benzodiazepine treatment prescribed was "at the high level of acceptable limit but not so much as to be judged bad practice". I do not accept this view given the published information regarding the use of Benzodiazepines such as Xanax and the consistency of that information with the uniform view expressed by the other expert witnesses. In making her observation Dr Quadrio did not refer to the fact that the actual period involved was some seventeen months. She did not refer to any of the literature including product information and practice guidelines. She did not discuss what, in her view, would amount to an appropriate period for such a drug to be prescribed.

[109] As a consequence of the negligence of the defendant in this regard I find that the first plaintiff became psychologically habituated to the drug and

physiologically dependent upon the drug which led to her suffering considerable difficulties in withdrawing from the Benzodiazepines.

[110] There was an alternative, efficacious and preferable course of treatment available. I accept the evidence of Dr Phillips in this regard. As a consequence of the negligent failure of the defendant to adopt the regime suggested by Dr Phillips, or a similar regime, the first plaintiff was subjected to a lengthy period of inappropriate treatment with the consequences set out above.

[111] In addition I find that the defendant was negligent in failing to inform the first plaintiff of the true nature of the drugs which he was prescribing. He failed to inform her that they were psychologically and physiologically addictive and he failed to provide her with the opportunity to consider and choose a different approach. Had she been appropriately advised I find that she would have declined to undertake the course of treatment in fact implemented. She would have agreed to a course of treatment of the kind suggested by Dr Phillips.

[112] Further, the defendant was negligent in his treatment of the first plaintiff by virtue of his conduct in permitting, indeed encouraging, her dependence upon him and allowing the relationship to become sexualised leading to sexual intercourse occurring between psychiatrist and patient. The defendant encouraged the growing dependence of the first plaintiff upon him. He did this by adopting the regime of pharmacological treatment

referred to and by fostering an inappropriate close personal relationship with his patient. Examples of that relationship can be seen in the many visits to her in hospital which, I find, went beyond what was necessary or appropriate. It is also to be seen in the social contact outside of the doctor/patient relationship, the passing of compliments of an inappropriate kind, the making of negative remarks relating to her husband, the encouraging of the relationship with X, the fact of and the nature of the massages and, ultimately, the request for and participation in the act of sexual intercourse. The sexualisation of the therapy had the effect of negating any benefit that the first plaintiff may have derived from her treatment by the defendant.

[113] The effect of this conduct, together with the impact of the drug regime, ensured that the first plaintiff suffered the history of which she complains rather than substantially recovering over a period of two to three months.

[114] I therefore find that the defendant is liable to the first plaintiff for the damage suffered by her as a consequence of his negligent conduct. In the event that I reached such a conclusion counsel for the first plaintiff invited me to refrain from considering the other causes of action raised in the pleadings. I accept that invitation.

Damages

The Third Plaintiff

[115] I note that the claim by the third plaintiff was abandoned during the course of the final address by counsel. I therefore dismiss the action of the third plaintiff against the defendant.

The First Plaintiff

Pain and Suffering and Loss of Amenities of Life

[116] In relation to the first plaintiff I have set out in the course of these reasons the impact of the negligence upon her. In summary I find that had she been provided with treatment of the kind suggested by Dr Phillips she would have resolved her problems over a period of two to three months from July 1995. As it was she has undergone considerable pain and suffering and disruption to her life as a consequence of the conduct of the defendant.

[117] She is now at a point where she is largely free from the consequences that resulted from the treatment provided. Her ongoing problems are minor and are controlled. Those problems were likely to have been present to some extent at this time whatever may have been the nature of her treatment. However she is now less trusting of psychiatrists and is likely to be more vulnerable should further problems arise.

[118] Making due allowance for all the matters raised and taking into account the contingency that problems may have arisen in the course of the alternative treatment regime referred to above, I award the first plaintiff $55,000 as damages for pain and suffering and loss of amenities of life. Given that the plaintiff is now largely recovered from her problems I apportion $50,000 of this sum to past pain and suffering and loss of amenities of life.

