# SUPREME COURT OF QUEENSLAND

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| CITATION: | *Di Carlo v Dubois & Ors* [2003] QSC 204 |
| PARTIES: | **SALVATORE DI CARLO**<br>(plaintiff)<br>**v**<br>**DR PHILIP JAMES DUBOIS**<br>(first defendant)<br>**PHILIP DUBOIS (MEDICAL) PTY LIMITED (ACN 010 673 864)**<br>(second defendant)<br>**DENNIS RICHARD OSBORNE, PHILIP JAMES DUBOIS, STEPHEN BENNETT KELLER, PIYOOSH KOTECHA, GARY EDWARD O'ROURKE, MARK JAMES READY, PETER STOREY, CHARLES BRUCE LEIBOWITZ, PETER CHARLES LUSH, NICHOLAS DAUNT, DAVID ALEXANDER NOBLE AND PETER FERGUS LEGH trading under the firm name of style of QUEENSLAND X-RAY SERVICES**<br>(third defendant)<br>**DR MICHAEL CORONEOS**<br>(fifth defendant) |
| FILE NO: | SC No 1281 of 1996 |
| DIVISION: | Trial Division |
| PROCEEDING: | Civil Trial |
| ORIGINATING COURT: | Supreme Court at Brisbane |
| DELIVERED ON: | 16 July 2003 |
| DELIVERED AT: | Brisbane |
| HEARING DATE: | 21 November 2002, 22 November 2002, 25 November 2002, 26 November 2002, 27 November 2002, 28 November 2002, 29 November 2002 |
| JUDGE: | Mackenzie J |
| ORDER: | **The plaintiff's action against the first, second and third defendants is dismissed with costs, including costs of the first trial and any other reserved costs.**<br><br>**The plaintiff is entitled to judgment against the fifth defendant in the sum of $80,000 with costs, including reserved costs as between them to be assessed. Costs are to be assessed on the basis of District Court costs** |

**appropriate to the judgment amount.**

CATCHWORDS: TORTS – NEGLIGENCE – ESSENTIALS OF ACTION FOR NEGLIGENCE – GENERALLY – where plaintiff underwent CT Scan – where plaintiff claimed he specified to his neurosurgeon, the fifth defendant, that he would not undertake an invasive procedure – where plaintiff and fifth defendant pleaded a plain CT Scan was ordered - where severe reaction to contrast medium – where claim that CT Scan procedure not explained – where no direct warning given as to risks of CT Scan – whether fifth defendant negligent in not specifying a plain scan only was to be carried out – whether first , second and third defendants liable for breach of duty of care in not carrying out plain scan only – whether first, second and third defendants liable for failure to warn of material risk

DAMAGES – MEASURE AND REMOTENESS OF DAMAGES IN ACTIONS FOR TORT – MEASURE OF DAMAGES – LOSS OF EARNINGS AND EARNING CAPACITY – EXPENSE FLOWING FROM PLAINTIFF'S INABILITY TO WORK – GENERALLY – NON-PECUNIARY DAMAGE – LOSS OF AMENITIES OR CAPACITY FOR ENJOYMENT – where plaintiff sought damages for negligence – where plaintiff claimed financial loss and loss of amenities of life – where plaintiff had extensive pre-incident medical history and history of stress – where plaintiff also suffered unconnected injury after the event – where significant component of plaintiff's anger over the event derived from a misapprehension of the nature and properties of contrast dye used – where misapprehension due to mistake of fact, not irrational belief – whether loss wholly attributable to CT Scan incident – extent to which any negligence caused loss of economic capacity

*Hribar v Wells* (1995) 64 SASR 129
*Rogers v Whitaker* (1992) 175 CLR 479
*Rosenberg v Percival* (2001) 205 CLR 434

COUNSEL: N M Cooke QC for the plaintiff
R V Hanson QC, with P L Feely, for the first, second and third defendants
The fifth defendant appearing on his own behalf

SOLICITORS: Baker Johnson for the plaintiff
Flower and Hart for the first, second and third defendants
The fifth defendant appearing on his own behalf

**The Action**

[1] The plaintiff who is a barrister seeks damages for negligence. The first defendant is a radiologist. The second defendant is a company on behalf of which it is alleged the first defendant was acting in the provision of radiological services and medical treatment to the plaintiff. The third defendant was a partnership of which the first defendant was a member. He was allegedly acting for it in the provision of radiological services and medical treatment to the plaintiff. The fifth defendant is a specialist neurosurgeon. He is also a friend of the plaintiff. The action against the fourth defendant was discontinued some time before the action came to trial.

[2] On 2 October 2001, the trial commenced before Byrne J and a jury. However, the jury was discharged and the trial adjourned when the plaintiff sought leave to amend the statement of claim. The defendants had been jointly represented. However, as a result of the amendments it was necessary for the fifth defendant to be separately represented. He amended his defence and appeared on his own behalf in the present trial.

[3] A condensed summary of what was pleaded is that the plaintiff had discussed with the fifth defendant certain symptoms he was experiencing. The plaintiff and the fifth defendant went together to the third defendant's premises on 29 May 1993 where they met the first defendant. A radiologist employed by the third defendant carried out a CT scan using contrast medium. The plaintiff suffered a reaction to the contrast medium and alleges injury to his health and psychological wellbeing with consequent financial loss and loss of amenities of life. It is claimed that his medical history was not ascertained before the procedure was performed. He was neither told he would be injected with contrast medium, nor of the risk of a reaction occurring. Against the fifth defendant it is pleaded that the plaintiff told him some days before the procedure was undertaken that he did not wish to be injected with contrast medium. The fifth defendant either failed to inform the other defendants of this or, if he did inform them, the other defendants failed to comply with the plaintiff's request. It is also pleaded that the plaintiff was deprived of the opportunity of refusing the procedure because of the circumstances referred to.

[4] It is clearly established that the plaintiff was injected with contrast medium when the CT scan was being performed, that he had a reaction to the dye and that there was no direct warning of possible risks given. The first and fifth defendants had remained outside the room in which the procedure was being performed. However, when the emergency happened the first defendant assisted in treating the plaintiff. The evidence also establishes that after the plaintiff had been treated for the reaction, it was decided some time later, since he had been injected with the contrast medium, to carry on with the procedure that had been interrupted. Nothing of concern was discovered radiologically when the results were reviewed. Other issues concerning the process and surrounding events are more controversial. It is now necessary to descend into more detail about the evidence.

**The Plaintiff's History**

[5] The plaintiff was born in October 1956 in Sicily and migrated with his family to Australia in 1963. He joined the police force in July 1975. One of the areas in which he worked was the Licensing Branch in the period when it was controversial.

He gave evidence of a stormy relationship with some elements of the force. He was eventually retired from the police force as medically unfit in May 1987.

[6] He had commenced a law degree in 1982 but was excluded from the course when he had done a substantial part of it because of "double failure". However, he was then accepted as a candidate for the Barristers Board examinations and completed the Board's requirements. He was admitted to the Bar in May 1991.

[7] Prior to being retired from the police force he had been on stress leave. He was called as a witness at the Fitzgerald Inquiry. Further, his brother-in-law who lived nearby to him was murdered in unexplained circumstances by someone who shot him when he was in the driveway of his home. The circumstances of this and things that he heard about it caused him further stress.

[8] After he ceased to be a police officer he became a commercial painter during the Expo period but suffered the misfortune of having to become bankrupt from May 1990 to June 1993 because of a building owner defaulting on a debt due for painting work. Early in 1988 he began work at Murrell Stephenson, Solicitors, as a law clerk doing mainly personal injuries work. He was then recruited by Baker Johnson, Solicitors, and worked for them for about a year and a half before going to the Bar. He entered into an arrangement under Part 10 of the *Bankruptcy Act* 1966 (Cth) in about 1997 and remained subject to it at the time of trial. The relevance of this will become apparent later.

**Pre-incident Medical History**

[9] There is evidence that the plaintiff had asthma as a child but it did not persist into adulthood. He had at times prior to the incident concerned in this action suffered dizzy spells. In 1991 he complained of sensory abnormalities which were investigated for physical causes by Dr Hall, a physician. His reports concluded that in the absence of any neurological signs or indication of cardiac problems they were more likely to be stress related. It was reported by Dr Hall that the plaintiff said he had been subpoenaed to give evidence against the former Police Commissioner, Mr Lewis. Dr Hall said that after the plaintiff was admitted to the Bar, he seemed to improve.

[10] There are other aspects of the history apparently given that also suggest that the plaintiff was subject to the effects of the considerable stress throughout the years preceding the incident to which the present proceedings relate. On 20 December 1991, about 7 months after the plaintiff went to the Bar, Dr Bird, an Ear Nose and Throat specialist, was told by him, when positional vertigo was being investigated, of an inability to concentrate well and loss of memory.

[11] Dr Saines, a neurologist, reported on 20 February 1992 as follows:

> "He has subsequently explored the other symptoms of poor concentration and forgetfulness. He states that, on one or two days of each week, he is unable to interpret the legal documents he is reading. There is no suggestion of dyslexia but it seems to be a problem with him organising his thoughts and becoming involved with the task. He can otherwise perform normally, including appearances in court, and I do not think that staff or other family have noticed any problem. Likewise, his memory disturbance is

> erratic with short term loss of appointment times and other tasks which have not interfered significantly with his work."

He formed the conclusion that the neurological symptoms were functional in type and in response to long standing and more recent stress. He asked the plaintiff to consider his lifestyle and reduce stress.

[12] By May 1993 the plaintiff had begun to experience dizzy spells again and became apprehensive about his condition. On 14 May 1993, 2 weeks before the CT scan was done, he spoke to Dr Middleton, a psychiatrist, about them. According to Dr Middleton the plaintiff described a pre-occupation with fear of illness which the plaintiff described as "carcinoma phobia". He also described a fear of "losing it" in court. Dr Middleton's report sets out a history of stresses and traumas associated with the period leading up to the Fitzgerald Inquiry and the death of his brother-in-law. The history records that the plaintiff said that after he went to the Bar, life returned to normal and that he felt that he was coping well with his barrister's practice. He also said he had financial problems dating from the past. When he began to experience dizzy spells he was frightened he might have a brain tumour and convinced himself that he had one. Dr Middleton said that the plaintiff described that on some days he had difficulty reading briefs and suffered from lack of coordination.

[13] Dr Coroneos said that when he examined the plaintiff on 25 May 1993, he complained of recurring episodes of essential dizziness. At that time there were no clinical features of vertigo or raised intracranial pressure. The plaintiff was concerned with the continuing symptoms and anxious as to the likelihood of pathology in his central nervous system. Dr Coroneos said he eliminated the possibility of a "mass lesion" but told the plaintiff that despite an essentially normal clinical examination one could not exclude such pathology. On that basis he advised that a CT examination of the brain and cervical spine could be performed. He said that the plaintiff was extremely anxious at the prospect of undergoing those examinations and told him that he had a strange feeling that they would find pathology; (in that report there is no reference to the plaintiff being disinclined to undergo invasive procedures or to have an injection of contrast medium). On that occasion Dr Coroneos offered to come to the procedure with him so that he could take immediate steps in the event that any pathology was identified. At this time the plaintiff knew Dr Coroneos, having met him at a Baker Johnson party. The plaintiff said that because he was aware of Dr Coroneos's expertise he had decided to consult him. His account of what he told Dr Coroneos is consistent with considerable concern on his part that he may have a tumour.

[14] Although there are no reports in evidence from Dr Mulholland, the plaintiff was under his psychiatric care in the second half of the 1980's. In 1987 the plaintiff was admitted to Toowong Private Hospital in consequence of his condition. In that year he was retired from the police force on medical grounds.

**Motor Vehicle Accident 1994**

[15] There is evidence that the plaintiff was involved in a traffic accident on 3 March 1994 in which he suffered injuries. Dr Pentis, an orthopaedic surgeon, reported in December 1994 that the plaintiff complained of pain in the shoulder joint musculature and the cervical region including limited movement of his neck most of

the time. He also complained of headaches for a few days at a time. He said that it was uncomfortable to sit for long periods without changing position especially when reading and writing. Activity aggravated his neck and chest pain.

