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Leonard v Kulatilake — a medical practitioner's duty to warn about uncertainty

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Abstract

A medical practitioner was found liable in negligence in relation to the re-excision of a skin lesion.

Introduction

The Magistrates Court of the Australian Capital Territory found a medical practitioner liable in negligence for failing to provide her patient with sufficient information relating to the re-excision of a skin lesion. Specifically, the court found that the patient Ms Leonard did not receive sufficient information about the practitioner's uncertainty about the nature of a regrowth at the excision site. She was also not sufficiently informed about alternative options for treatment, including simply monitoring the regrowth.[1]

The re-excision procedure itself had been executed with due care and skill, but was not medically necessary. The complications, consisting of an infection and its after-effects, were held to be reasonably foreseeable as a result of the unnecessary procedure. Damages were awarded.

Background

Ms Leonard attended Dr Kulatilake's office in December 2013 concerned about two small moles on her chest and upper ankle. The mole on the ankle was 5x4 mm in size. While Dr Kulatilake did not consider that the appearance of either mole suggested malignancy, she removed them both on 9 December 2013 at Ms Leonard's request, and without complications.[2] The histopathological report unequivocally identified the ankle lesion as a blue naevus, which is a non-malignant skin condition.[3] The postoperative course was initially unremarkable.[4]

Ms Leonard subsequently developed a small regrowth at the excision site and presented again for assessment on 23 January 2014. Dr Kulatilake initially suggested a "watch and wait" approach, but upon further consulting some medical literature, became concerned that the regrowth might possibly be pre-malignant. She recalled Ms Leonard to have the regrowth excised, which was done on 3 February 2014.[5]

The re-excision took longer than the removal of the initial lesion and caused some bleeding which necessitated pressure sutures for the wound closure.[6] Ms Leonard had not expected the procedure to take as long, and to cause the amount of postoperative pain and limitation of movement and activity that it did. She subsequently developed an infection at the excision site which required urgent admission to hospital for treatment with intravenous antibiotics.[7] Following discharge, Ms Leonard was unable to engage in her normal activities of caring for her grandchildren and refereeing multiple amateur basketball games per week for a number of months. She did not sustain any permanent functional impairment.[8] However, she was left with scarring at the excision site which was visible when she was not wearing socks, and it made her feel self-conscious.[9] Ms Leonard further complained of having felt depressed and gaining weight during the period of low activity because of the complications, though she did not ultimately provide any evidence in relation to this.[10]

Ms Leonard alleged that Dr Kulatilake was negligent in relation to information provided, and the execution of the procedure.

Established legal principles at common law

The principle determining Dr Kulatilake's duty of care in relation to provision of information as articulated by the High Court in *Rogers v Whitaker*[11] was not in dispute. This requires the standard of care being based on "the paramount consideration that a person is entitled to make his own decisions about his life".[12]

The court further quoted the High Court in *Wallace v Kam*[13] in relation to the scope of a duty to warn. This is a comprehensive duty to warn of material risks. A risk of physical injury is material if it is a risk that a reasonable person in the position of the patient would be likely to attach significance to, or if it is a risk to which the medical practitioner knows or ought to know the particular patient would likely attach significance in choosing whether or not to undergo the treatment.

Applicable statute

The Civil Law (Wrongs) Act 2002 (ACT) codifies the common law of negligence in the ACT. The court referred to ss 42 (Standard of care), 43 and 44 (Precautions against risk) in the judgment.

Factual issues

The contested factual issues revolved around the information that was provided to Ms Leonard prior to her signing the form consenting to the excision of the regrowth, and whether the re-excision procedure had been carried out with due care and skill.

Evidence about information provided

Ms Leonard recalled being informed that the regrowth might be cancerous and had to be excised, but she also provided evidence that potential complications or additional treatment options had not been discussed with her. She indicated that she would not have consented to the procedure if she had been warned of those risks.[14]

She signed a standard consent form which contained a list of topics supposedly discussed with the her, but the form did not provide details of such topics.[15] She provided evidence that no further discussion of relevant potential complications such as infection and mobility impairment had occurred, and she was given no other option but to have the growth re-excised. Specifically, she argued that "she did not know what questions to ask and was reliant upon the advice of Dr Kulatilake."[16] Dr Kulatilake in contrast provided evidence that she had gone through the consent form with Ms Leonard and had verbally warned Ms Leonard about those potential complications during the consultation, prior to the patient signing the form.[17]

The court found that a brief discussion of these potential complications had occurred, and that the potential of a referral to a specialist was raised by Dr Kulatilake, but that it had not been further pursued in view of the doctor's clear preference for excision.[18] Furthermore, the treatment alternative of simply monitoring the regrowth was not offered by Dr Kulatilake. There was agreement between the parties that the option of Dr Kulatilake liaising with a specialist for an additional opinion, as opposed to Ms Leonard seeking a consultation, was not raised by the doctor.[19]

Expert evidence

Evidence was provided by Professor Jon Emery and Dr Mary-Anne Lancaster, both senior general practitioners (GPs), as well as by dermatologist Associate Professor Stephen Shumack and plastic and reconstructive surgeon Dr Anthony Tonks.

The four experts agreed that infection and scarring were the two key risks for a procedure of the kind undertaken here. Of interest, the experts also agreed that the patient should have been informed that scarring is unpredictable.[20] They also agreed that the procedure was one reasonably undertaken by a general practitioner at the practice, and had been undertaken with due care and skill, including the orientation of the incision and the wound closure with pressure stitches.[21] However, none of the experts indicated that they would have had a concern about the regrowth being malignant or pre-malignant.

The two GPs disagreed on the appropriateness of the re-excision without any additional specialist advice, with Dr Lancaster affirming that she similarly would have undertaken the re-excision, but after informing the patient that this was quite possibly an overly cautious approach.[22] Prof Emery indicated that in view of Dr Kulatilake's uncertainty about the nature and likelihood of malignancy of the regrowth, obtaining a specialist opinion would have been required.[23]

Associate Professor Shumack and Dr Lancaster also indicated various options for obtaining a small biopsy to assess the regrowth, rather than excising it completely with what would be expected to be clear margins (if it turned out to be malignant).[24] Whilst ultimately accepting the evidence of Professor Emery, the Magistrate, interestingly, noted that he was impressed with the suggestion by Dr Lancaster of a frank disclosure of personal reasoning with the patient, conceding to the patient that concerns about a possible pre-malignancy necessitating additional excisions may constitute the doctor "being paranoid".[25]

Liability

In view of the above, the court found that Dr Kulatilake had been negligent through a failure to take adequate precautions for the safety of the plaintiff, namely by failing to obtain specialist guidance and failing to adequately warn Ms Leonard of the risks of injury and other possible complications.