[119] The plaintiff is entitled to interest on the amount of $50,000 from the time the negligence occurred until judgment pursuant to s 84 of the Supreme Court Act.

[120] In *Rosecrance v Rosecrance* (1998) 8 NTLR 1 the Court of Appeal applied an interest rate of four percent on the non-economic loss over the whole of the period, noting that this has been the consistent approach by the Northern Territory Supreme Court since the High Court decision in *MBP (SA) Pty Ltd v Gogic* (1991) 171 CLR 657. The Court observed (at p7):

> "We consider that before changing what has become the settled practice to award 4 percent on the non-economic loss items this Court should hear evidence. Such evidence has not been put forward in this matter. In the absence of evidence we are not inclined to interfere."

[121] In the absence of evidence on the issue I am bound by that decision and I therefore allow interest at the rate of four percent for a period of four years. I calculate that sum as approximately $8,000.

Aggravated and Exemplary Damages

[122] The first plaintiff has claimed both aggravated and exemplary damages.

[123] Aggravated damages are compensatory and are awarded to reflect the circumstances and manner of the defendant's wrongdoing: *Uren v John Fairfax & Sons Limited* (1965) 117 CLR 118 at 149. On the other hand exemplary damages are not compensatory in nature but rather are awarded to punish and deter the defendant from committing such conduct again: *Lackersteen v Jones* (1988) 92 FLR 6 at 40. Such damages are awarded where the conduct of the defendant in the commission of the wrong complained of was "high handed, insolent, vindictive or malicious or had in some other way exhibited contumelious disregard of the plaintiff's rights": *Uren v John Fairfax & Sons Limited* (supra at 129); *XL Petroleum (NSW) Pty Ltd v Caltex Oil (Aust) Pty Ltd* (1985) 155 CLR 448 at 471.

[124] In *Uren v John Fairfax & Sons Limited* (supra at 149) Windeyer J described the distinction between aggravated damages and exemplary damages in the following terms:

> "The formal distinction is, I take it, that aggravated damages are given to compensate the plaintiff when the harm done to him by a wrongful act was aggravated by the manner in which the act was done: exemplary damages, on the other hand, are intended to punish the defendant, and presumably to serve one or more of the objects of punishment – moral retribution or deterrence."

[125] Any award of exemplary damages is not confined to the "intentional" torts. Recovery of exemplary damages is governed by the conduct of the

wrongdoer not by the nature of the tort: *Coloca v BP Australia Limited; Thompson v James Hardie & Co Pty Ltd* (1992) Aust Torts Reports 81-153 at 61,164. However there must be, on the part of the tortfeasor, "a conscious disregard of the plaintiff's rights": *Hart v Herron* (1996) Aust Torts Reports 81-395 at 63,486.

[126] In *Backwell v AAA* (1997) 1 VR 182, a case where exemplary damages were awarded in a medical negligence action, Ormiston JA, with whom Brooking JA agreed, warned against "the risks of inappropriately excessive awards by way of exemplary or punitive damages". He went on to say (at 208):

> "But in each case the question emphasised in all the authorities is that exemplary damages must be calculated by considering what is appropriate to punish the defendant, whereas compensatory damages are calculated upon the basis of what is sufficient to satisfy the plaintiff's claim. It is recognised that the plaintiff obtains a windfall benefit but that that is not inappropriate if it is necessary to punish the defendant for his or her conduct. It is said to act as a general deterrent but nevertheless a deterrent which is appropriate to the defendant's own behaviour and situation. If the ordinary damages already awarded are sufficient to impose a punishment, then the plaintiff cannot fairly complain if no more is added. For if the defendant's behaviour was of a kind which should have inflated the damages payable as compensation to the plaintiff, then it is appropriate to award aggravated damages which are now seen as different in nature from exemplary damages."

[127] Further, in that case, it was observed that the capacity of the defendant to pay will be a relevant consideration. In the present case I have very limited information as to the capacity of the defendant to pay. I am aware that he

has assets within the jurisdiction but I do not have particulars of the value of those assets nor of the extent to which they may be encumbered.