[16] Dr Pentis said that there would be a long term incapacity to the left chest in respect of lifting, bending and working overhead. With respect to the "more significant" injury to the cervical spine the plaintiff was likely to be left with long term problems which would affect his work, especially reading, writing, working at computers and the like. There may be an improvement over time in relation to the soft tissue injury.

[17] Dr Tomlinson, a neurosurgeon, reported on 2 June 1995 that the plaintiff had suffered a deceleration hyperflexion injury with a rotational component. In addition to the soft tissue injuries associated with the kind of accident, he had suffered a compression fracture of the C5 vertebra. He expressed the view that the plaintiff would continue to suffer pain in his neck and shoulder and headaches because he had suffered a significant injury. He would suffer in the long term especially having regard to his congenital fusion at C2-3. Long term, his condition would probably deteriorate, he would need to modify his work practices and may find it difficult in later years to continue desk work. He put his disability at 25% total disability of his cervical spine.

[18] Dr Devereaux, a rheumatologist, reported on 5 June 1995 that the cervical ligament strain may still cause pain difficulties for 12 to 18 months. Dr Martin, an orthopaedic surgeon, reported on 4 June 1996 that the plaintiff gave a history of still suffering chest, neck and upper back pain and headaches from the accident, which were constant. Dr Martin did not consider that the plaintiff was suffering from pain related to the accident.

[19] Dr John Cameron, a neurologist, reported on 8 July 1996 that the plaintiff gave a history that while there was an improvement in his neck discomfort up to the time of examination he still suffered intermittent discomfort on both sides of the neck. The plaintiff gave him a history that when he was in court he experienced neck pain after about 2 hours. His ability to work at night was compromised by the pain. He believed that the discomfort had plateaued.

**Events associated with CT scan**

**(a) The plaintiff**

[20] The plaintiff denied having any problems with stress in his practice prior to 1993. He said that prior to seeing Dr Middleton he had recurring dizzy spells about which he had not been reassured. He became a "bit distressed" by them and consulted Dr Middleton. He also decided to see Dr Coroneos because he was apprehensive and worried about the recurring symptoms.

[21] When he saw Dr Coroneos the plaintiff told him he was concerned that he might have a "tumour or something". Dr Coroneos said it was highly unlikely because if he had one over the period described he would have known by then. After Dr Coroneos examined him he told the plaintiff not to worry about it because he had found nothing. However, he could have a CT scan to exclude the possibility absolutely.

[22] The plaintiff said that he asked what it was and was told it was a scan that took slices. He asked whether it was invasive or non-invasive. He was told it was like a plain X-ray. He said he told Dr Coroneos "Well I don't want any invasive tests I don't want anything that – you know, if its just like a plain X-Ray, I'll have a plain X-ray. You know, I'll have that". Dr Coroneos again assured him it was non-invasive and explained how the machine worked; (there is no mention in this evidence of any reference to contrast). After the examination Dr Coroneos said that he was 99.9% sure that there would be nothing there.

[23] The plaintiff said that Dr Coroneos gave him a blue referral form. Although his evidence is a little vague as to precisely what was on the form, he said that Dr Coroneos "wrote something like CT brain or plain CT brain or CT brain and cervical spine, plain CT scan". Dr Coroneos volunteered to be present during the scan because he would be at the Mater in any event that morning.

[24] On 29 May 1993 the plaintiff went to the defendants' premises. He said he was nervous and anxious and in particular worried that if something was found he would know immediately because Dr Coroneos would be there. He was introduced to Dr Dubois and then to Mr Brown. He could not recall whether he gave the blue form to Dr Dubois or Mr Brown, although he thought it was one of them. Mr Brown took him into the CT room and said he was going to do some scans. The plaintiff was placed in the machine and thought that he went in and out of the machine about 3 times. He was not conscious of Mr Brown leaving the room during the procedure. He thought he was "wandering around the room".

[25] He then said that Mr Brown said something to the effect "Are you an asthmatic". The plaintiff said he replied "No" and was about to say "but" when Mr Brown said "you'll just feel a little prick". The plaintiff said that he then felt something go into his arm and instantaneously started choking, suffered from instantaneous fear like a panic attack that he had suffered in earlier years and felt as though his eyes and tongue were swelling. He said he was almost positive he heard someone say something about adrenalin and heard Dr Coroneos and Dr Dubois talking. He said that he became even more frightened when he heard someone say "We have to take him to emergency" and a voice which he thought was Dr Dubois' saying "No, no he might respond. He might respond. He might be alright." He thought that he was being stopped from being taken to emergency. He said that he also had a recollection of a case in which he had been responsible for the file when working in a solicitor's office where he believed Dr Dubois had been involved in an incident where he had delayed sending someone to emergency; (This later was one focus of the plaintiff's anger towards Dr Dubois). He said that he did not remember being discharged from the emergency centre but did remember being rolled somewhere else on the bed. He accepted that he must have had the second CT scan that day.

[26] He gave evidence that he suffered a further reaction the next day and was taken to the Mater Emergency Centre again. He believed that while he was there, Dr Dubois came to the area where he was and deliberately ignored him (which Dr Dubois denied). This was another focus of his anger towards Dr Dubois later. A third arose from an erroneous belief he had for some time that the substance administered to him was more risky than another that was available.

[27] Significantly in this respect, there is no record in Dr Middleton's notes of the consultation one week after the incident occurred of any complaint that he had been

given contrast contrary to instructions or against his wishes. What is recorded is a complaint that non-ionic agent was available. It is surprising that no such complaint appears if there had been a disregard of a request for a plain scan. In addition, even allowing for the immediate traumatic affects of the incident on him, it is difficult to accept that a person who had skill in the precise area of the law involved would not have articulated, in a timely way, a complaint that he had suffered consequences of being injected with contrast contrary to his wishes or instructions if it were the case. There is nothing to suggest that any such complaint was made orally or that Dr Dubois' attention was drawn to the blue form as proof that only a plain scan was ordered.

**(b) Dr Dubois**

[28] Dr Dubois's recollection of the detail of what happened in the period between the plaintiff's arrival and his reaction to the contrast medium was limited, a fact relied on by Dr Coroneos in relation to the acceptability of their respective versions. He did not recall whether the plaintiff came by prior arrangement but recalled Dr Coroneos being at the practice and telling him he was accompanying the plaintiff who was his friend for a CT scan. Dr Dubois said that he was conscious of the plaintiff's profession from the conversation that occurred. He agreed that it was not unusual for Dr Coroneos to take a special interest in his patients.

[29] Dr Dubois's recollection was that he and Dr Coroneos sat in an office and discussed at some length the procedure that was to involve a study of the brain and neck. Dr Coroneos explained to him that the plaintiff was particularly anxious that he had various symptoms and was particularly concerned that he might have a brain tumour. In cross-examination by Dr Coroneos, Dr Dubois said that his recollection was that the normal things in such a case were to be done and that Dr Coroneos would be well aware that it would involve contrast. He said that if there had been a specific instruction to him to deviate from that normal practice and give a plain CT scan only, he would certainly recollect such an event because he would have "engaged in significant debate" about it.

[30] He was unable to recall specifically whether there was a blue referral form but believed that there would have been, because the case was not of a kind where the procedure might be performed without one. He was prepared to accept that according to this practice there would have been a blue form. Unfortunately, one of the difficulties about this aspect of the matter is that the form is no longer available. In 1996 there is a reference in a letter to Dr Dubois's insurer to the blue slip, implying that it had already been disposed of in the ordinary course of the practice's document retention policy. Dr Dubois said that he had also kept notes of what had happened but in the 3 years that passed before the action commenced they had become lost, possibly during renovations of the premises. He had received a letter from the plaintiff dated 30 June 1995 which he sent to the insurers. This was the first time he had occasion to report it to them for fear of legal action. He also pointed out that, by that time, the period for which documents were usually retained had passed. The contents of the blue form can, at best, be inferred, if there is a sufficient basis to do so.

[31] Both Mr Cooke and Dr Coroneos pursued this issue on the basis of Health Insurance Commission documents and item numbers. One thing is certain. There is no dispute that contrast medium was administered to the plaintiff. The issue is whether

the documents support the proposition that it was done contrary to the request of Dr Coroneos for a plain scan.

[32] Two reports were generated by the first defendant. The first referred to an unenhanced brain CT with the notation that the patient had a severe allergic reaction to non-ionic contrast agent and the procedure was terminated. The second refers to a CT brain scan performed 2 hours after the injection of the contrast medium and after treatment for allergic reaction. It also refers to a CT of the cervical spine and of the thoracic spine. The markings suggest they were typed by different secretaries. A letter from the Health Insurance Commission shows that claims were made on 9 June 1995 by the plaintiff in respect of two item numbers, 56006 and 56209. The former relates in the relevant schedule to a non-contrast head CT scan. The second relates to a CT scan of the spine without contrast. However, a letter from the HIC relating to the plaintiff's claims shows those numbers, but the item descriptions of the claims are shown respectively as CT brain scan without contrast and CT brain scan with contrast. It seems unlikely that the explanation suggested by Dr Dubois that there was some discrepancy because of billing policy with respect to gap is consistent with the documents. However, the matter of what was on the blue form remains in my view inconclusive because of the discrepancies between the numbers and the descriptions in respect of which the claims on Medicare were apparently allowed.

[33] Returning to the events of the day, Dr Dubois said that after discussion of the case with Dr Coroneos he introduced the plaintiff to Mr Brown. Dr Dubois's recollection of what he told Mr Brown is vague. He could not recollect specifically telling him that the plaintiff was extremely anxious and obsessed with his health. He accepted that Mr Brown would have taken charge of administering the plaintiff's scan and followed the practise protocol and given contrast in accordance with it. He agreed that, at least, he would not have told Mr Brown not to give contrast. He said, however, that he had a "high level of confidence" that an unusual variation from the protocol would have triggered a recollection because he would have had an in-depth conversation about why there would be a departure from best practice. He said that he could not categorically deny that the blue form asked for a plain CT scan.

[34] After the plaintiff had been left with Mr Brown, Dr Dubois did not stay to observe the procedure. He said that he remained generally in the area attending to other duties. He conceded that it was possible that he spent time in conversation with Dr Coroneos although he had no specific recollection. He had no recollection whether Dr Coroneos was watching the procedure. He rejected the propositions that the plaintiff had been injected with contrast medium when there was no medical reason to do so and that it had been done contrary to a request by Dr Coroneos for a plain scan. He said that because of the degree of resolution achievable using the generation of equipment available at that time it was routine to give contrast when doing a scan of the cervical spine.

[35] Dr Dubois recalled being called into the CT room because Mr Brown believed that the plaintiff was having a severe reaction and would have been the person who administered the adrenalin. He recalled Dr Brandon from the adjoining emergency centre arriving and the plaintiff being removed there. He accepted that the plaintiff had a severe allergic reaction. He said that the procedure that had been aborted by the reaction was completed later in the day. His recollection of how it came about was that Dr Coroneos reappeared personally at the practice, gave Dr Dubois a

progress report on the plaintiff and asked if they would rescan him when he was fit enough because he would be unlikely ever to want to receive an injection of contrast agent again. It would be wise and to the plaintiff's benefit to complete the examination while the contrast was still in his system. According to Dr Dubois's recollection the plaintiff returned to the department, was placed in the scanner and had the remainder of the study. He believed that the thoracic spine had been X-rayed because of something the plaintiff said to Mr Brown about symptoms in that area.

[36] Dr Dubois said that if he knew that a patient did not want to be injected with contrast he would not do so unless the process had been explained and the patient consented. In a situation where he was discussing a case with a referring doctor, even if the blue form asked for a particular procedure he would rely on the outcome of the discussion in deciding what should be done. In the circumstances explained to him by Dr Coroneos, he would expect a contrast CT to be suggested.