The court reached this finding in spite of accepting evidence that Ms Leonard had briefly been informed about risks resulting from the re-excision, specifically the risk of infection and reduced mobility, and that Ms Leonard had provided written consent to the procedure.[26] However, given Ms Leonard's circumstances and concerns, this brief explanation about potential complications was not sufficient, given the weight she would likely attach to such problems:

> Further, reasonable care and skill would have involved communicating to Ms Leonard the scale and detail of Dr Kulatilake's uncertainty about the possible diagnosis and providing her with meaningful information that would allow her to balance the risks of waiting and monitoring the site for a further period of time with the risks of undergoing

> the re-excision. Dr Kulatilake did not provide information in that detail. This obligation should be understood in the context of Ms Leonard originally requesting the mole to be removed because she was concerned about her appearance, the re-excision involving a much larger incision, and the increased possibility of infection and or scarring due to the size, location and repeated nature of the re-excision. Dr Kulatilake ought reasonably to have known that Ms Leonard would be likely to attach significance to the ultimate appearance of the site. Therefore the possibility of infection and scarring would be expected to effect whether or not Ms Leonard chose to undergo the procedure. Briefly mention [sic] infection and scarring as possible complications was not sufficient.[27]

Central to the court's finding of negligence was the Magistrate's view that competent medical practice required the practitioner to acknowledge the limitations of her own knowledge and experience:

> Based on the evidence and findings I have described above, it is clear that at the time of the re-excision, a reasonably competent general practitioner would have understood that the patient had a condition that the practitioner was not familiar with and that they should either wait for the clinical symptoms to become clearer or seek additional expertise. The reasonably competent general practitioner would have understood that they did not have an understanding about whether any concern they were entertaining was justified. They would have understood that their expressed concern and recommendation would be decisive in guiding the decision of the patient in relation to future treatment. They would have understood that there were additional resources that could be utilised. They could speak with another practitioner better qualified in the field, for example a dermatologist and or they could refer the patient to a specialist. While re-excising the growth was an option immediately available to the general practitioner, doing so without a clear understanding that it was necessary or appropriate would not be consistent with principle of doing no harm.[28]

It was clear that the complications would not have arisen but for the re-excision procedure having been performed. The court accepted the evidence of Ms Leonard that, had she been informed and warned about the potential scale of the risk of infection and immobility, she would not have agreed to the re-excision.[29] The negligent advice and the resulting re-excision had therefore factually caused the complications.

Under s 45(1)(b) of the Wrongs Act, the court then had to assess if in view of this factual causation, the scope of liability should include the complications. It answered this question in the affirmative because the procedure itself had not been necessary, and Dr Kulatilake would have realised this if she had sought guidance as appropriate in view of her limited knowledge.[30]

Reasonable foreseeability of complications

Given that the complications that eventuated were known risks of the procedure and that the procedure itself was found to be unnecessary, the court found that liability should appropriately attach to these complications:

> It is clear that the re-excision was a necessary condition of the infection and associated scarring, and consequential damage experienced by Ms Leonard. Additionally, infection and scarring where known risks and therefore foreseeable consequences of the re-excision. In circumstances where the re-excision was simply not necessary and Dr Kulatilake would have learned this if she had recognised the limit of her knowledge and sought guidance from a more qualified practitioner, it is appropriate for her liability to extend to the harm so caused.[31]

Award of damages

The court assessed Ms Leonard's damages in the amount of $42,565 in total.

Conclusion

The case illustrates the importance of medical practitioners acknowledging and acting upon the limits of their own knowledge and experience, including by informing patients about uncertainty in a diagnosis underlying further treatment and by seeking additional specialist guidance where necessary.

This case also illustrates that a practitioner can be liable for negligence, notwithstanding certain potential complications being addressed in a written consent form. The Magistrate was prepared to look behind the signed consent form to assess what actual discussion about risks took place. As the Magistrate noted:

> I place little wait on the fact that Ms Leonard signed the form. That of itself does not corroborate the claim that advice about risks was provided. However, the act of Ms Leonard taking the time to read through the form would have provided a clear pause in the consultation, and therefore an opportunity for at least a brief mention of the risks involved.[32]

In this instance, the Magistrate found that because of the patient's particular concerns, competent practice required that the risks of infection and impaired mobility be addressed more fulsomely than mere mention in a consent form.

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Footnotes

1. *Leonard v Kulatilake* [2019] ACTMC 9.
2. Above, at [11]–[12].
3. Above n 1, at [13].
4. Above n 1, at [14].
5. Above n 1, at [16]–[20].
6. Above n 1, at [21].
7. Above n 1, at [23]–[35].
8. Above n 1, at [27]–[35].
9. Above n 1, at [37].
10. Above n 1, at [90].
11. *Rogers v Whitaker* (1992) 175 CLR 479; 109 ALR 625; 67 ALJR 47; BC9202689.
12. Above n 1, at [5] citing above, (1992) 175 CLR 479 at 487.
13. *Wallace v Kam* (2013) 250 CLR 375; 297 ALR 383; [2013] HCA 19; BC201302166.
14. Above n 1, at [84].
15. Above n 1, at [47].
16. Above n 1, at [48].
17. Above n 1, at [49].
18. Above n 1, at [51].
19. Above n 1, at [52]–[53].
20. Above n 1, at [61] and [69].
21. Above n 1, at [61] and [69].
22. Above n 1, at [66].
23. Above n 1, at [63].
24. Above n 1, at [65] and [70].
25. Above n 1, at [66] and [67].
26. Above n 1, at [51]–[52].
27. Above n 1, at [82].
28. Above n 1, at [80].
29. Above n 1, at [84].
30. Above n 1, at [84].
31. Above n 1, at [83].
32. Above n 1, at [51].

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Does the doctor cross a line? New guidelines on sexual boundaries in the doctor-patient relationship

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Abstract

Trust in the doctor-patient relationship is fundamental to good medical practice. Sexual misconduct destroys this, harms patients and the community and brings the medical profession into disrepute. The new Medical Board of Australia guidelines provide further clarity for the profession and community on these issues.

The new guidelines

On 12 December 2018, the Medical Board of Australia (Medical Board) released new guidelines to assist medical practitioners understand the various types of behaviours that can constitute a breach of sexual boundaries and place a doctor's registration at risk — *Guidelines: Sexual Boundaries in the Doctor-Patient Relationship* (the Guidelines).[1] The Guidelines also explore ways to minimise the risk of a boundary violation occurring. They are an update of earlier guidelines reviewed following public consultation.