[128] In the present case I hold that there is a basis for the awarding of exemplary damages against the defendant. As I have already found, he allowed the first plaintiff to become dependent upon him and then took advantage of that dependence. He knew that the first plaintiff had suffered childhood sexual abuse and that, along with her psychological condition at the time of seeking his professional assistance, made her vulnerable to the sexual advances he subsequently made. She was at the time in a very confused state. The defendant took advantage of the prevailing circumstances to satisfy his own needs. He did so knowing his conduct was wrong and he urged the first plaintiff not to tell her spouse and she said that the defendant said it was "between me and him and no-one else need know". Further he charged the first plaintiff for a psychiatric attendance on that occasion. His conduct consisted of conscious wrongdoing in contumelious disregard of the interests and welfare of the plaintiff.

[129] In the circumstances of this matter and bearing in mind the award made in relation to general damages I award the amount of $30,000 by way of exemplary damages. I make no additional award in relation to the claim for aggravated damages.

Past Gratuitous Services

[130] The first plaintiff has claimed damages for past gratuitous services of the kind discussed in *Griffiths v Kerkemeyer* (1977) 139 CLR 161. The nature of the services provided by the second plaintiff are described in a submission made in writing and dated 15 November 1999. Essentially the claim relates to the performance of domestic duties and household services by the second plaintiff at a time when the first plaintiff was incapacitated by virtue of her medical condition.

[131] There is now no doubt that a plaintiff has a right to recover damages in respect of voluntary services and assistance of relatives and friends. The right to claim rests with the injured party and there is no duty on that party to account for monies received to those who may have provided the service.

[132] It was held in *Griffiths v Kerkemeyer* (supra at 193) that the value to be placed on the services rendered was "the standard or market cost of services". However as that commercial rate may include a profit element and may allow for tax which the first plaintiff will not have to pay, it is appropriate that the services be valued at less than the market rate in some cases: *Carrick v Commonwealth of Australia* (1983) 2 Qd R 365.

[133] The claim of the first plaintiff is that the second plaintiff provided up to 46 hours of voluntary assistance each week between September 1995 and October 1997. The schedule of the claimed hours is set out in Exhibit P16

and the arithmetical errors contained therein have been corrected in the written submission to which I have referred.

[134] The total hours claimed is 3,448.37 covering the whole of the period. No records were kept of the assistance provided by the second plaintiff to the first plaintiff and the information provided to me is necessarily an estimate based upon the recollection of the second plaintiff. I also bear in mind that the second plaintiff may well have provided some of these services in place of the first plaintiff in any event during the course of that period, whether or not she had been incapacitated. Further, it is likely that the first plaintiff may have been incapacitated for periods within that time, even had the defendant provided an appropriate regime of care. In addition there were periods when the first plaintiff was unable to undertake tasks because of other matters such as her undergoing a hysterectomy in September 1996. Again there were periods when the first plaintiff may have been able to undertake tasks but when she did not do so, for example in October and December 1996 when she was spending time with X. In all of the circumstances and applying a broad brush approach I allow a claim for such services for a period of 2,500 hours.

[135] The evidence before me is that the Red Cross Home Care Service of Darwin charges $21 per hour for the provision of such services where "a compensation claim or other funding is available". I was not provided with any information as to how that figure was calculated and whether it included any amount by way of profit or allowance for taxation. In the circumstances

I propose to allow compensation at the rate of $15 per hour. The total allowance in this regard is therefore $37,500. I allow interest on this amount at the rate of 4 per cent per annum for four years giving an additional amount of $6,000.

[136] No other claim for the provision of gratuitous services provided was pressed.

Medical, Ambulance and Hospital Expenses

[137] The first plaintiff has claimed these expenses and has detailed them in a document which became Exhibit P28. The claim was addressed in written submissions dated 15 November 1999.