**(c) Dr Coroneos**

[37] Dr Coroneos gave evidence that he was introduced to the plaintiff by Mr Boccabella at a Baker Johnson function in 1993. The plaintiff broached the subject of consulting him at the function with the result that a few weeks later Dr Coroneos saw him in his rooms on 25 May 1993. The plaintiff said he was troubled by vertigo which, despite consultations with other doctors and tests, had never been diagnosed definitively. He was worried because it was a recurrent problem. He had a concern that there might be a tumour. Dr Coroneos said that after a lengthy examination of the plaintiff he came to the conclusion that the condition was probably idiopathic benign positional vertigo. Notwithstanding Dr Coroneos' explanation that it was not serious, the plaintiff was still concerned about it. Dr Coroneos eventually said that if the plaintiff wanted they could do a CT scan which would support his diagnosis and opinion. The plaintiff inquired about the procedure and what it showed. Dr Coroneos said that it was just like having an X-ray. According to Dr Coroneos the plaintiff made it quite clear that he would not entertain the procedure if there was any possibility of any risks and did not want anything invasive. Dr Coroneos said that he told him there were no risks and that a plain CT was all that was required. Dr Coroneos said that the plaintiff did not explain what he considered to be "invasive". He also specifically disagreed with the evidence that the plaintiff gave at the abortive trial, but did not repeat at this trial, that the plaintiff had raised the issue of contrast with him.

[38] When the plaintiff expressed concern about the possibility that something adverse might be found, Dr Coroneos offered to be there so that it could be addressed immediately. Dr Coroneos thought that he had checked during his normal rounds at the Mater Hospital to find out when the plaintiff was expected and went to the other defendants' premises at the appropriate time. He saw the plaintiff in the reception area. After the matters in reception had been attended to they went to the general preparation area where Dr Coroneos spoke to Dr Dubois. According to Dr Coroneos he told Dr Dubois that the plaintiff was extremely anxious and that he did not think anything significant would be found. He said that what he told Dr Dubois related to the plaintiff's anxiousness about the possibility of a tumour (not about the risk of the procedure itself). He says that he indicated to Dr Dubois that a plain CT was what he wanted. He was questioned at some length as to why he wanted only a

plain CT scan to be performed since the purpose of the exercise was to eliminate any residual possibility that there might be a tumour or something similar. He said that he was so certain that nothing would be found that he considered the process akin to a screening test rather than an investigative or diagnostic examination. For that reason he thought a plain CT scan was sufficient, there being no indication for contrast.

[39] Dr Coroneos said that Mr Brown then took the patient with him into the CT scan room. He and Dr Dubois stayed in the general preparation area, about 6 to 8 feet from the console, and talked about matters not related to the case. He was questioned about whether he had looked at the images as they came up on the console screen while the procedure was being carried out. He was referred to Mr Brown's evidence to the effect that he and Dr Coroneos were in the console area doing so. Initially he said that he was not looking at the images as they were coming through but later when being cross-examined about the content of certain statements to which reference will be made soon, he said he may have looked at some of the images. He did not dispute Mr Brown's evidence as to the time that elapsed before the reaction occurred.

[40] Dr Coroneos gave evidence that Mr Brown came out of the room at one point and said that something had happened. He and Dr Dubois went into the room where Dr Coroneos saw the plaintiff showing signs of suffering a reaction to the contrast. Dr Dubois administered adrenalin and Dr Coroneos set about reassuring the plaintiff. Then Dr Brandon from the adjoining emergency centre came in and the plaintiff was taken there for treatment. Dr Coroneos went there but did not participate in the treatment. Once the plaintiff was stabilised Dr Coroneos went back to his rounds.

[41] Dr Coroneos said that he was not consulted about the taking of the contrast scan after the plaintiff had been released from the emergency centre. Nor did he ask that it be done. The evidence is problematical, since it seems unlikely that the plaintiff would have returned without encouragement from a source other than one at the rooms of the other defendants. Dr Coroneos said that he had never raised with Dr Dubois the allegation that he had disregarded his instructions to administer only a plain CT scan. He said that he did not consider it appropriate to do so.

[42] Dr Coroneos was also questioned about the circumstances surrounding the creation of two varying forms of letter sent by him to Baker Johnson in June 1996. One is stamped "draft" and the original of it retrieved from Baker Johnson's file, although not discovered, is stamped as having been received on 17 June 1996. That was in the period between the issuing of the writ and its service. Two differences were focused on. One was that in the draft there is a sentence which reads: "Subsequently the radiographer administered the contrast material". In the later letter, stamped as having been received on 19 June 1996, the corresponding sentence reads:

> "I then saw the radiographer administer the contrast medium."

Dr Coroneos gave evidence denying that he saw the radiographer administer the contrast medium.

Another passage in the draft reads:

> "He was extremely anxious with the prospect of undergoing these examinations and I felt this was most likely related to the possibility of a lesion being uncovered."

In the other letter it reads:

> "He was extremely anxious with the prospect of undergoing these examinations and he told me that he had some strange feeling that they would find pathology."

[43] There are other passages, not specifically cross-examined upon, that were also expressed, in the draft, in a way that expressed conclusions rather than stated facts, as the later version did. The letters were not hand signed but stamped with Dr Coroneos's signature. He maintained that he had not been advised by anyone as to the form in which the passages in the letter received on 19 June 1996 should be phrased. He said that the reason for the difference may have been either a misreading of notes or mishearing a tape on the part of his secretary, or amendments made by him, with the document marked "draft" being inadvertently sent first to Baker Johnson. His practice of doing drafts of reports and revising them was, he submitted, consistent with this.

[44] A solicitor from Baker Johnson who had the carriage of the file at the time of the letters denied having spoken to Dr Coroneos about the form of the statements. He relied on his meticulousness in making file notes of any conversations he had in connection with matters for which he was responsible and gave examples of file notes around the relevant time in support. There is no reason not to accept his evidence in that regard but the most likely explanation, having regard to the nature of the changes made, is that the statement received on 19 June 1996 had been amended to conform more closely to the rules of evidence and suggests the intervention of a legal mind, even eliminating the solicitor directly responsible for the file.

[45] Dr Coroneos was also questioned concerning his financial relationships with the plaintiff with a view to testing whether he had a financial interest in the outcome of the proceedings. Dr Coroneos admitted having lent the plaintiff $30,000 in 1996 at a time when the plaintiff was in financial difficulty. That had not been repaid and Dr Coroneos was a creditor in the arrangement entered into by the plaintiff under the Part 10 of the *Bankruptcy Act*. The question was asked in the context of whether Dr Coroneos had been told by the plaintiff that the debt would be repaid out of the proceeds of the judgment. He denied that there was any such arrangement or that his evidence had been affected by such considerations. It was also established that the plaintiff had acted without charge for Dr Coroneos in legal proceedings some at least of which were a consequence of his conviction for offences of fraud against Medicare. Dr Coroneos refuted the suggestion that his friendship with the plaintiff influenced his evidence.

**(d) Mr Brown**

[46] Mr Brown, the radiographer who performed the procedure, was very experienced. He qualified as a radiographer in 1978 and had worked in the practice since 1984. Since he had not been asked until about 2 years before the trial to recall events on the day, he was unable to recall some aspects of the fine detail of them with clarity. He did recall knowing in advance by means of a telephone call from Dr Coroneos

that the plaintiff was coming. He was not sure whether it was on the day of the procedure or earlier that the call was made. When he was introduced to the plaintiff by Dr Coroneos upon arrival, he was not given any information by him about the plaintiff's medical condition or history.

[47] Mr Brown said that the procedure upon a patient arriving was for the blue form to be given to the receptionist who put the patient's details onto a computer. After that was done the form was put in a plastic sleeve which came to the radiologist. As I understand Mr Brown's evidence, he did not specifically recall seeing the form before the sleeve came to him in the CT scan room. He had no clear recollection of what was on the form.

[48] He took the plaintiff into the room which is a lead-lined room with a viewing window from which a person in the console area can see in. Mr Brown explained the normal procedure in 1993, the first step in which was to correctly position the patient. Then, he would enter the details, some of which were reproduced on the film, into the CT machine, using the referral form as a source. Once the patient's positioning and the recording of the information had been done, the radiographer would come out of the room, and take a pilot image (which was unenhanced) for the purpose of setting the slices to be photographed. The photographic image would appear on the console screen. Once those steps had been performed, the apparatus would be properly aligned and activated to take the slices automatically. At this stage the photographs would be unenhanced by a contrast medium. The protocol was to do the brain first if the brain and spine were both to be photographed. The protocol at the time was that almost all brain scans were done with contrast. When the time came to do the spine, the radiographer, who had to be outside the room while the machine was operating, would re-enter the room, reposition the patient and then leave the room again. He would plan where each of the images of the discs would be taken and align the machine.

[49] In 1993 it was necessary to use contrast for photographing the spine. Mr Brown said he had a routine he followed when he returned to the room to administer the contrast medium, although he could not recall the exact conversation he had with the plaintiff. He said that he asked specifically if the patient was asthmatic and if he had had contrast agent given to him before. He would also ask whether the patient was allergic to shellfish. If he got a positive response to any of those questions he referred the case to the radiologist on duty. Since he did not do so on the day in question he assumed that he got a negative answer to each question.

[50] The next step was to place a tourniquet on the patient's arm to find a vein. The patient at this time was out of the scanner in a position where he could access the arm. The radiographer would then draw up the contrast into a syringe by means of a canula. He would check to find if the vein was accessible, swab the area with an alcohol swab and insert a butterfly needle into the vein, securing it with tape. He would then insert the syringe into the fitting and tell the patient that he was going to inject him, that he may feel a warm feeling and maybe a funny taste in his mouth. It would last for about 30 seconds and then go away. He said that he referred to "injection" not to "feeling a prick". The last mentioned word was one that he deliberately avoided using. The injection of the contrast itself took about 15 seconds because of the viscosity of the agent and the time from commencing giving the information about possible sensations to the completion of the injection would be of the order of 30 seconds. After the injection was finished he would disconnect

the syringe and go from the room to take the images. With cervical scans it was necessary to come and go from the room, after each image was taken, to realign the machine.

[51] Mr Brown said that he had almost completed the cervical scan when, about 6 or 7 minutes after the injection, the plaintiff said he was having trouble breathing. Mr Brown formed the opinion that he was having a reaction to the contrast and requested medical help. Both Dr Dubois and Dr Coroneos came into the room. He rejected the proposition that the plaintiff had reacted adversely almost as soon as the injection began.

[52] Unfortunately, the best evidence on this issue is unobtainable. Each of the images taken on the day would have had the time imprinted on it. However, the practice did not archive the photographs and electronic images were only kept for 6 to 12 months after the procedure. The plaintiff gave evidence that his copies could not be located. He was unsure whether he had ever had them. He looked where he kept his other X-rays and at his chambers but had not found them. He said that he only looked for them about a week before the trial when a request was made by the solicitors for the first to third defendants. He was unaware whether they contained information that would throw light on the issue of how far into the procedure it was before he had his reaction.

[53] I am satisfied that the plaintiff's recollection of the timeframe of the proceedings cannot be accurate. The evidence of how the procedure is performed and a lack of any reason to suppose that the procedure was not followed in this case is inconsistent with his evidence. There are separate steps of putting on the cuff to find a vein, insertion of the butterfly needle, and the explanation of possible sensations (even if it was brief). In my view the steps prior to the injection would cause a person whose firm intention was not to have an invasive procedure to question what was happening. The opportunity to do so existed for sufficient time for the process to be questioned. Depending on the view of the evidence taken there was about a minute to four minutes involved. The view just expressed is not intended to suggest that failure to do so of itself would constitute consent to the procedure in all circumstances. The fact that no question was raised at the time about what was happening is a circumstantial fact which, along with others, points to the conclusion referred to later.

[54] The evidence of Dr Coroneos that he told Dr Dubois that only a plain scan was required was denied in Dr Dubois's evidence. Dr Dubois gave evidence that given the practice then in operation at the practice, almost all brain and cerebral spine scans in circumstances described to him about the patient were done with contrast. There is a good deal of evidence that the potential benefits of a contrast scan in circumstances like the plaintiff's were well known in the radiological and neurological communities. Dr Dubois's evidence that if he had been told that only a plain scan was required in those circumstances he would have asked why contrast was not being sought gains some strength from that circumstance.

[55] Dr Coroneos' evidence that Dr Dubois expressed no surprise and made no inquiry of him about it is problematical. There was no practical reason for administering only a plain scan, leaving aside a placebo effect, of which there is no suggestion. A "screening" CT scan, referred to by Dr Coroneos, performed for the purpose of seeing if anything calling for further investigation existed was unable, according to

the evidence, to achieve conclusively the purpose of the consultation, to eliminate the very minor possibility which troubled the plaintiff that there may be a tumour.