The key points of the Guidelines are:[2]

- Sexual misconduct is an abuse of the doctor-patient relationship and can cause significant and lasting harm to patients.
- Sexual relationships with current patients are never appropriate.
- Physical examinations should only occur when clinically indicated and with the patient's informed consent.
- Good, clear communication is the best way to avoid misunderstandings.
- Doctors are responsible for maintaining professional boundaries.

Implications of sexual misconduct

Under the Health Practitioner Regulation National Law (as in force in each state and territory), "notifiable conduct" warranting a mandatory report to the Australian Health Practitioner Regulation Agency (AHPRA)[3] includes engaging in sexual misconduct in connection with the practice of the profession. Any allegation of a sexual boundary breach by a doctor will be assessed and/or investigated by the regulators. If a boundary violation has been found to occur, it can result in serious disciplinary action for the doctor with very significant consequences to their career, potentially deregistration.

What is inappropriate conduct?

There are a wide range of behaviours that breach sexual boundaries. Examples noted in ss 3.1 and 3.2 of the Guidelines include:[4]

- *Relationships*
  - — engaging, or attempting to engage, in a sexual relationship (despite patient consent) with a current patient
  - — such relationships with a former patient or individual close to a patient (eg, a spouse, carer, parent/guardian or other family member) could also breach sexual boundaries
- *History-taking and physical examinations*
  - — seeking sexual history or preference information when it is not clinically relevant and without explaining why it is necessary to discuss these matters
  - — conducting a physical examination that is not clinically indicated, or where the patient has not consented to it
  - — asking a patient to undress more than is necessary or failing to provide a privacy screen/cover could also breach sexual boundaries
- *Behaviours*
  - — behaviours of a sexual nature including making sexual remarks, gestures or innuendos, flirtatious behaviour, inappropriate touching, engaging in sexual behaviour in front of a patient or using words intended to arouse or gratify sexual desire
  - — any unwelcome sexual behaviour likely to offend, humiliate or intimidate a reasonable patient

- *Exploitation and abuse*

  — using the power imbalance to abuse or exploit the patient's trust or vulnerability for sexual purposes

  — sexual harassment

  — sexual assault — this may include conducting or allowing others, such as students, to conduct examinations on anaesthetised patients when they have not given explicit consent

Getting close to the boundary — warning signs to doctors

Doctors need to be alert to warning signs which indicate that boundaries are being, or about to be, crossed. Potential signs may include:[5]

- a doctor revealing intimate details about their life
- fantasising about a patient
- extending social invitations
- patient requests for non-urgent appointment at unusual hours or locations when other staff might not be present
- patients behaving overly affectionate or asking personal/intimate questions
- patients attempting to give gifts

If a doctor recognises any inappropriate feelings or behaviour either from themselves or the patient, the doctor should try to re-establish boundaries and seek advice from an experienced and trusted colleague or professional indemnity insurer. If there's a possibility that boundaries could be breached or the doctor's ability to remain objective is compromised, the doctor should transfer care to another practitioner bearing in mind the need to do this sensitively so a vulnerable patient is not further harmed.[6]

Former patients and those close to the patient

Even though a patient may no longer be under the doctor's care, there remains the possibility that a power imbalance could continue long after the professional relationship has ended, making such a relationship inappropriate. Likewise, a relationship with an individual close to the patient may affect the judgment of both the doctor and individual, potentially compromising the patient's health care.

When considering if a doctor used their professional relationship to engage in a sexual relationship with a former patient or person close to the patient, the following factors will be considered:[7]

- the duration, frequency and type of care provided by the doctor
- the degree of vulnerability of the patient
- the extent to which the patient is reliant on an individual close to them
- the extent of the patient's dependence in the doctor-patient relationship or emotional dependence on the doctor by an individual close to the patient
- the importance of the patient's clinical treatment to the patient and individual close to them
- the use of knowledge or influence obtained as the patient's doctor to pursue a sexual relationship with an individual close to the patient
- the time elapsed since the professional relationship ended
- the manner and reasons why the professional relationship ended or was terminated
- the context in which the sexual relationship started

A recent decision of the Western Australian State Administrative Tribunal[8] highlights the seriousness of a practitioner engaging in a relationship with a former patient. The patient sought regular treatment from the practitioner psychiatrist over a period of almost 20 years. Approximately 2 years following the last medical consultation, the psychiatrist and patient commenced a close personal friendship which later developed into a sexual relationship for approximately 2 years. It was submitted on behalf of the psychiatrist, as a mitigating factor, that the practitioner was not aware that the Royal Australian and New Zealand College of Psychiatrists (RANZCP) Code of Ethics[9] provided that a personal relationship between a psychiatrist and a former patient is always unethical. The psychiatrist had retired from practice, meaning suspension was not possible. The Tribunal reprimanded and disqualified the psychiatrist from applying for registration as a health practitioner for 15 months.

Physical examinations

For physical examinations, the Guidelines indicate that good medical practice involves the following:[10]

- explaining why the examination is necessary, what it involves and allowing the patient to ask questions or refuse the examination
- obtaining the patient's permission if medical students or anyone else is to be present during an examination or consultation
- obtaining informed consent
- assessing whether a patient who is a minor or who is impaired is capable of giving informed consent and if they are not, seeking consent from a substitute decision-maker
- allowing a patient to undress and dress in private; a doctor should not assist a patient to undress unless the patient is having difficulty and asks for help

- allowing a patient to bring a support person
- being aware of any verbal or non-verbal sign the patient has withdrawn consent
- providing suitable cover during an examination so that the patient is covered as much as possible and not leaving the patient undressed for any longer than is needed for the examination
- using gloves when conducting intimate examinations

Observer or chaperone

Doctors have the right to choose to have an observer present during an intimate examination or a consultation generally. Conversely, a patient has the right to refuse an observer, and in that case the doctor can either proceed without an observer or find another doctor to perform the examination or consultation.[11]

Social media

In an era where individuals can be readily accessed on social media or other digital communication, it is important for doctors to put in place clear boundaries when a patient attempts to communicate with them about matters outside the professional relationship. The doctor should politely decline to engage with the patient and direct them to their usual, professional communication channels.[12]

Final word — the importance of clear communication

Finally, and a key point to remember, is that the Guidelines reinforce the importance of clear communication as the most effective way to avoid misunderstandings in the doctor-patient relationship. They indicate that good medical practice includes:[13]

- listening to patients, asking for and respecting their views about their health, and responding to their concerns and preferences
- informing patients of the nature of, and need for, all aspects of their clinical management, including examination and investigations, and giving them adequate opportunity to question or refuse intervention and treatment
- trying to confirm that your patient understands what you have said
- responding to patients' questions and keeping them informed about their clinical progress.