[138] In the course of her treatment by the defendant the first plaintiff was sent to various specialists for further assessment relating to her physical symptoms. The written evidence of Dr Phillips in that regard was as follows (Exhibit P3 p19):

> "There is no doubt that [the first plaintiff] had experienced a number of physical symptoms involving a number of bodily symptoms. Some of her physical symptoms were demonstrated to have an organic base (abdominal pain associated with helicobacter infection, menorrhagia associated with disordered proliferative endometrium).
>
> Dr Marinovich had a duty of care which included referral of [the first plaintiff] to other specialists in the situation where he believed that she was suffering significant symptoms of disease beyond his area of expertise and skill. He could not be criticised for this."

[139] In his oral evidence before me Dr Phillips referred to this issue. He said:

> "I think it must be said that the majority of [the first plaintiff's] physical symptoms were in the domain of gastro-intestinal disturbance. She was so found, I understand, on one occasion to have a giardia infection, and on another occasion, or I think two occasions, to have a helicobacter infection, and it's possible that those organisms could have led to some of the symptoms she had. I am also aware that elsewhere, and I think earlier she had been diagnosed as having an irritable bowel syndrome, which in part is a psychologically determined disorder. Now to come back to the thrust of your question, I believe that certainly in part, and maybe in greater part, [the first plaintiff's] unexplained gastro-intestinal symptoms were psycho-physiological in nature and associated with either her depression or her problems with Xanax withdrawal. I think the explanation for them is probably going to be broadly in the psychological arena."

[140] The first plaintiff has claimed expenses relating to the attendances upon her of Dr P T Flett (a pathologist), Mr M Bailey (an acupuncturist), Ms M. Leggo (a dietician), Ms L M Hart (a naturopath), Dr M Keen (a radiologist) in the period from the commencement of treatment by the defendant through to 26 September 1996 when she had her hysterectomy. The submission was made that those persons were seen because of the physical symptoms which the first plaintiff experienced during that period and, it was submitted, those symptoms "were all caused by or materially contributed to by the drug regimen prescribed for the first plaintiff by the defendant".

[141] Although it was suggested in evidence that some of the physical symptoms may be attributable to the drug regimen, apart from what is set out above there was no specific evidence called on this issue. In particular there was no evidence called in relation to the treatments or testing provided by each of the persons I have identified. Further, there was no evidence called in

relation to the physical symptoms which resulted from the helicobacter infection, the menorrhagia and, ultimately, associated with the lead up to the hysterectomy.

[142] It was not until all physical causes had been excluded that it could be said that it was inappropriate to pursue investigations of physical causes of her pain and discomfort. None of the medical experts whose opinion was provided to me expressed the view that the defendant failed to provide an appropriate standard of care by not recognising that the symptoms may be caused by other than physical matters at any particular time. It was not until the first plaintiff was seen by Dr Williams at the Vales Hospital in South Australia that the conclusion that the symptoms were "functional" in nature was expressed. In those circumstances I am unable to accept that the first plaintiff has established that the defendant was negligent in arranging or causing the physical examinations to take place.

[143] In all of the circumstances I am not satisfied that the need for those services arose out of the negligent conduct of the defendant. Nor am I satisfied that they would not have been required whatever treatment may have been provided by the defendant. In addition the services provided by Mr Bailey, Ms Leggo and Ms Hart were, I understand, sought by the first plaintiff without reference to her medical advisers including the defendant.

[144] The same observations apply to the continuing treatment and testing which followed the hysterectomy. For the same reasons as I have expressed above

I do not allow the claims in relation to Dr Rich (pathologist), Dr Howard (specialist physician), Dr Osborne (radiologist), Dr Campbell (general surgeon), Dr Purser (an anaesthetist), Dr Robertson (radiologist), Dr Williams (gastroenterologist) and those to whom Dr Williams referred the first plaintiff, including Dr Abbott, Dr Marion and Dr Albertyn.

[145] In passing I note that some of the information conveyed in the submissions made on behalf of the first plaintiff in relation to Exhibit P28 and appearing in the document dated 15 November 1999 was not established by evidence before me.

[146] In relation to the admissions of the first plaintiff to the Darwin Private Hospital on 13 March 1996, 13 December 1996, 18 December 1996, 10 January 1997 and 18 February 1997 I note that each of those admissions was primarily brought about by a panic attack suffered by the first plaintiff. Whilst she was in hospital other examinations took place but it was the onset of a panic attack which was the principal reason for her admission. The other matters were incidental. In those circumstances and given the observations I have made above regarding the prospect that the alternative treatment regime proposed by Dr Phillips would have resolved these problems within a few months, I hold that these amounts are recoverable.