[56] The most compelling reason, however, for not accepting Dr Coroneos's evidence that he told Dr Dubois that a plain scan only was required is his own evidence that he did not raise the issue of disregard of the instructions to give only a plain CT scan. It was not raised during the period when it was apparent that the plaintiff was having a reaction to contrast. No reference was made to the fact that the blue request form required only a plain CT scan at that time or in any subsequent timely way. It is incomprehensible that no complaint was made until a long time after the event that contrast was used contrary to a request only for a plain scan if that was the true situation.

[57] I accept that care is required in cases where specific recollection is lacking and practice is relied on to prove critical facts (*Hribar v Wells* (1995) 64 SASR 129, 139-140). However, in the present case, the combination of circumstances leaves me unpersuaded that there was a request by Dr Coroneos of Dr Dubois for a plain CT scan only. That conclusion is independent of any conclusion as to what the terms of the discussion between Dr Coroneos and the plaintiff were. That issue is defined as between them by Dr Coroneos' admissions that the plaintiff did not want to undergo an invasive procedure and that he told the plaintiff that what would be done was not invasive.

**Credibility issues**

[58] A number of issues were raised with regard to the plaintiff's credibility. Some which relate directly to his account of events immediately preceding and subsequent to the CT scan have been explored in previous sections. A number of issues of credit not directly related to those events were also explored. Particular focus was placed on interrogatories administered in the District Court action relating to the motor vehicle accident. In his answer to interrogatory 4, he said that prior to 3 March 1994 he did suffer an illness but could not say whether the illness had or would have any permanent effect on his health. He did not answer the subsequent interrogatory which sought details of such illness if the answer to the previous interrogatory was affirmative. In his evidence he focused on the word "permanent" as the reason for answering in that form.

[59] Interrogatory 9(a) related to illnesses, especially of a psychiatric or psychological nature, and asked whether since the date of the accident the plaintiff had ever suffered from any illness which had any permanent effect on the plaintiff's health or caused the plaintiff to be absent from work for any period of time. The substance of the answer was that he did not recall ever suffering any illness which had a permanent effect on his health or caused him to be absent from work for any period of time longer than day or two. However, he had been away from work for up to 3 hours a day from time to time directly related to symptomology of his cervical spine and/or back. He had also been away from work "in respect of an unrelated matter".

[60] There was no disclosure of the nature of this matter, which he conceded in cross-examination was concerned with the consequences of the reaction to the contrast medium. He maintained that his psychiatric condition was irrelevant to quantum in respect of the motor vehicle claim. When pressed, he advanced the reason that he did not want to disclose that he was seeing a psychiatrist on a regular basis. He said

that that was why he had referred to it as an "unrelated matter". He also said that he had disclosed taking anti-depressant drugs which should have alerted the defendant. However, he also accepted that in hindsight it was possible that a reader of the interrogatories may assume that their use was due to the effects of the motor vehicle accident.

[61] Interrogatory 6 which related to the plaintiff's state of health immediately prior to the accident was answered to the effect that it was "on a physical basis, good". He expressed the view that this invited the other party to seek further elaboration. He denied trying to conceal the disabling affect of the illness, and answered the interrogatories in that manner so as not to "proliferate any further", gossip which he believed was being spread, with a content of Schadenfreude, about him seeing a psychiatrist.

[62] It is inescapable that the form in which the interrogatories were answered is suggestive of a carefully devised strategy to avoid a direct lie but not make disclosure with the explicitness and frankness required. He was also questioned about the statement of loss and damage in that action which stated that prior to the accident the plaintiff enjoyed perfect health. He deflected the suggestion that this was untrue on the basis that it was not his document and that at that time, such documents were "taken with very little value", as they were prepared by clerks in solicitors' offices, without consulting clients, by reference only to the documentary evidence.

[63] There were other attacks upon his credibility including ones in relation to the reason for delaying discovery in that action until an order was made some 3 years later, issues relating to debts owed to family members and friends in the context of his financial affairs, with particular focus on the use of their voting power to avoid bankruptcy, statements made to Suncorp in relation to his claims under a disability policy, and discrepancies between various documents relating to his financial affairs generally. The matters mentioned in this paragraph are mostly probably more peripheral than central to the issues which must ultimately be determined, although some are relevant to quantum. They are specifically mentioned lest it be thought that they have been overlooked in the absence of detailed discussion of them.

[64] There was lengthy cross-examination, to some extent necessitated by the difficulty the plaintiff exhibited in meeting the proposition head on, directed towards establishing that there was a variation between the opening of the plaintiff's case at the first trial and his evidence at that trial, both of which versions varied in important respects from the plaintiff's evidence in this trial. In the opening at the first trial the following appears:

> "He then said to him, 'If you want to exclude the possibility of a tumor, the point 1 percent possibility that it might be a tumor, we could have a CAT scan.' There was some discussion about what was involved in that. He was told, Mr Di Carlo will tell you, that it was like having an x-ray, there was nothing intrusive about it. The question of contrast was raised. Mr Di Carlo said, 'What's that?' He was told, 'We will inject a dye into your vein.'
>
> Mr Di Carlo said to Dr Coroneos, 'No, I don't want any of that. I don't want any intrusive procedure.'

It will be noted that this passage has the appearance of one being quoted from a version given in direct speech.

[65] The plaintiff's evidence at the first trial in examination-in-chief was as follows:

> "He said, 'If you are still uncomfortable, you can have a CT scan.' I said, 'What's that involve?' He said, 'It's a plain x-ray, straightforward, just a plain x-ray.' I said, 'Where would I do that?' He said, 'I've got a friend – a good friend of mine who is in radiology at the Mater Hospital. You can have it there.' And I said, 'What does that involve?' He said, 'It won't involve anything.' I said, 'Is it invasive?' Or something to that effect. He said, 'No, no, no, no. There's nothing invasive. It's a straightforward x-ray.' I said – I mentioned something about contrast. I said, 'I've heard that they can inject contrast,' or something to that effect. He said no. I said, 'I don't want any of that."

[66] The evidence of the plaintiff in the present trial is summarised in paragraph [22] above. That evidence is also arguably different from the opening in the present trial where it was said that there was discussion about what was involved in a CT scan "and during the course of the discussion the plaintiff told Dr Coroneos that he did not want any intrusive procedure and there may have been some mention about contrast being used".

[67] The plaintiff gave evidence that since the version given in the previous trial was closer in time to the incident it was likely to be correct. The only reason for the variation was bad memory. He refuted the suggestion that the variation was due to a realisation that discussion about contrast with Dr Coroneos was damaging to his case against Dr Dubois. He did not accept the proposition that the words read in the opening of the first trial referred to above were apparently being read from a statement.

[68] Having regard to the combination of the plaintiff's imperfect recollection of events surrounding administration of the contrast and other matters that affect confidence in the reliability or transparency of his evidence, I do not accept that he was not asked about relevant risk factors prior to administration of the contrast. Even though I do not accept the accuracy of the plaintiff's recollection of what was said to him before the contrast was administered, he did not suggest that no question was asked of him. The conclusion that he was asked relevant questions is supported by the fact that Mr Brown did not refer any concerns over risk factors to Dr Dubois. Nor do I accept that there was a request for a plain scan only, or that the plaintiff believed that there was one. The general approach to his evidence otherwise will be to look for supporting evidence and to decide, in conjunction with evidence to the contrary, whether to act on it or not.

**The Plaintiff's Evidence of Change in Him**

[69] The plaintiff's evidence was to the effect that notwithstanding the symptoms of which he complained to various medical practitioners prior to the CT scan, he was having no trouble in his practice from those episodes. The fact that he described the symptoms in the terms used requires at least some discounting of the accuracy of his assessment of the efficiency with which he was able to perform, although he may have been able to mask the problem from others.

[70] The issue was brought into focus in the following passage of his cross-examination by Mr Hanson:

> "…. if I got dizzy then what would happen is that I would become anxious and if I became anxious that was the events. I mean, I don't remember it specifically, but they were never a problem with my work between 1991 or 1993 in the sense that I did all of my work myself. I never engaged anybody else. I worked long hours and I was able to earn an income of 76,000 with my own efforts in my first year when fees were significantly less than they are now or in 1995.
>
> Did you tell Dr Saines on the same occasion that you had memory disturbance which was erratic?-- No.
>
> No?-- No. I wouldn't tell Dr Saines that I had memory disturbance which was erratic. If that's a diagnosis of his, then that's not something I told him.
>
> Did you tell him anything that could have led him to arrive at such a diagnosis?-- I told Dr Saines, as I told Dr Bird, that I was having dizzy spells, that I was scared, that I wondered at that time whether it was some brain mass, whether there was some problem that I had in that area and that would make me anxious and when I got anxious I would forget things, I would become distracted, I would lose concentration and could we find the cause of them.
>
> Can we agree on this, Mr Di Carlo, that some health problems interfering with your ability to run your practice were nothing new in May of 1993?-- No.
>
> We can't agree on that?-- No.
>
> Doesn't this interfere with your practice if one or two days each week you are unable to interpret the legal documents you are reading, a problem organising your thoughts and becoming involved with the task, erratic memory disturbance? Does that not interfere with your practice?-- It didn't interfere with my practice. If that is his interpretation that didn't interfere with my practice. I did all of my work. In fact I did work for other barristers who had to go on holidays. In one particular case I did eight briefs for Goss Downey & Carne for another barrister to assist him because he had to go somewhere overseas.
>
> Do you still get these dizzy spells, Mr Di Carlo, that triggered this whole event which has brought us here today?-- No, the dizzy spells didn't trigger the whole event that has brought us here today, the injection of a contrast has brought us here today.
>
> Thank you. Do you still get the dizzy spells of which you complained which led to the event that brings us here today?-- No.
>
> No?-- No.

> When did they resolve?-- Pretty much after the - I don't remember them after 1993.
>
> Very well. You will agree with me, will you not, that the two complaints that we see here at the top of page 5 are nothing new?-- I don't know what you mean by that.
>
> You had suffered the same symptoms before 29 May 1993, perhaps in a different intensity or to a different degree, but the same symptoms had been there. Can we agree on that?-- Certainly in a different intensity and certainly in a much shorter span of period and that is the period of those dizzy spells when I didn't know what was causing them.
>
> But those causes are not presently operative; is that the case?-- No, I don't get dizzy any more.
>
> So the dissociative condition of which you presently complain is solely attributed to 29 May 1993; is that your case?-- It's not my anything. It's a matter for the doctors what they think. I don't have an opinion other than to say that before that I've never felt like this and after that I did."

**Other Evidence of Change in the Plaintiff and his Practice**

[71] Several witnesses gave evidence in this category. Mr Maher, a barrister, gave evidence that he devilled for the plaintiff in late 1995 and early 1996. The work was mostly personal injuries advices on quantum, pleadings, and advice in commercial matters. He received an average of $200 as a fee. He did 4 or 5 advices on quantum per week, preparing a hard copy which was given to the plaintiff for revision. He did an average of 1 pleading per week covering personal injuries, vendor and purchaser, commercial disputes and body corporate matters. He said that the plaintiff tended to dwell on detail which was often inconsequential when the draft was being discussed. He described the plaintiff as being disorganised and an emotional man. He said that he often had medical appointments. He knew that other counsel also devilled for the plaintiff.

[72] In May 1996 Mr Maher was asked by the plaintiff to be his junior in *Naomi Marble and Granite Pty Ltd v FAI General Insurance Company Limited* (1999) 1 Qd R 507. He was told that the trial was estimated to last for 2 weeks. However, the hearing lasted for 126 sitting days and did not conclude until just before Christmas 1996. At the time, Mr Maher had only been admitted for a few months and said that it was his first Supreme Court trial. They were opposed at trial by two Queen's Counsel with the resources of large firms backing them.

[73] He said that the plaintiff was not organised and became extremely emotional during the trial largely because he thought he was being treated unfairly. He reacted "very disproportionately to pressures, *sotto voce* comments coming from the Bar table or rulings by the trial judge". He attempted to reargue matters that had been ruled on, often in heated terms. According to Mr Maher the plaintiff lacked concentration for

the matters in hand and the organisation of material relating to witnesses. Because of the difficulty of getting instructions from the client and material for the trial, and a general lack of resources, the plaintiff was absent from the trial preparing witnesses and material for periods. Mr Maher had to continue with the trial. The plaintiff was also absent for what he told Mr Maher were doctor's appointments. He agreed that the plaintiff also did other work during the trial but was not sure if it involved appearing in trials or chamber work.