At the end of the day, the Guidelines reinforce that there are things which doctors have no doubt that are inappropriate, but that there is a spectrum of potential grey areas and slippery slopes. The key is insight — doctors knowing their patient, being conscious of patient behaviour and their own reactions and being thoughtful around where circumstances can present a risk of things going wrong.

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Note: MIGA contributed to the public consultation on revision of the Medical Board's guidelines — its submission is available at www.medicalboard.gov.au/News/Past-Consultations/Consultations-January-2018.aspx.

Footnotes

1. Medical Board of Australia *Guidelines: Sexual Boundaries in the Doctor-Patient Relationship* (12 December 2018) www.medicalboard.gov.au/Codes-Guidelines-Policies/Sexual-boundaries-guidelines.aspx.
2. Above, at 2.
3. Or in Queensland, the Office of the Health Ombudsman, which receives all complaints against registered health practitioners.
4. Above n 1, at 3; see *Hill v Medical Council of NSW* [2019] NSWCATOD 52, where issues relating to examination of patients under anaesthetic were explored at a preliminary stage.
5. Above n 1, at 4.
6. Above n 1, at 4.
7. Above n 1, at 5.
8. *Medical Board of Australia v Arvid Herbert Gunnar Linde VR:175/2016*.
9. RANZCP, Code of Ethics, July 2010, www.capda.ca/_Library/resources_ethics_codes_and_practice_guidelines/psychological-society-of-ireland-code-of-professional-ethics.pdf.
10. The Guidelines indicate that gloves may not be necessary involving certain neonatal and paediatric examinations: see above n 1, at 5.
11. Above n 1, at 5–6.
12. Above n 1, at 6.
13. Above n 1, at 2.

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Coronial inquest exposes systemic gaps in the diagnosis, care and treatment of chest pain in rural hospitals

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Abstract

A coronial inquest into the sudden death of Alexander Costello highlights the need for rural hospitals to provide staff training on clinical pathways and for nursing and medical staff to follow the "Chest Pain Pathway" policy, and ensure accurate record keeping and timely consultation with, and referral to, regional/metro hospitals for matters requiring specialist medical attention.

Introduction

A coronial inquest into the unexpected death of young man in a rural hospital has exposed a systemic failure to adequately comply with a NSW Health Policy on the diagnosis, care and treatment of chest pain.[1] The Coroners Court of NSW recently handed down its findings and recommendations, which underscore the critical importance of ensuring compliance with the Chest Pain Pathway (CPP) policy at hospitals that lack emergency or coronary specialists.

Summary of facts

Mr Costello was a 37-year-old married man with a young family.[2] Whilst generally fit and healthy, he had a family history of the rare heart condition of aortic dissection.[3] At approximately 1.50 pm on 9 April 2016, Mr Costello presented to the emergency department (ED) at Gunnedah Hospital (the Hospital) in northeastern NSW with severe chest pain.[4] Despite a busy ED, Mr Costello was assessed as the most serious case and seen within minutes by the only treating doctor, Dr Gittoes.[5] Following various tests and examinations, Mr Costello was diagnosed with gastritis and transferred to an unmonitored ward. At 8.30 pm, Mr Costello collapsed, with all attempts to revive him unsuccessful. He was pronounced deceased at 8.55 pm.[6]

A post-mortem found that Mr Costello had suffered a Type A aortic dissection causing rupture of the aorta into the pericardial sac, resulting in tamponade, a compression of the heart.[7] An inquest was held to investigate Mr Costello's care, treatment and diagnosis at the Hospital and to examine whether Mr Costello should have been transferred to another hospital and whether his death was preventable.[8]

Recording of family history

Mr Costello's father had survived an aortic dissection and his cousin, aged 35, had died of the condition in 2012.[9] The Coroner found that whilst Mr Costello and his family members had conveyed his relevant family history to medical staff, there was a failure to adequately relay and record this critical information.[10] Mr Costello's wife gave evidence that she had informed the nursing staff in the presence of Dr Gittoes of the family history of a heart condition.[11] Dr Gittoes recalled a mention of a cousin but considering it non-specific and did not record any adverse family history.[12] The Coroner further found that although Mr Costello's wife had mentioned the term "artery" to a nurse, this information was not relayed to Dr Gittoes.[13] Whilst the accounts provided by the family and medical staff varied in relation to the content of the history, RN Mainey corroborated receipt of information about some form of heart disease. However, she did not record these disclosures, having considered that Dr Gittoes had already taken a complete history. The failure of medical staff to convey or record the relevant family history meant that it was not properly considered in diagnostic decisions.[14]

Diagnosis

Following his arrival at the Hospital, Mr Costello promptly underwent numerous investigations. An electrocardiogram (ECG) was conducted at 2.03 pm and 2.06 pm and appropriate blood tests were taken, including troponin levels, which measure damage to the heart; all returned normal results, indicating that a diagnosis of myocardial infarction could be ruled out.[15] After considering and excluding several other possible diagnoses, including abdominal aortic aneurism,[16] Dr Gittoes made a diagnosis of gastritis, taking account of the amount of alcohol consumed by Mr Costello on the preceding night.[17]

Dr Gittoes acknowledged that a diagnosis of gastritis was not consistent with the reported symptoms of numbness and pain in Mr Costello's right leg and loin area. However, in observing Mr Costello's ambulation for toileting purposes, the doctor inferred that these symptoms had improved and thus appeared to have accorded them little weight in his diagnostic decision-making. Dr Gittoes thus excluded the possibility of a cardiac condition.[18]

However, Mr Costello's wife observed that his mobilisation efforts were undertaken with considerable difficulty and that he was physically exhausted. He continued to experience and complain of chest and back pain and vomited throughout the afternoon and evening. Shortly before he collapsed, Mr Costello informed another family member that he had "bad chest pains", which hadn't improved.[19] The recorded pain levels were found to be consistent with the family's observations.[20]

Role of CPP in diagnosis, care and treatment

The NSW Health Policy Directive PD 2011_037: Chest Pain Evaluation (NSW Chest Pain Pathway)[21] sets out the minimum standards for the management of patients presenting with chest pain or other symptoms of myocardial ischaemia. Specifically, the CPP is an NSW Health Policy that provides guidance on the diagnosis, treatment, management, risk classification and review of patients presenting with chest pain.