[147] The amounts claimed in relation to the Vales Private Hospital Adelaide I do not allow for the reasons expressed in relation to the claims I have rejected above.

[148] In all the circumstances I allow the following items from Exhibit P28:

Dr L. M. Marinovich	$6381.30
Dr D. K. Sheppard	$ 70.00
Dr G. Goodhand	$ 408.00
Dr E. K. Lee	$ 20.85
Dr S. M. Smith	$1705.00
Dr R. A. Sanders	$ 85.15
Dr L. W. Davies	$ 274.25
Dr B. Nebenzahl	$ 124.70
Dr M. D. McGrath	$ 194.40
New South Wales Ambulance Service	$ 156.85
	$9420.50

[149] In addition I allow the cost of treatment subsequent to the return of the first plaintiff from Sydney in relation to the following medical practitioners:

Dr A. M. Green	$1121.00
Dr T. Adams	$ 188.00
Dr D. Symons	$ 43.00
	$1352.00

[150] I allow the charges in respect of the St John of God Hospital in Sydney in the amount of $16,910.00.

[151] In addition I allow the amount of $953 in respect of the claimed transport costs of the plaintiff between Darwin and Sydney and return.

[152] The total sum allowed under this head is $28,635.50.

[153] The claim made by the first plaintiff for loss of income was abandoned in the course of the trial. By the conclusion of submissions there was no claim by any of the parties for loss of income.

Second Plaintiff – Loss of Consortium

[154] Actions for loss of consortium have been abolished by legislation in some jurisdictions in Australia. However they remain in the Northern Territory. A husband may recover damages for an injury to his wife which causes him to lose, permanently or temporarily, some or all of the advantages which are included in the concept of consortium, see Luntz: Assessment of Damages (3rd Ed.) par 10.1.1 et seq.

[155] In *Toohey v Hollier* (1955) 92 CLR 618 it was said (at 627) that:

> "(S)uch elements as mental distress are to be excluded but the material consequences of the loss or impairment of his wife's society, companionship and service in the home and the expense of her care and treatment incurred as the result of the injury form proper subjects of compensation of the husband."

The husband's grief or pity at his wife's circumstances is not compensable and nor is his distress at the "atmosphere of gloom" created by his wife's condition.

[156] In this matter the second plaintiff suffered a loss of consortium arising out of the negligent treatment provided by the defendant in respect of the first plaintiff. He was placed under a significant pressure as a consequence of the incapacity of his wife. He lost the society and companionship of his

wife over a period of time. Fortunately the relationship survived and the evidence is that it is now a strong and loving relationship.

[157] There was interference with the sexual side of the relationship for a considerable period but that has now been resolved.

[158] There was a significant impact upon the life of the second plaintiff with a substantial limitation of the first plaintiff's capacity to perform domestic duties, employment duties within the company, to manage the household and to provide to the second plaintiff comfort, society and fellowship. Although it is difficult to quantify a claim for damages of this kind and, in addition, I must be careful not to duplicate damages, I regard a proper sum to be awarded in this area as $10,000.

Summary of Conclusions

I summarise my conclusions as follows. I find that the defendant was negligent in his treatment of the first plaintiff and thereby caused loss and damage. I propose to award the following sums:

First Plaintiff

Pain and suffering and loss of amenities of life.	$ 55,000.00
Interest thereon.	$ 8,000.00
Past gratuitous services.	$ 37,500.00
Interest thereon.	$ 6,000.00
Hospital and medical expenses.	$ 28,635.50
Darwin Private Hospital	$ 16,345.00
Exemplary damages	$ 30,000.00
Sub total	$181,480.50

Second Plaintiff

Loss of Consortium (Second Plaintiff)	$ 10,000.00
Total	**$191,480.50**

The defendant shall pay the costs of the first and second plaintiff.

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