[74] In cross-examination Mr Maher said that the plaintiff had identified key issues prior to the trial commencing. However, in terms of day to day organisation, presentation and function of the trial, many of those aspects seemed beyond his ability to do at the time. While the plaintiff appreciated the key issues and argued them with vigour, Mr Maher agreed that there was "some force" in the suggestion that the trial was beyond the plaintiff's ability and experience. By the end of the day the plaintiff would be exhausted, teary and disproportionate in his reaction to things that he felt had gone against him. As Mr Maher put it, "I can only say that the trial itself seemed to be getting him down or exhausting him".

[75] Mr Maher said that he only appeared with the plaintiff on one other occasion, in a criminal trial. On that occasion the plaintiff seemed in control, composed and doing his job properly until the trial ended in a mistrial after the District Court judge stopped the plaintiff's cross-examination and an exchange ensued which resulted in the trial being aborted.

[76] Other witnesses gave evidence concerning the plaintiff's practice and capabilities at various times. Mr Kevin Lynch, a barrister who was on the same floor as the plaintiff from the time he came to the Bar in 1991 to early 1993, said that he was practising on a part-time basis and arrived at about 8.30am and left at about 5.30pm. The plaintiff was in chambers before he was and was there when he left. He said that he appeared to be busy for a new counsel and to have a promising future. He said he had no reason to believe that he was suffering from any illness, although there was no conversation about the subject. Having taken a part-time appointment on a Tribunal, Mr Lynch gave up his chambers in early 1993 and did not have any significant contact with the plaintiff again until the year before the trial. By that time he appeared to have lost confidence. I am satisfied that Mr Lynch gave his evidence in a balanced manner. It supports the view that the plaintiff was busy in his initial period at the Bar, but because of the circumstance that Mr Lynch did not have ongoing contact with him in the period following the incident with which the present trial is concerned his evidence does not represent a complete "before and after" snapshot of the plaintiff.

[77] Mr Murrell, a partner of the solicitors' firm Murrell Stephenson, gave evidence that the plaintiff had been employed at that firm from 1988 to about 1991 as a paralegal. According to Mr Murrell the plaintiff worked "incredibly long hours". He said that the plaintiff was gregarious, outgoing and well adjusted at that time. While Mr Murrell was not involved directly in briefing the plaintiff when he went to the Bar he was aware that other employees of the firm briefed him in personal injuries and medical negligence matters. He did not know whether and, if so, at what time such briefing ceased.

[78] Mr Boccabella, a barrister who had chambers on the same floor as the plaintiff when the plaintiff commenced practice in 1991, said that the plaintiff had a "big personal

injuries practice" after he came to the Bar. He seemed busy and enthusiastic. Mr Boccabella at that time tended to arrive about 9am and leave by 6pm. The plaintiff was there when he arrived and when he left. The plaintiff was still on the same floor in 1993 but had moved from chambers adjacent to Mr Boccabella's by that time. He did not see as much of him for that reason. The plaintiff subsequently moved to other chambers and Mr Boccabella said that he had not seen a lot of him since then. At a time that Mr Boccabella could not specify he thought that the plaintiff did not socialise as much, seemed melancholy and was difficult to get on with after some time.

[79] Mr Twohill, a solicitor at Southport, knew the plaintiff from 1991 onwards in a social and professional capacity. Between 1991 and 1995 he had his own firm and briefed the plaintiff principally in criminal matters. He gave the plaintiff a couple of family law briefs but decided that the plaintiff was better suited to criminal law. He said that he had been asked to give a statement about 2 months before the trial in relation to this matter. He said that he had noticed a change in the plaintiff towards the end of 1993. He fixed this time by reference to particular trials recorded in his diary. He said that prior to the change occurring the plaintiff had been prompt, diligent, thorough in his preparation and had a good demeanour towards the court and clients. After the change he became a bit short tempered and distracted, could not be relied on to return calls and was not putting as much effort into cases. His manner in court also deteriorated. Mr Twohill stopped briefing him in 1995. When pressed he said he could not say that the change he observed was sudden. He said that he had not seen the plaintiff since 1998.

[80] Mr Hutton is a barrister who had chambers on the same floor as the plaintiff from the time the plaintiff went to the Bar until he went to other chambers. He said that the plaintiff was confident, affable, a good colleague and a good friend. He gave evidence of an act of personal kindness performed by the plaintiff when he was suddenly taken ill. He agreed that he had been and was still fairly friendly with him. He said that although he worked in criminal law and the plaintiff worked in personal injuries, the plaintiff had a quantity of briefs to be envied. Mr Hutton partly attributed that to the fact that the plaintiff had worked as a solicitor before coming to the Bar. In late 1993 or early 1994 he noticed the plaintiff taking medication which the plaintiff said was an anti-panic drug. He did not enquire further about the cause of the illness but formed the view that it was more a mental than a physical situation. After that the plaintiff seemed to "lose the plot a bit". While Mr Hutton could not say that the plaintiff continued to deteriorate he said that he went from a person who was sure of himself to someone who seemed to lose interest, from someone who was always there to someone who was not there all the time. All he could say was that he noticed a change in him but could not say what caused it.

[81] He said that he was aware that a number of junior barristers whom he could not specifically name except Mr Maher, devilled for the plaintiff. He was asked in cross-examination whether the plaintiff was so busy that the pressure of work may have ground him down. Mr Hutton said he was not qualified to say that but agreed that he had seen busy barristers burn out through working too hard.

[82] Mr Dzjelalia is a solicitor who at relevant times worked for several firms on the Gold Coast. He had known the plaintiff for about 10 years. While working at a firm he left in mid 1995 he had briefed the plaintiff in personal injuries and criminal

matters. Initially, in about 1993, the plaintiff was his preferred counsel for this kind of work. There was a turnaround time of 3 to 4 weeks for paper work and the quality of the work satisfied him. In late 1993 or 1994, more probably 1994, the turnaround time became longer. Mr Dzjelalia said that he made phone calls on occasions but got no response. He also told the plaintiff that if he was too busy to do the work to let him know and he would get someone else to do the particular work and brief him when he was not so busy. Eventually he stopped briefing him for a while.

[83] When he changed firms and was doing mostly personal injuries work, he began to brief him again. In 1996 the plaintiff's work slowed down with the result that Mr Dzjelalia stopped briefing him again. In cross-examination he agreed that he had had to hurry other counsel up on occasions also. When Mr Dzjelalia went to another firm where he was engaged to do commercial work but was given a few personal injuries files, he briefed the plaintiff in one matter where the plaintiff had acted previously for the client. He did not brief him in commercial work because he had a particular counsel whom he used for that work.

[84] Further evidence concerning the nature of the plaintiff's practice was given by Ms Thorpe. She commenced working part-time for the plaintiff a couple of days a week in April or May 1999, which was the last year of her study for the degrees of LLB and B.Com. She began to work fulltime for him in July 2000. She completed a Graduate Diploma of Legal Practice at QUT in 2002. She gave evidence that throughout her employment she prepared advices and pleadings and did research including research for submissions. Enlarging on that, she said that she would give the prepared document to the plaintiff to check. Sometimes he dealt with it promptly but other times he did not do it immediately. On some occasions she had to prompt him to do the checking because solicitors were pressing for the documents.

[85] With respect to his work patterns, Ms Thorpe said that the plaintiff was custodial parent of his 15 year old son by the time she went to work for him. During school term he normally arrived about 9am after dropping his son at school. He left about 3 or 3.30 to pick him up. During the school holidays the plaintiff tended to arrive and leave later. Some days he did not come in at all but phoned to check what was happening. She said that his mood was variable. Some days he would be in a good mood but on other days was "more grumpy or sort of a bit more snappish". That often occurred if he was interrupted by a series of phone calls. She was aware that he took medication. Some times he took an afternoon nap. He was not fit or active and often came back from conferences and other commitments complaining of tiredness.

[86] She said that he did settlement conferences, mediations and limited court work. The impression left by her evidence was that notwithstanding that her experience was limited she did a substantial part of the preparation of the work of the plaintiff's practice subject to his checking her work. She expressed the opinion that it was necessary for someone to perform that kind of function since her experience was that it was rare for the plaintiff to "sit down and just start and finish something". She also said that he would sometimes take work home and come in with work that he had done at home but by no means on a regular basis. She agreed that she did not know whether he did substantial work at home rather than in chambers. All of

this evidence must be viewed in the setting of medical evidence concerning complaints made by the plaintiff about his condition.

[87] Dr Upton was the plaintiff's general practitioner since 1990, and a friend of the plaintiff's. He said that the plaintiff had not complained to him of the symptoms of which he had complained to Drs Bird and Saines. He said that he knew that the plaintiff had had stress in his background. He said that he had attended the plaintiff on the day after he had had the reaction and found him extremely distressed because he believed he had nearly died.

[88] Dr Upton said that after that incident the plaintiff became depressed, anxious, lethargic and appeared to have lost interest in everything. He had become obsessed with his health, particularly his blood pressure. However, Dr Upton did not accept the proposition that the plaintiff was hypochondriac. Dr Upton said that the plaintiff's personality appeared to change after the incident. He said that the stress and anxiety after the incident was of a significantly greater degree than he had observed before. Dr Upton ceased to be the plaintiff's general practitioner at an unspecified date "several years later". After that he saw him perhaps once a year.

[89] His written report summarised that he had been consulted by the plaintiff, apart from the days immediately following the incident, on 5 occasions over a period of about 4 months concurrently with his being treated by Dr Middleton. Dr Upton's assessment of the plaintiff based on his knowledge of him as a friend as well as his general practitioner is summarised in the following paragraphs from his written report:

> "I know Mr Di Carlo personally and the change to his behaviour and personality after the incident 29/5/93 was quite remarkable. Prior to the incident despite his problems in the Police Force where he was previously employed and personal problems involving his family, Mr Di Carlo was an outgoing happy and bright individual excited abut his new career. Overnight he became anxious depressed and obsessed with his health. He would see me several times a day sometimes at home requesting 'a check up' i.e. blood pressure and pulse rate to be taken. He would not eat seafood as he associated this with iodine and the IV contrast media used for a CT scan. He would fall asleep while out on social occasions and his lifestyle dramatically changed.
>
> There is no doubt that Mr Di Carlo has suffered a very severe post traumatic stress syndrome."

[90] One observation that may be made about the body of evidence about changes in the plaintiff's demeanour is that the medical witnesses have observed them as being immediately sequential upon the reaction to the dye. Those of his professional colleagues who were in a position to give a "before and after" picture seem not to have noticed a change until late 1993 or early 1994.

**Psychiatric Evidence**

[91] The only direct psychiatric evidence was given by Dr Middleton. As previously mentioned he saw the plaintiff about 2 weeks before the present incident. He said

that he had met the plaintiff socially on a couple of occasions prior to that date when he observed nothing overt by way of abnormality in his behaviour patterns. Those occasions were limited to lunch and coffee.

[92] When Dr Middleton saw him on 14 May 1993 he noted that the plaintiff was very worried and convincing himself that he perhaps had a serious disease. He had marked somatic focus. He was very prone to pick up on issues of physical wellness or any change in his apparent markers of physical health and was thinking the worst of them. Dr Middleton formed the view that this was consistent with post-traumatic stress disorder. Dr Middleton also formed the view that he was dissociative at that time, indicated by the facts that the plaintiff complained of losing track when cross-examining in court and being unable to maintain total concentration. The traumatic events of previous years were discussed with the plaintiff in the context of the underlying mechanics of the dissociation.

[93] Dr Middleton said that the plaintiff had symptomatology of post-traumatic stress disorder syndrome before the CT incident. The plaintiff was a traumatised person and even when such people achieved reasonable functioning, they carried a significantly increased vulnerability. Where a person suffering from the condition becomes traumatised again there is a tendency to exaggerate symptomatology which is harder to settle down. He accepted that given the pre-existing condition, the plaintiff may have periodic flare-ups of his symptoms. He expressed the view that the plaintiff, prior to the CT incident, had improved substantially. While he carried vulnerabilities, had some somatic focus and was prone to dissociate somewhat, the indications were that, while he may have had periodic exacerbations, it could be expected over time that his symptomatology would generally recede if there were no further insults to his system and nothing to bring his mind back to the underlying issues.