According to the CPP, in the absence of abnormalities in ECG results, clinicians are to consider aortic dissection.[22] According to expert witness, Associate Professor Anna Holdgate, Dr Gittoes should have considered this diagnosis following the negative troponin result in accordance with the CPP.[23] By contrast, Dr Gittoes considered several differential diagnoses but not aortic dissection.[24]

Although nursing staff had completed the CPP and placed it in Mr Costello's medical file, Dr Gittoes did not recall sighting it, let alone adhering to its protocol. Accordingly, Dr Gittoes was unaware that the CPP had rated Mr Costello low-risk, which in the presence of recurrent ischemic pain such as Mr Costello was experiencing and reporting, required a clinical re-stratification. Dr Gittoes stated that he was never specifically instructed to use the CPP. He did however acknowledge that he was well aware of and had experience in following the clinical pathway for presentations of chest pain.[25] Whilst the Coroner accepted expert evidence that the CPP is only a guide and not required to be used by experienced emergency specialists, he found that Dr Gittoes was not an experienced emergency physician[26] and had not encountered the rare presentation of an aortic dissection previously.[27] The CPP is intended to guide clinicians precisely in such circumstances.[28] The Coroner found that the NSW Health Policy on CPP was not appropriately followed.[29] Mr Costello's death highlighted the importance of properly using the CPP in accordance with NSW Health Policy at sites that lack emergency or coronary specialists.[30]

The Coroner further found a poor understanding of the application of the CPP and of the delineation of the roles and responsibilities for determining the risk levels and stratification decisions among nursing and medical staff at the Hospital.[31] The Coroner attributed this lack of understanding to a failure by the Hospital management to provide its staff with adequate induction and continuing education on the CPP.[32] This omission contravened the state's health policy mandating that the Hospital's general managers coordinate CPP education requirements for clinicians.[33]

Specialist training and equipment in rural hospitals

Unlike hospitals at major regional centres and major cities which have emergency specialists, the Hospital is staffed by local general practitioners (GPs). Additionally, unlike its regional and urban counterparts, GPs in rural hospitals are not required to complete specialist training, nor is CT scanning or MRI imaging available. The Coroners Court noted that without the services of local GPs, emergency facilities like the ED at the Hospital would be unable to operate.[34] Thus, rural sites are subject to comparably lower minimum standards due to skill and resource shortages and the prohibitively onerous nature of imposing specialist training requirements on GPs.

The unavailability of specialist training and equipment in remote areas is addressed via access to advice and referral to hospitals offering specialist services. Of interest, however, the Coroner noted that although it was a normal practice for regional doctors to phone medical specialists at the Tamworth Hospital, Dr Gittoes gave undisputed evidence that he had a low threshold in requesting advice from and transferring patients to Tamworth.[35]

In respect of the management of chest pain, the CPP is designed to provide an internal safety mechanism against the unavoidable deficits in medical expertise at rural sites. Therefore, the lack of specialist training in rural hospitals renders adherence to the CPP by ED physicians yet more vital to the provision of quality health care services and outcomes.

Failure to consult with or transfer to Tamworth

The Coroner noted that it is normal practice for a GP at the Hospital to consult by phone with medical specialists at Tamworth.[36] Although Dr Gittoes had

turned his mind as to whether transfer to Tamworth was appropriate, he deemed Mr Costello's mobilisation to be significant and accordingly formed the view of a clinical improvement. Dr Gittoes resultantly decided against requesting advice from, or transferring Mr Costello to, Tamworth.[37]

The Coroner found that Mr Costello should not have been transferred to an unmonitored ward at the Hospital.[38] Rather, following the negative troponin result at 3.30 pm, Dr Gittoes should have referred Mr Costello to Tamworth for CT scanning and confirmation of his diagnosis.[39] The Coroner found that transfer to Tamworth was the appropriate referral pathway that would have enabled transfer to John Hunter Hospital for surgery.[40]

Death not preventable

Despite the failures of medical staff to record essential information, adhere to the CPP protocol or consult with or transfer to Tamworth, the Coroner found that Mr Costello's death was not preventable.[41] This finding was based on time estimates of travel to Tamworth for diagnostic confirmation and to John Hunter in Newcastle for specialist cardiothoracic surgery. It further took account of probable delays in accessing diagnostic services and treatment, namely CT scan and surgery waiting times, as well as the 20–30% mortality rate for the required surgery.[42] The Coroner thereby concluded that Mr Costello would likely not have survived even if he had been transferred at the appropriate time.[43] This finding underscores the present inequality of access to health care outcomes for individuals located in remote areas of Australia, the consequences of which can be catastrophic and fatal.

Coronial findings

In making his determination, the Coroner took into consideration the lack of specialist emergency doctors and diagnostic equipment, and the doctor's sole responsibility for all patients in a very busy ED.[44] Notwithstanding these significant barriers, the Coroner found that several aspects of Mr Costello's treatment, monitoring and diagnosis were neither reasonable nor appropriate:

- Dr Gittoes's notes were inadequate, evidencing a failure to record the time of entries or properly record information regarding the family history of heart conditions or critical information relating to the onset and specific nature of the pain.[45]
- Dr Gittoes did not consider aortic dissection as a possible diagnosis when it was reasonable to do so, in light of all available clinical information and the CPP.[46]
- The CPP was not appropriately utilised or followed.[47]
- Mr Costello should have been urgently transferred to Tamworth.[48]

Recommendations

Pursuant to s 82 of the Coroners Act 2009 (NSW), the Coroner recommended that all nursing and medical staff who perform duties at the Hospital ED be educated on the importance of the clinical use of the NSW Health CPP and receive training on their specific roles and responsibilities in its application. Audits are to be performed at the Hospital to ensure compliance with this recommendation.[49]

Comments

The findings from this inquest clearly demonstrate the need to provide internal training on clinical pathways for all nursing and medical staff and to ensure appropriate record keeping, including of relevant family history. In this respect the Coroner also noted that the NSW CPP Policy includes obligations on facility general managers to coordinate local education requirements for clinicians.[50] This case further highlights the critical importance of timely consultation with, and referral to, regional/metro hospitals for matters requiring specialist medical attention. Lastly, this case demonstrates the importance of accurate and timely documentation of relevant consultations and diagnoses in the patient's medical notes.

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Footnotes

1. Coroners Court (NSW) *Inquest into the death of Alexander Costello* (9 November 2018) www.coroners.justice.nsw.gov.au/Documents/COSTELLO%20Alexander.pdf.
2. Above, paras 1 and 7.
3. Above n 1, para 8.
4. Above n 1, para 1.
5. Above n 1, para 12.
6. Above n 1, para 1.
7. Above n 1, paras 2–3.
8. Above n 1, para 4.
9. Above n 1, para 8.
10. Above n 1, para 25.
11. Above n 1, para 19.
12. Above n 1, para 18.
13. Above n 1, para 23.