[94] Dr Middleton said that after the CT incident the plaintiff displayed marked evidence of ongoing symptomatology in the spectrum of post traumatic stress, a very marked somatic focus, a marked proneness to dissociation to the point where he completed a test which scored high in the range of people who had been through major traumas. The overall effect of the written reports is that the plaintiff was in considerable distress and showing marked signs of post-traumatic stress disorder throughout the remainder of 1993. By November 1993, he was describing his fluctuations in mood as becoming more settled. Some days he could do a lot of work while on others he did nothing. Post traumatic symptomology was still very evident. In April 1994 (about one month after the car accident) he reported difficulty still with dissociation but generally felt improved. In April 1995, he said he was functioning at half capacity.

[95] Dr Middleton expressed the opinion that over the year preceding the 28 June 1996 report, the plaintiff's functioning had improved generally. He had plateaued, but Dr Middleton thought that the burden of the drawn out litigation process was not helping. One other factor that in his opinion contributed to the continuation of the plaintiff's condition was that he wanted an opportunity to discuss the incident directly with those involved and those attempts were not responded to. He thought that that had compounded the feeling of alienation he had about the whole incident. Dr Middleton also accepted that the plaintiff was prone to be triggered by things happening outside his work. He said that the plaintiff had been distressed when his daughter had to have a CT scan with the thought that she may be exposed to some

risk exacerbating his own anxiety. The effects of the Naomi Marble trial on his capacity to carry out his practice effectively were significant.

[96] The barest of passing references in Dr Middleton's evidence and the absence of any specific reference to the *Naomi Marble* trial in his reports focuses one of the areas of concern about his evidence for the purpose of determining the complex issues involved in this trial. His reports appear to have as their major premise that the plaintiff's ongoing incapacity to function personally and professionally was linked to the effects of the reaction to the contrast. The relationship between that and subsequent traumas is not explored. The *Naomi Marble* trial was obviously an extremely stressful experience, extended by disciplinary proceedings arising out of complaints made against the plaintiff on account of his conduct. The plaintiff did not attribute his decision to undertake the trial to impaired faculties of judgment. The evidence of Mr Maher about the trial appears elsewhere in paragraphs [73]-[74]. The most relevant piece of evidence in this regard, in the context of Dr Middleton's acceptance that the plaintiff's working capacity was "quite diminished" is the following:

> "What about his capacity to undertake, for example, long trials – longer than three days?-- Yeah, he had one extraordinarily long trial, and that really led up to him going off work, really, and I think it was one of the longer trials in Queensland Court history. He didn't cope with that well.
>
> All right?-- It was after that that he really went off work. You know, he can hold it together for shorter matters, and, you know, I think longer trials are problematic. When he went back to work – you know, having been off work in mid-1998 and he had set himself a goal of doing that particular murder trial for some time, he was in quite a quandary as to whether he was going to make it, and he was always worried about whether he did his clients justice. That was his biggest concern."

[97] The effect of Dr Middleton's evidence seems to be that by the time the *Naomi Marble* trial commenced, the plaintiff's condition had improved and plateaued. He was capable of coping with short trials, but long trials were problematic. The unresolved anger over what he perceived to be a refusal of the first defendant to acknowledge what had happened was a major contributor to continuation of the condition. More will be said about this aspect later.

[98] The traumatic event of the motor vehicle accident in 1994 is not mentioned at all. It is true that the plaintiff did not claim any psychological or psychiatric sequelae of the accident in his legal proceedings. However, it is surprising that there is no reference to whether the plaintiff mentioned it to Dr Middleton as part of the historical record.

[99] He was asked about the prognosis once the present proceedings were completed. He said that while it would not be a short term thing he would be cautiously hopeful that the plaintiff's work capacity would progressively increase over a 2 to 3 year period, on the assumption that there were no other major assaults on his equilibrium. He would remain vulnerable but could get back to a reasonably

consistent practice as a barrister in that sort of timeframe. It appears that that conclusion was contingent upon him maintaining a research assistant.

[100] In cross-examination Dr Middleton was taken through a comparison between his original notes with the report he gave some 3 years later. The thrust of the cross-examination was that in the original notes some events which might be interpreted as indicating a high level of anxiety contemporaneous with the consultation had been converted into events happening at a time in the past in the written report. Dr Middleton suggested as an explanation that he may have written the notes in that form originally in the belief that the plaintiff was talking about his behaviour immediately prior to the consultation but later as the issues were refined it became apparent that they were in fact past events. That, he said, may account for the discrepancy.

[101] He was also cross-examined about the consultations with Dr Bird and Dr Saines with particular reference to the symptoms described to them. Dr Middleton's evidence was to the effect that the doctors did not appear to be particularly concerned about the plaintiff's condition. However, he agreed that it was very likely that the sort of symptoms he had at those times were functional. The thrust of Dr Middleton's evidence was that the plaintiff had suffered a serious insult by reason of the reaction to the contrast medium and that his level of functioning after that occurred was at a lower level than it had been in the 2 or 3 years preceding it, notwithstanding that he was displaying some indicia of post-traumatic stress disorder in those years. In his 18 August 2000 report, he put the level of disability, specifically related to the reaction at 15-20%, with the expectation that at times he would decompensate and be unable to work.

**Assessment of Medical Evidence**

[102] The plaintiff suffered a severe reaction to the contrast agent when being given the CT scan. I am satisfied that the experience was frightening to him since he believed that he had almost died. Whether or not that was the case is something that need not be resolved since the consequences of the experience are what are important. Prior to suffering the reaction, he had suffered post-traumatic stress disorder for a number of years due to a combination of circumstances in his earlier life. His condition had lessened in intensity from the level that had prevailed when he was hospitalised in 1987.

[103] However, he had complained of symptoms consistent with his not having completely recovered from the condition in 1991 and 1992 when he was practising as a barrister. The concerns that the plaintiff had at these times seem not to have been disclosed to his general practitioner at the time, nor to Dr Middleton later. He described in those years to some medical practitioners events that had the capacity to impact upon his practice if they were persistent. No physical reasons were discovered for what he had described.

[104] Two weeks before the reaction to the contrast medium, he was, according to his psychiatrist, highly dissociative in the context of post-traumatic stress disorder and was considerably anxious. The history the plaintiff gave included difficulty in reading briefs on some days and what the doctor described as recurrent dissociation while cross-examining, fear of "losing it" in court and a somatic focus which caused the plaintiff to suspect he was suffering from a serious illness.

[105] There is no reason not to accept that the manifestations described existed at the times when the plaintiff complained of them, whether or not one accepts Dr Middleton's rationalisation of the conflict between his notes, which speak of other matters which would also indicate stress as if those too existed at the time of the consultation just before the CT scan, and his later reports which suggest that they were events in the past.

[106] In summary, I am satisfied that the intensity of the plaintiff's underlying pre-existing post-traumatic stress disorder was prone to vary. Stressors might bring an exacerbation of it into existence. Whether or not it would then revert to a relatively dormant level once the stressor had ceased to operate was not something that could be confidently predicted.

[107] The critical points for present purposes are firstly that the plaintiff was suffering, on a periodic basis, from manifestations of things that must have been serious enough to cause him to seek psychiatric assistance 2 weeks before the incident. Secondly, their tendency to affect his capacity to practice effectively was apparently concerning him and the focus on the fear that his state of health was not good could not have helped in that regard. Thirdly, there is a high likelihood that any major stressor in his private or professional life at any time would affect his level of functioning in his practice because of the exacerbating effect it would have on his underlying condition. That is an important matter since the plaintiff's essential proposition is that he should be compensated for all such economic loss as he can prove on the basis that it is causally connected to the fact that he suffered the reaction to the contrast medium.

**Duty of Care**

[108] As the major judgment in *Rogers v Whitaker* (1992) 175 CLR 479 acknowledges at 488-489 the amount of information or advice which a careful and responsible doctor would disclose depends upon a complex of factors including the nature of the matter to be disclosed, the nature of the treatment, the desire of the patient for information, the temperament and health of the patient and the general surrounding circumstances. The distinction is made between whether treatment is carried out according to the appropriate standard of care – where responsible professional opinion will be very influential and often decisive – and whether the patient has been given all relevant information to choose between undergoing or not undergoing the treatment – where the more important issue is the communication of relevant information to the plaintiff in terms which are reasonably adequate for the purpose. At page 490 the frequently quoted passage is stated in the following terms:

> "The law should recognise that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the plaintiff's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it."

[109] In *Rosenberg v Percival* (2001) 205 CLR 434, Gleeson CJ at page 441 points out that information about risk is, in cases of this kind, being considered in the context

of a communication between two people who have a common view that there is a serious reason in favour of the contemplated procedure:

> "The more remote a contingency which a doctor is required to bring to the notice of a patient, the more difficult it may be for the patient to convince a court that the existence of the contingency would have caused the patient to decide against surgery."

On the same page he highlights the difficulty inherent in examining cases of this kind through the prism of hindsight.

[110] As Gummow J points out at p 456, it is necessary to define the relevant risk. That involves reference to the circumstances in which the injury can occur, the likelihood of the injury occurring and the extent or severity of the potential injury if it does occur. Those factors are to be considered from the point of view of what a reasonable medical practitioner in the position of the defendant ought to have foreseen at the time. With regard to determining materiality of risk the issue is whether a reasonable patient or particular patient would have been likely seriously to consider and weigh up the risk before reaching a decision on whether to proceed with the treatment (p 459). That then leads to the question whether the particular patient would not have had the treatment had a warning been given (p 462).

[111] It is accepted that the test whether the patient would have undertaken the surgery is subjective although the question whether a reasonable person would or would not have done so in the patient's circumstances provides a useful reality check (p 443, 480). It is certainly not unnatural and almost inevitable that a person who has suffered from a serious experience following medical treatment will, in hindsight, be persuaded that had they known of the possibility that the complication might occur they would not have undergone the procedure. It is in that sense that measuring the evidence of the plaintiff against what might be expected of a reasonable person in the plaintiff's position when the procedure was being contemplated is of some importance, although not decisive.

[112] As McHugh J points out at page 443-4, in exceptional cases the judge may reject the patient's testimony as not credible, but nevertheless infer from the objective facts that the patient would not have proceeded. That inference would ordinarily be based not only on the objective facts but also on the tribunal's assessment of the general character and personality of the patient. At page 449 he said that the onus is on the patient to prove that he or she would have decided not to have the procedure if given a warning of the risk of harm. That meant that the patient must prove what he or she would have decided to do. When the direct testimony of the person on the causation issue has been rejected, it is unlikely, as a matter of fact, that the patient will succeed on that issue unless the objective evidence in favour of the patient is very strong.

[113] The evidence suggests that there is no dispute that there is a known risk of an adverse reaction to contrast, which is greater when certain known predisposing factors exist. There is no dispute that the risks relevant to the present case were known at the relevant time. However, in the absence of pre-disposing factors the likelihood of the occurrence of an adverse reaction was, according to the evidence, not high. In the present case, I have not accepted the account given by the plaintiff and Dr Coroneos of the events leading up to and surrounding the performance of the procedure. It is also plain that the plaintiff remained very concerned that he may

suffer from a serious condition notwithstanding what he had been told as to the unlikelihood of it by Dr Coroneos. Looking at the matter objectively in light of the findings of fact and the lack of any reaction to what must obviously have been preparation to administer an injection, I am satisfied that the plaintiff has not discharged the onus of proving that he would not have undergone the procedure had he been directly warned. In addition, the case is one which involved, to an extent, medical judgments of competing potential risks and drawing of a balance as to the best approach in the circumstances to informing the patient, for reasons enlarged on in the next section.

**Medical Evidence Concerning Warnings**

**(a) Professor Palmer**

[114] Professor Palmer, an authority on reactions to contrast media, the author of papers on the subject and a key participant in one important study, gave evidence of the rates of adverse reaction. He said that the rate of an adverse reaction for non-ionic contrast agent was 1 in 6000. The study in which he was involved had no cases of death and he was unsure whether there were any examples which would be generally known to radiologists in 1993.