14. Above n 1, para 25.
15. Above n 1, paras 13 and 29.
16. Above n 1, para 15.
17. Above n 1, para 31.
18. Above n 1, para 33.
19. Above n 1, para 37.
20. Above n 1, para 38.
21. NSW Health, Chest Pain Evaluation (NSW Chest Pain Pathway), 9 June 2011 (updated 30 November 2017) www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2011_037.pdf.
22. Above n 1, para 34.
23. Above n 1, para 53.
24. Above n 1, paras 29 and 36.
25. Above n 1, para 35.
26. Above n 1, para 67.
27. Above n 1, paras 36 and 67.
28. Above n 1, para 67.
29. Above n 1, para 68.
30. Above n 1, para 69.
31. Above n 1, paras 67–8.
32. Above n 1, para 68.
33. Above n 1, para 66.
34. Above n 1, para 26.
35. Above n 1, para 27.
36. Above n 1, para 27.
37. Above n 1, para 32.
38. Above n 1, para 50.
39. Above n 1, para 53.
40. Above n 1, paras 55–6.
41. Above n 1, para 63.
42. Above n 1, paras 54–62.
43. Above n 1, para 62.
44. Above n 1, para 47.
45. Above n 1, paras 47–8.
46. Above n 1, para 48.
47. Above n 1, para 48.
48. Above n 1, para 49.
49. Above n 1, para 70.
50. Above n 1, para 65.

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Bulletin

Expert evidence, expert advocacy and normal fortitude claims for mental harm — Frangie v South Western Sydney Local Health District t/as Liverpool Hospital

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Abstract

This case concerned whether Liverpool Hospital (the Hospital) failed in its duty of care when failing to take precautions and initiate medical treatment upon the discharge of Mr Norman Frangie. Mental harm claims were made by the family members and the court was asked whether the psychological harm caused to the four plaintiffs in this case was reasonably foreseeable for a person with normal fortitude in the event of Mr Frangie's death.

Introduction

Following the death of Mr Frangie on 21 November 2016, proceedings were bought by four members of the deceased's family.[1] The claims were bought for pure mental harm and Pt 3 of the Civil Liability Act 2002 (NSW) (the Act) applied.

The plaintiffs submitted Mr Frangie's death was caused by the defendant's negligence, and claimed non-economic loss and past and future medical expenses. The defendant disputed liability to any of the plaintiffs on the basis that the indicia under s 32(1) of the Act were not made out. The defendant submitted a s 5O defence and argued that the treatment and management of Mr Frangie was consistent with "what was widely accepted in Australia by the professional opinion as competent professional practice."[2] An "inherent risk" defence under s 5I of the Act was argued but later abandoned. The defendant submitted that if, in the event that the s 5O defence was not made out, then the plaintiffs had not proved breach of duty under s 5B of the Act.[3] Lastly, the defendant submitted the alleged breaches of duty did not cause Mr Frangie's death.

Although Mr Frangie's death was not subject to an autopsy, it was thought on the balance of probabilities that Mr Frangie's death was a consequence of a ventricular fibrillation (VF) and ventricular tachycardia (VT).[4]

Background

On 13 November 2016, 70-year-old Mr Frangie was at home in the company of his son, Michael. In the evening he complained to Michael that he was hot and sweaty. As he was preparing to go to bed, he stumbled, hit his head on the door and fell on the floor. An ambulance arrived not long afterwards. The ambulance officers detected that he was having a heart attack and was in cardiogenic shock.[5]

Mr Frangie had a range of comorbidities namely, diabetes, nerve damage, high cholesterol, high blood pressure, poor kidney function, high potassium and a previous stroke.[6] He had recently undergone an amputation of one of his toes.[7] On arrival at the Hospital, he was subject to a coronary angiogram; this revealed:

> … diseased anterior descending artery (up to 70% narrowing); diseased circumflex artery (up to 50% narrowing); and totally occluded right coronary artery (100% narrowing).[8]

Mr Frangie had suffered a ST elevation[9] myocardial infarction (STEMI). This occurs where the blood flow decreases or stops to part of the heart, thereby damaging the heart muscle. One of the heart's major arteries was blocked. This is a profoundly life-threatening medical emergency.

On 14 November 2016, Mr Frangie was first seen by Dr Leung, a cardiology staff specialist within the Hospital.[10] By this time Mr Frangie's heart rate and blood pressure had improved significantly, but he was dehydrated. Dr Leung discussed with him a management plan. Dr Leung also discussed with him the findings of the angiogram, mentioning that the Hospital had fixed the blocked artery by insertion of two non-overlapping drug stents but that there was another artery that would need to be fixed after he had recovered from his current heart attack. On the same day, his pacing wire was set at a rate of 50.[11]

On 15 November, Dr Leung made an assessment of Mr Frangie's heart function by measuring his left ventricular ejection fraction (LVEF); Dr Leung performed two measurements of an "EF Biplane", being

51% and 63%, which produced an average of 56%.[12] On 16 November, the pacing wire was removed and an echocardiography was performed.[13]

Dr Leung did not see Mr Frangie on 16 or 17 November. Instead, Professor Leung, a more senior colleague and cardiologist consulted Mr Frangie. Professor Leung reported to Dr Leung that Mr Frangie was doing well; he was stable and no longer needed the pacing wire.[14]

On 17 November, Professor Leung spoke to Dr Leung again; he reported that Mr Frangie was stable and said that he could re-commence his prior antihypertensive medications. Mr Frangie was expected to be soon fit to go home.[15] On 18 November, Dr Leung reviewed Mr Frangie again; tests performed did not show anything unexpected and so Dr Leung formulated a discharge plan for Mr Frangie.[16]

With the removal of the pacing wire, Mr Frangie was placed on dual anti-platelet agents (aspirin and ticagrelor) to stop the stent blocking up. He was to receive Stiolto for his atrial fibrillation, Atacand to help his heart function improve and medicines for his diabetes. There were other recommended drugs for post-STEMI treatment.

Mr Frangie was discharged from the Hospital on 18 November but died at home 3 days later on 21 November 2016.