[115] While the boundaries of categories of reaction were not necessarily precise he believed that the plaintiff's reaction as described to him was a severe reaction although possibly brief. He gave evidence that it was more common for a reaction of this kind to be immediate than delayed, although some were of the latter kind. He said that the vast majority occurred within the first minute or two minutes, or five minutes at the most. There were some delayed reactions that occurred after 15 to 20 minutes but they were usually of the mild to moderate category. The severe anaphylactic responses were usually fairly obvious before the injection of contrast medium had finished.

[116] He said that there was an obligation on the radiologist to consider the need for a contrast study and to obtain a history of risk factors. Amongst high risk groups were patients with previous reactions to contrast media, asthma sufferers and those with a significant allergic history (not to drugs). The extent and nature of previous indications of allergies was important in evaluating the necessity for the use of contrast medium. If presented with a patient with a risk factor, he had to consider three options. One was to do a non-contrast CT only. The second was to proceed with the contrast injection if the information was vital to further management in an emergency situation and the third was to rebook the patient and treat with steroids for 24 hours before performing the procedure.

[117] It was his usual practice to tell the patient that after the injection he may feel a metal taste in his mouth and perhaps a warm flush. He would explain that he was going to inject the patient with the contrast medium before proceeding to do so. It was not his practice to warn of the risk of death or severe reaction principally because there was evidence, although not uncontroversial, that anxiety produced in a patient by the procedure might itself be a factor in causing an adverse reaction. He said that the desirability of giving warnings of an adverse reaction was in 1993 subject to different views. In his view, due to the fact that attitudes were shifting at that time there was no "usual practice". If a patient came for a plain CT scan and it was decided to use contrast, he would explain the procedure.

[118] He was asked about the implications of a patient complaining of dizziness with the possibility of a brain tumour. He agreed that an acoustic neuroma was a possibility and that that was a situation in which a contrast medium study would be appropriate. He agreed that if the referring neurosurgeon was 99.9% certain that there was no tumour, an enhanced scan would be necessary to eliminate the residual possibility. In such a case if the referring doctors specifically asked for a non-contrast study, he would suspect a mistake in the request. If a radiographer was involved he would expect him to ask the questions of the patient and relay any information to the radiologist. When he came to administer the contrast medium he would ask the questions in any event himself. Professor Palmer said that it would ordinarily take about 3 to 4 minutes from affixing the tourniquet to the completion of the injection. If the neurosurgeon was present and a decision had to be taken to do a contrast scan when a non-contrast had been requested he would certainly discuss it with the neurosurgeon.

**(b) Professor Thomson**

[119] Professor Thomson, who had worked at Royal Melbourne Hospital and the Alfred Hospital in Melbourne and was also highly qualified, was working at the former institution in 1993. He said that after Professor Palmer's study use of non-ionic contrast medium became almost universal. He said that the practice at the hospital was that patients receiving intravenous iodinated contrast media were questioned prior to the injection about previous similar injections, any prior reaction to them, their allergic history including asthma, hay fever and medication. At that hospital the radiographers were not trained to administer the contrast medium and the injection was done by a radiologist.

[120] He said that the rate of severe reaction in people with no known risk factors was about 1 in 10,000. He reported on the steps taken in the case of patients with an elevated risk of reaction. If a request was made not to give contrast but the reason for the request was not written in the request form the referring doctor would usually be aware of the limitations inherent in some situations by not using contrast medium. He believed that neurosurgeons would be well aware of the benefits of contrast enhancement and the potential for overlooking small tumours or vascular abnormalities when non-contrast head scans were performed. He said that by 1993 there had been sporadic deaths with non-ionic contrast which had been reported and were widely recognised. He said it was not a general practice to obtain a written consent form for intravenous contrast media and the normal practice was for a brief verbal explanation of the effects and risks of contrast to be offered, usually on the examination table and verbal consent being given prior to injection.

**(c) Mr Winningham**

[121] Mr Winningham was a radiographer, with 11 years experience at the time of his statement, who practiced on the Gold Coast. As a matter of personal choice, following a case of severe reaction, he had not injected patients himself with ionic or non-ionic contrast medium. However, from his experience of being present either the radiologist or he would inquire routinely about allergies, including seafood allergies, personal or family histories of asthma and adverse reactions previously to contrast medium, amongst other things. He said he would also be on alert for anxious patients who had fears about the examination and the injection and take that into account.

[122] He said that it was a common practice, if a radiologist was not there at the time when the radiographer made the inquiries just referred to, for the radiologist to ask the questions again upon arriving. He explained that an explanation of the fact that dye would be used and the procedure involved in the injection would be given. He said that advice would be given that there were risks. He put the risk of dying at 1 in 250,000.

**(d) College Guidelines**

[123] Guidelines dated 27 July 1990 and March 1993 by the Royal Australasian College of Radiologists referred to ionic and non-ionic contrast medium infrequently causing serious adverse drug reactions and rarely causing death. A tentative view expressed in the 1990 document that the risk of adverse drug reactions may be reduced by a factor of 6 if non-ionic contrast medium was used became a definite statement to that effect in the 1993 document.

[124] The document also stated that non-ionic contrast media are the agents of choice for those patients whom the radiologist identifies as being at high risk by virtue of previous reactions to contrast media, asthma, significant allergic disease, previous episodes of anaphylaxis, and excessive anxiousness, amongst others. For patients not in those categories, the document continues, the choice of contrast medium is influenced by multiple considerations. It is the responsibility of a radiologist to choose the contrast medium most appropriate to the type of examination and the patient's needs having regard to the differing physical and pharmacological properties and side effects of the available contrast media. That appears to refer to the type of medium not whether it ought to be administered at all.

[125] It is convenient to mention that the plaintiff was for a period after the incident under a misapprehension that he had been injected with ionic contrast when non-ionic was available. It appears that he thought that the contrast with which he had been injected contained iodine whereas the alternative did not. That is not the case. An emerging theme through Dr Middleton's reports was unresolved anger about that and other circumstances relating to a desire on the part of the plaintiff to resolve the issue with Dr Dubois without litigation.

[126] It was not until 1995 when letters, two of which are in evidence and one of which is not, were sent to Dr Dubois by the plaintiff. Although it is implicit in Dr Middleton's evidence that the subject had by this time been raised with him by the plaintiff, the letter raises for the first time with Dr Dubois the allegation that he had been injected with iodine contrast "without any instructions or advice" to the plaintiff. They were unanswered because of legal advice in that regard to Dr Dubois, and assumed the character of a further rebuff so far as the plaintiff was concerned.

**(e) Dr Dubois**

[127] Dr Dubois said that in 1993 the practice used non-ionic contrast since there was a body of evidence that it was significantly safer than ionic. That was not only in respect of the risk of death but also in respect of severe reactions which were about 6 times less frequent. At that time radiologists in the practice were trained to administer contrast medium and a standard protocol for inquiring about risk factors was operative. Dr Dubois was not sure whether it was in writing at that time. At

that time no written questionnaire was given to the patient. He explained the process in the following terms:

> "The standard procedure for people injecting contrast in our practice, such as Mr Brown, would be to make an inquiry of risk factors. And then, if there were no significant risk factors, to proceed with the injection. If at any time Mr Brown felt that as a result of his interrogation of the patient, or for any other reason, that there were risk factors, then he would come to the radiologist and the radiologist would then further interview the patient and inject the contrast agent, if appropriate, or advise the patient of alternatives that might be available."

[128] Dr Dubois said that evidence of a previous reaction was the primary risk factor as well as a history of allergies especially to seafood and a history of asthma. The training in the practice for radiologists and radiographers was to ask the patient specifically about the risk factors and to tell them that they were about to be injected with X-ray contrast or dye. They were also told that they may feel a warm flush and get a metallic taste. Dr Dubois was asked whether it was unusual for radiographers to administer the contrast. He said that it was not. He said that the position in teaching hospitals, as referred to by Professors Palmer and Thomson could not be equated to private practice. Nor could practices in teaching hospitals be extrapolated to suggest that there was a practice to that effect generally in New South Wales and Victoria.

[129] He said that no warning of the possibility of a reaction was given at that time. In the practice, the risk of mortality was estimated as less than 1 in 250,000 and the risk of any adverse reaction at all at much less than 1 in 1,000. He said that the view that a warning ought not to be given as to the possibility of a reaction was within the range of informed opinion within the College of Radiologists.

[130] In 1993 almost 100% of cervical spine CT's were done with contrast. It was a policy of the practice. In the case of brain CT's for the purpose of reassuring a patient by ruling out a tumour, the same would be the case. Because of conferences and interactions with high level referrers such as Dr Coroneos both of those facts would be well known. He agreed that medical responsibility for administration of the contrast lies with the radiologist. He said that he knew, from talking to Dr Coroneos, that the plaintiff was anxious. The risk factor of any reaction in such a case would be 1 in 2,000 approximately. He did not recall telling Mr Brown about the patient's anxiety.

**Breach of Duty of Care?**

[131] The evidence concerning the practice in 1993 with regard to giving a warning of possible reaction to contrast medium is to the effect that a direct warning was not given by any of the witnesses. The rationale for that approach was that there was a perception that there was evidence that a heightened anxiety level in the patient may be a factor increasing the risk of an adverse reaction. A balance was drawn between the need to warn of material risks and the risk of increasing the chance of an adverse reaction, by heightening the patient's anxiety, by implementing a procedure of not giving a direct warning but asking questions designed to ascertain whether the particular patient fell within a known risk category. If an answer given indicated

that a patient had a risk factor, the decision whether to proceed or not was made by a radiologist. As a matter of practicality, asking a patient if he was anxious would seem to have a distinct downside. If he was already anxious, or not anxious, but in either case asked why the question was asked and was told that anxiousness was a risk factor, it would seem counter-productive.

[132] Dr Dubois' evidence, which was not seriously challenged, was that, in his practice, the decision to follow the procedure adopted was arrived at after consideration. I am satisfied that it is not a case where there was no identifiable reason for adopting the procedure in operation in the practice. The particular case is not one where there was a specific inquiry by the patient as to risk, let alone one that eventuated. The judgment to implement the procedure which involved not giving a direct warning of risk factors was made after considering what were essentially medical issues. The procedure implemented was not inconsistent with mainstream medical opinion at the time.

[133] The case is one where there was a system in place, the purpose of which was to minimise one risk while providing a means for identifying other known risk factors, which, if discovered, would be further considered by a radiologist. To the extent that ultimate responsibility is said to rest upon the radiologist, the system followed was designed to accommodate it. In my view, the standard of care inherent in that system was reasonable and, on the facts found, there was no breach of the duty of care owed to the plaintiff by the first, second and third defendants.

**Damages**

[134] I am satisfied that the plaintiff's experience of reacting to the contrast medium heightened the level of his post-traumatic stress disorder. However, for how long that particular aggravation persisted is a complex question. A little over eight months after the incident he was involved in the motor vehicle accident. While it is not possible to reach a precise conclusion as to the seriousness of the injuries and the extent of loss on the evidence available, it appears to be accepted that he suffered injuries causing him pain and suffering and economic loss. The medical evidence and the fact that the matter was settled for $25,000 evidences this. In the plaint he alleged he had, inter alia, lost income and suffered diminution in his capacity to earn income in the future. In the statement of loss and damage he gave examples of his inability to work at all for a time and of continuing reduced ability to perform his work and alleged continued partial incapacity because of the injuries up to the time of issuing the plaint, 17 months after the accident. He quantified his past loss at $6,900 and future loss of $100 per week for 27 years. His evidence was to the effect that he settled for less than the claim was worth to be rid of it. "Double dipping" in respect of this diminution of earning capacity must be avoided.

[135] In the course of that action, he said as a result of the injuries sustained in the motor vehicle accident the permanent effect was constant mild to moderate pain in the cervical spine and moderate to severe spasm and occipital headaches, occasional to frequent. His injuries, especially his cervical spine injury, rendered him unable to work for remuneration to the extent of 1 ½ hours in the morning and 2 hours at night and intermittently during the day. He said that while he was unqualified to express an opinion as to permanency, if the level of pain, restriction of movement and weakness continued, he assumed his practice would be restricted to the same extent in the future.

[136] In relation to whether he had suffered any illness which had caused him to be absent from work for any period of time, he answered that he did not recall any illness that caused him to be absent from work for longer than a day or two. However, he had been away from work for up to 3 hours per day from time to time due to the symptoms in his cervical spine and back. He had also been absent from work in respect of an unrelated matter. He did not answer the subsequent interrogatory requiring details of the nature of the illness that had caused him to be absent from work in the event that the former answer was in the affirmative.

[137] It is expressly sworn in the interrogatories that 3 hours per day diminution in working capacity from the time of the motor vehicle accident to August 1997 was attributable to physical injury. It was at least implicit that the level of discomfort was not tapering off. Had the issue of post-traumatic stress disorder been raised at a trial it would be necessary, if he were to make out the claim as to economic loss, to deny that the post-traumatic stress disorder was a factor in the amount of loss claimed. The proposition that economic loss because of the motor vehicle injury could be distinguished from and identified as a separate category from the additional economic loss in respect of the injury relied on it the present action would involve considerable forensic difficulty. The main point, however, is that while the motor vehicle accident claim was being litigated, the plaintiff was claiming that up to 3 hours per day were being lost because of his physical injuries caused in that accident, and compromised that claim for $25000 on an undisclosed basis which implicitly involved acceptance that some economic loss was caused by those injuries.

[138] In 1996 the *Naomi Marble* trial began. It was not suggested, as I understand the evidence, that the plaintiff alleges that he took the brief because his judgment was clouded by the effects of post-traumatic stress disorder aggravated by the effects of the reaction to the contrast medium. The trial turned out to be a very stressful event. The consequences of the trial upon the plaintiff referred to in evidence by Mr Maher and in the evidence of the plaintiff himself, some of which were ongoing and separately stressful to him, are difficult to relate convincingly to the reaction to the contrast agent.

[139] The evidence also establishes that the nature of the underlying condition is such that traumatic events are not unlikely to trigger exacerbations that may or may not subside to their previous level. Whether they do or do not following a particular precipitating event is by no means predictable. The case is one where the plaintiff has plainly had the misfortune of suffering a substantial number of events over the years, before and after the incident with the contrast medium, that have taken their toll upon him. However, the plaintiff bears the onus of proof in this trial of a causal relation between negligence of the defendants and loss of economic capacity. I accept that there was a period of exacerbation of the underlying post-traumatic stress disorder following the reaction to the contrast medium. It is much more problematical whether the plaintiff has established that his reaction to the contrast medium is a substantial cause of all ongoing economic and other loss.

[140] One aspect of this upon which Mr Hanson dwelt is the evidence that a significant component of the plaintiff's anger over what had happened was that he misinformed himself as to the nature and properties of the substance with which he was injected. He believed he had been injected with a medium that was inherently less safe than another that was available. Not having made reasonable enquiries from an

appropriately qualified person about it, he laboured under the misapprehension for a substantial period, during which his anger over what he believed had happened was fuelled by his mistaken belief. The intensity and probably the duration of his condition was contributed to by it. It was submitted that it was not reasonably foreseeable that this chain of consequences would follow from his reaction to the contrast. Therefore a defendant should not be liable for those consequences in the circumstances.

[141] The evidence is that the plaintiff's anger was not solely the result of the belief about the contrast medium. I am satisfied that the plaintiff believed while the reaction was happening that he was at risk of dying. While I do not accept that that there was any actual delay in implementing emergency treatment, I accept that the plaintiff may have heard words that, in the heat of the moment, he misinterpreted in that way. Likewise, I do not accept that there was any intentional snub the following day, although the plaintiff may have interpreted something in that way. Both of those incidents would, one would expect, have had relatively transient effects but for their magnification in conjunction with the erroneous belief about the contrast medium.

[142] The case has particularly unusual features which require a pragmatic solution rather than an intricate theoretical analysis. It is not open to find that the plaintiff was entirely deprived of the capacity to act rationally after the reaction occurred, nor that there was a delusional belief on the particular subject. There were times when he displayed avoidant behavior, but nevertheless he was, according to his evidence, generally able to conduct his practice, albeit at a reduced level without assistance, during the following years. He had the professional training and access to appropriate professional sources of information to find out accurately the nature of the treatment administered to him. For reasons that are inadequately explained, he formed a mistaken understanding of it, of the nature of a mistake of fact, and failed to correct it for several years after he had done so. The major element of his anger was a direct consequence of his self-induced misunderstanding.

[143] The case is in that way somewhat different from one where a plaintiff suffers psychological consequences due to a disturbed view of reality caused by the accident. The case must be decided in the context of its own facts as they emerged at trial. In my view the basis of calculation of damages should reflect the circumstances referred to above. For reason already explained, I also have difficulty with the application of Dr Middleton's assessment, insofar as it does not address the role that subsequent events may have played in causing or in perpetuation of any lessening in the plaintiff's capacity to practice.

[144] The evidence relating to quantum is unsatisfactory. The loss of some of the plaintiff's records, which, according to his evidence, were disposed of after incidents of vandalism in chambers by burglars has the consequence that details to support other documents tendered in evidence is less detailed than might otherwise have been the case. There are also inadequately explained discrepancies between the documents which were tendered. I am satisfied that the plaintiff did use the services of other barristers to devil for him and that on the basis of the evidence of Ms Thorpe, he employed her full time as a research assistant. However the comments made previously about a causative link are equally appropriate to those issues. One other matter concerning quantum requires comment. In the course of his evidence, the plaintiff referred in a general way to the success of other counsel whom, in his early years, he considered as his peers. He argued that this was an

indicator of his loss, even though no evidence of their earnings was given in any cogent form. It is sufficient to say that early promise, self-belief in a level of legal ability and an assumption of continuing parity with a peer group are inexact predictors of future success due to a range of factors. The destructive effect on continuity of work of being committed to a long trial or other brief is a well known phenomenon as well.

[145] With regard to assessing economic loss, it was submitted that it would be reasonable to calculate it on the loss of a number of briefs to advise on quantum or to draw pleadings, and to add to the sum so derived a substantial part of the cost of a research assistant into the future. As noted above, the financial information is not helpful for several reasons. In some respects it is contradictory. It is also incomplete. In some respects, it is difficult to be confident that private business affairs have been isolated from matters that are integral to the basis of the claim for financial loss. The documents do not clearly show any consistent pattern demonstrating that the plaintiff's practice had diminished. It is therefore not easy to find objective verifiable proof that there has been any particular level of loss. There is some support for the plaintiff's evidence, at what is essentially anecdotal level, that some solicitors were dissatisfied with the service that he was providing and stopped briefing him at various periods. In one instance, the plaintiff's briefing appears to have stopped in the year when he was enmeshed in *Naomi Marble*, although in others it seems to have occurred earlier. Letters complaining of tardy work relate to a period from June 1997 to March 1998.

[146] While there are cases where the need for forensic accounting evidence seems marginal because of the familiarity of the issues involved, this is not such a case for the kinds of reasons discussed. However, there is no accounting analysis of the financial affairs of the plaintiff, the state of the evidence as to them is unsatisfactory and there is no expert assistance as to whether apparent contradictions may be reconciled. It may be conceded that this case is one where the nature and extent of loss would be heavily influenced by the findings of fact and that there may be a variety of possible methodologies for attempting to calculate loss. Nevertheless, the problem arising from the lack of any degree of certainty that perceptions of loss are verifiable lies in the fact that the plaintiff bears the onus of proof of the fact of loss and its quantum.

[147] I am satisfied that in the immediate aftermath of the incident, the plaintiff's underlying condition of PTSD was aggravated and that it is safe to assume that there was some economic loss and some entitlement to recompense for loss of amenities of life. The fact that he now takes care about his diet and is more restricted in his lifestyle is an ongoing diminution of his quality of life. What was said earlier about the erroneous belief as to the properties of the substance with which he was injected does not affect this aspect of the matter, since because of the reaction, his desire to protect himself from future adverse reactions to a similar component to that actually contained in the dye, which is potentially contained in other foodstuffs, cannot be regarded as unreasonable.

[148] The major problems with regard to assessment of economic loss are, firstly, the fact that there was the pre-existing serious condition that had already shown signs of a propensity to recur. Just before the incident, the plaintiff had felt the need to consult a psychiatrist about symptoms with a capacity to affect the effective performance of his practice. There had been earlier instances of complaints of similar problems.

Secondly, there is the evidence that the condition is inherently prone to aggravation by something stressful occurring. Such stressful incident or situation might occur in any context. It would not necessarily be work related; it could occur in personal life unrelated to work. Thirdly, there is the direct example of the *Naomi Marble* trial as an incident that itself led to the consequences described above to the plaintiff by 1996 at the earliest and 1997 at the latest.

[149] The point to be made is that whatever loss might be attributed to the injection of the contrast must be very substantially discounted to allow for the high degree of likelihood that given the plaintiff's medical history, some other incident would have occurred quite independently that affected his capacity to practice to a like extent within a relatively short time. In addition, there is the fact that some economic loss in the period from 1994 to settlement of the civil claim has to be attributed to the motor vehicle accident to avoid double dipping. As well, there is the conclusion that the intensity of the plaintiff's distress was protracted and elevated by his self induced misinterpretation of the kind of substance administered to him, which, for the reasons given, should be a discounting factor in itself

[150] For reasons developed above, the only satisfactory basis for compensating the plaintiff for economic loss is by accepting that he would have suffered some economic loss as a result of the incident for a limited period but estimating it as a lump sum in the absence of any more reliable basis.

[151] Applying the general approach referred to, I assess pain, suffering and loss of amenities at $25,000 inclusive of interest on the past component. Economic loss is not susceptible to precise categorization given the methodology adopted. I allow $40,000 inclusive of all components as a global sum for all such loss, past and future. With regard to special damages, for reasons previously given, the plaintiff would probably have resorted to a psychiatrist in any event from time to time given his underlying PTSD, its propensity to be aggravated by incidents occurring in the ordinary course of life and his resort to medical assistance for related symptoms prior to the incident. There is no reason to suppose that that pattern would not have continued even without the incident, although I accept that the need for psychiatric assistance was made more acute for a period following the incident. Associated travel costs and any necessary mediation are subject to the same comments. Having regard to these considerations, I will allow a global sum of $15,000 to cover these items, other specials and interest where applicable. Other heads of damage commonly claimed in actions of this kind are not sought and no award is made in respect of them.

**Liability of First, Second and Third Defendants**

[152] On the basis of the analysis above, the plaintiff's action against the first, second and third defendants is dismissed with costs, including costs of the first trial and any other reserved costs.

**Liability of Fifth Defendant**

[153] Irrespective of the findings of fact as between the plaintiff and the first, second and third defendants, the case between the plaintiff and the fifth defendant is governed by the pleadings, including admissions by the fifth defendant in the further amended defence filed after he chose to represent himself. The evidence of the plaintiff and the fifth defendant is generally consistent as to what passed between them. It is

summarised earlier in these reasons. The evidence is that, after discussion, there was a common understanding that only a plain uncontrasted CT scan was necessary. The plaintiff agreed to undergo the procedure on that basis. That is consistent with the fifth defendant's further amended defence. For reasons that it is unnecessary to speculate about, the fifth defendant adhered to that version of events without any suggestion of resiling from it.

[154] Since I am satisfied that Dr Coroneos did not tell Dr Dubois that a plain CT scan was all that was required and also infer, from the lack of early complaint that the written request had been only for a plain CT scan, that the request was not in those terms, the question is whether he failed in a duty resting on him to advise Dr Dubois of that fact. In my view, on the admitted basis that the plaintiff believed he was to have a plain scan and would not have undergone the procedure if he knew it was to be 'invasive', he had a duty to convey to Dr Dubois what procedure was required and, having discussed the case with him, to make it clear what limitations there were on the plaintiff's part on the kind of procedure to be performed. Accordingly, Dr Coroneos is liable to the plaintiff for the consequences of that failure.

[155] The plaintiff is entitled to judgment against the fifth defendant in the sum of $80,000 with costs, including reserved costs as between them to be assessed. Having regard to the sum awarded, costs are District Court costs appropriate to the judgment amount.