Court's consideration of legal principles

The plaintiffs' particulars of negligence were as follows:[17]

- failure to recommend the use of a wearable defibrillator after discharge
- failure to prescribe the drug Eplerenone
- failure to receive further assessment by cardiac MRI study before discharge

The court rejected the defendant's submissions that the s 5O defence applied to the above. By following the Court of Appeal's approach in *McKenna v Hunter & New England Local Health District*[18] it was determined that the treatment plan given to Mr Frangie consisted of "miscellaneous components" rather than a practice that is conformed to. The court confirmed the plaintiffs' submissions that such a treatment plan must involve an individualised inquiry.[19]

In light of the court's decision regarding s 5O, the standard of care was not modified, but was to be assessed by reference to the typical considerations of s 5B, requiring the plaintiffs to establish the content of the duty of care and whether it had been breached.[20] Accordingly, the plaintiffs accepted the defendant's position that the risk of harm was that the deceased's cause of death was most likely due to VF and VT. The court noted these risks were manageable by the defendant and, as such, adopted the risk of harm as "foreseeable" and "not insignificant".[21]

The court emphasised the issues relating to what precautions the Hospital should have reasonably taken with the identified "risk" of Mr Frangie suffering a fatal arrhythmia.[22] Associate Professor Adams, whose evidence was preferred to that of Dr Helprin, said the things that could have been done to deal with the risk were:[23]

- providing beta-blocker medication
- LVEF assessment
- if LVEF was less than 30%, consider placement of an implantable defibrillator in 6 weeks

Expert evidence and findings of expert advocacy

Dr Helprin, consultant cardiologist, was the expert witness for the plaintiffs and Associate Professor Adams was the defendant's expert. Dr Helprin contended that the plaintiffs' three particulars of negligence meant that if these steps were implemented, that on the balance of probabilities, Mr Frangie's death could have been prevented. This was disputed by the evidence of Associate Professor Adams.[24]

In relation to the Eplerenone, the court found Dr Helprin's evidence constituted advocacy and was of little use, as he relied on medical evidence in endorsing the drug which only observed patients with an LVEF of less than 40%, which would exclude Mr Frangie. However, Dr Helprin said it couldn't be ruled out that Mr Frangie may have benefitted from its use.[25] Associate Professor Adams disagreed with the use of this drug in the circumstances.[26] Dr Helprin's evidence was not deemed as helpful and Dr Leung and Professor Adams's evidence was preferred.

Concerning the defibrillator, Dr Helprin was cross-examined on two annexed articles to his report which discussed the categories and clinical indicators that warrant the treatment by use of a defibrillator. The court found that Mr Frangie did not fall within any of the categories. Another annexed article to Dr Helprin's report refuted Dr Helprin's contentions about the appropriateness of treatment as the LVEF was higher than what was considered as the threshold for defibrillator use. Further, in his own professional experience, Dr Helprin had never recommended use of the defibrillator to a patient post-STEMI and with a LVEF greater than 50%. Dr Helprin also accepted that it was not a usual practice nor did he have knowledge whether it was a recommended form of treatment in Liverpool Hospital. Associate Professor Adams was asked whether this treatment would be utilised at Royal Prince Alfred Hospital to which he answered "no".[27]

In relation to the cardiac MRI, Dr Helprin's evidence was not found to be persuasive as he contended that it was contingent upon which hospital the patient attended as to whether an MRI would be conducted despite it not being a usual occurrence.[28] Dr Leung accepted that such assessment was available, and conceded that it was not considered by her at the time, but said that it was not required for all STEMI patients. She referred to the 2013 ACCF/AHA Guidelines (updated in 2017) and said it was not standard treatment for patients.[29] Associate Professor Adams said a cardiac MRI was totally unnecessary in the circumstances. This was because there was good evidence from the ECG that the LVEF was normal; the basis of both measurement and visual assessment.[30]

The court's findings on the medical evidence

Eplerenone

The court determined that the Hospital's failure to prescribe Eplerenone did not represent an unreasonable failure to take this precaution against the identified risk. It was noted that the omission to prescribe this medication was in line with the guidelines for STEMI management, and the weight to be attached to the consideration of the unsuitability of this potential prescription given the deceased's high potassium levels, LVEF reading and possible renal impairment. As such this particular aspect of alleged negligence was rejected.[31]

Defibrillator

The court considered the evidence regarding the utility of a defibrillator vest. The court found no basis in relation to the studies relied upon by the plaintiff's expert to support the utilisation of this device in patients analogous to Mr Frangie. Dr Leung's evidence (which was supported by Associate Professor Adams's evidence) was accepted regarding the finding that the deceased's left ventricular function was only "mildly reduced" and that together with the proposed use of Eplerenone, there was a degree of "experimentation" with these treatments in the position of the deceased. Accordingly, this particular of negligence was also rejected.[32]

Cardiac MRI study

The final particular of negligence concerned the failure to conduct a cardiac MRI. The evidence of the two expert witnesses were considered, and again, the evidence of Associate Professor Adams's evidence was accepted, based upon experience and the absence of clinical studies to the contrary. The deceased's LVEF reading fell outside the clinical indication for such treatment, which was found to be more appropriate to "borderline" cases not applicable to Mr Frangie. Consequently, this particular of negligence was also rejected.[33]

Whilst the court accepted the plaintiffs' submission that Mr Frangie was at a high risk of mortality upon discharge, this did not affect the assessment of what a reasonable response to the identified "foreseeable" and "not insignificant" risk of Mr Frangie's cause of death to be by a VT or VF. The plaintiffs' submissions that the above precautions should have been implemented by the Hospital to manage the relevant risks were not established as they were not suitable for the deceased's condition nor acknowledged as accepted peer practice. Therefore, there was no breach of duty by the Hospital in its care to Mr Frangie.[34]

Causation

Although the breach of the Hospital's duty of care was not established, the court addressed the necessity for the plaintiffs to establish that the omission to take the three precautions (the use of eplerenone, defibrillator and cardiac MRI) resulted in the deceased's death. The lack of a clear determination of cause of death was problematic for the plaintiffs to establish causation together with the lack of evidence to support that any or all precautions would have prevented his death by VT or VF.[35]

Pure mental harm claims

The plaintiffs, identifying themselves as close family members of Mr Frangie, submitted they had all suffered pure mental harm. The plaintiffs were respectively:

- Jane — the wife of Mr Frangie and despite their separation referred to her relationship with Mr Frangie as "best friends".[36] Jane attended on Mr Frangie's home and witnessed him dead in the bathroom.[37] Jane established that she had suffered a recognised psychiatric injury.
- Michael — a son of the deceased; he had a history of post-traumatic stress disorder (PTSD) after a serious motor vehicle accident which killed his girlfriend at the time.[38] Michael had been living with his father up to the time of his death. Michael received a telephone call from his brother Peter whom informed him of his father's death; Michael then returned home to see his father dead in the bathroom.[39]
- Linda — a daughter of the deceased who had a long history of mental health problems but never obtained any psychological or psychiatric treatment until 2017.[40] Linda was 39 years of age and was single-handedly responsible for the care of three children. Nevertheless, she lived near her father and went to his house every day.[41] She came to the deceased's home after hearing that he had passed away. She went to the bathroom to see

the deceased. She said she touched his cheek and found it cold. She says that she was shocked and she froze; and was "heartbroken".[42]

- Yasmin — resided in Perth, living with her husband and four children. Despite living in Perth, she had a close relationship with her father.[43] She learnt that her father had suffered a heart attack by a telephone call from her sister. She promptly flew to Sydney and visited her father for the first couple of days before returning to Perth due to family commitments.[44] She had learned of her father's death by receiving a telephone call at 4 am (Perth time) on 18 November 2018 from her brother, Peter. She says she felt devastated when she heard of the news and flew back to Sydney that night. She saw the deceased after he had been placed in an open casket. She said that she had been sent a photograph of her dead father being found in the bathroom.[45]

The court considered whether the Hospital owed each plaintiff a duty of care, notwithstanding that their claims failed. The plaintiffs had to establish the indicia in ss 31 and 32(1) of the Act to recover damages relating to mental harm.

The defendants argued that none of the plaintiffs had witnessed the deceased "being killed" but only saw the aftermath of the alleged negligence. The defendant's submission was a direct reference to s 32(2)(b) of the Act and reliance was placed on *King v Philcox*[46] which was directed to a section of a different state's Act, albeit analogous but slightly different to the Act in consideration here. The court noted that psychiatric illness resulting from being *told* about a close family member's death does not exclude liability per *Gifford v Strang Patrick Stevedoring Pty Ltd*.[47] The plaintiffs must prove two things to enable recovery of damages pursuant to s 30 of the Act:[48]

(1) they suffered a "recognised psychiatric illness" (s 31); and
(2) the defendant should have foreseen that a person of normal fortitude might, in the circumstances, suffer a recognised psychiatric illness if reasonable care was not taken (s 32(1)).

"Normal fortitude"

The court considered previous authority in which the scope is of normal fortitude in the circumstances of a pre-existing susceptibility or vulnerability, which would make it unreasonable to require a defendant to contemplate that a plaintiff may suffer psychiatric injury. The defendant qualified this submission by stating that, in some instances, a person with a pre-existing psychiatric illness who witnessed a "truly shocking event involving the death or injury of a close family member"[49] would fall within the scope of normal fortitude under s 32(1). Notably, it is not necessary that the defendant foresee any specific psychiatric illness be sustained; merely that *any* psychiatric illness be foreseen.[50]

Materially, s 32(2) sets out a non-exhaustive list of circumstances for consideration, without assigning any hierarchy to the list of circumstances; the presence or absence of any of these considerations is not decisive.[51] The court held that it did not accept that a plaintiff be required to be present at the scene of the deceased's death nor that it is insufficient that the close family members only saw the aftermath of his death.[52] As such, pursuant to *Wicks v State Rail Authority of New South Wales; Sheehan v State Rail Authority of New South Wales*,[53] the concept of "shock"[54] was found and the court emphasised that shock relating to all causes of death, injury or being put in peril doesn't mean it must begin and end in an instant or occupy a time measured in minutes.[55] "Direct perception" was considered in *King v Philcox*, however the court found that s 32(2)(b) does not implicitly require the plaintiffs to have witnessed at the scene the death of Mr Frangie.[56] The court considered the "nature of the relationships" the plaintiffs had with the deceased, as set out in s 32(2)(c) of the Act. The court noted that it is not about the relationship's "legal status" but the closeness and affection shared. Relationships between parent and child are presumed to be close.[57] Finally, s 32(2)(d) assessed the existence or none of a pre-existing relationship between the plaintiff and the defendant. In this case, the court held that the subsection may be broad enough to embrace less formal dealings.[58] *Tame v New South Wales; Annetts v Australian Stations Pty Ltd*[59] illustrated that the concept can import prior communications, including representations made and expectations engendered during the course of those communications. The court was considering the four factors[60] of the normal fortitude test in light of s 32 and not in the context of s 30(2)(a).

Conclusion

The plaintiffs' claims which were heard concurrently ultimately failed, and a verdict and judgment for the defendant was entered, with each plaintiff being ordered to pay the defendant's costs.[61]

The case demonstrates a number of important points. Firstly, the s 5O defence will not be available in cases where a professional practice is not identified. The court found s 5O did not arise and "peculiar circumstances" or "individual inquiry" did not modify the ordinary standard of care.[62]

Secondly, in relation to breach of duty under s 5B, the particulars of negligence were considered through examination of the expert witnesses and inspection of the medical evidence and its relevance to the proceedings on

foot.[63] The court highlighted two points: the first being the importance of the court resisting an inevitable finding of negligence based on the fact that a not insignificant risk of harm was foreseeable and preventable; the other was that in reference to medical treatment options, due weight must be given to industry practice (even if that practice is not solely determinative of the standard of care).[64]

Thirdly, in terms of exposure to pure mental harm claims, a hospital can be found to owe a duty of care to relatives of its patients in the circumstances where it is reasonably foreseeable that a person with normal fortitude might suffer from or develop a recognised psychological illness as a consequence of the defendant's negligence. In this case, one of the plaintiffs affected had no direct contact with the hospital, but contact via telephone was enough to find liability for a resulting psychological illness. Plaintiff solicitors should bear in mind that "shock" has been interpreted broadly to allow for wider means of communicating shock and receiving shock. When the court was discussing the fact that the plaintiffs weren't present at the time of the death, they were not discussing those facts and circumstances in light of s 30(2)(a), rather it was being discussed in the context of the normal fortitude test in s 32(2)(b) and considered the four factors of the test.

Finally, this case should serve as a warning to solicitors to ensure that experts are properly instructed with all the relevant evidence required to form an independent and impartial opinion ensuring their opinions are underpinned by relevant medical evidence applicable to the circumstances of the patient. An expert witness is not an advocate for a party and has a paramount duty, overriding any duty to the proceedings or other person retaining the expert witness, to assist the court impartially on matters relevant to the area of expertise of the witness, as set out in Sch 7 — Expert witness code of conduct — of the Uniform Civil Procedure Rules 2005 (NSW).[65]

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Footnotes

1. *Frangie v South Western Sydney Local Health District t/as Liverpool Hospital* [2019] NSWDC 42; BC201940075.
2. Above, at [4].
3. Above n 1, at [4].
4. Above n 1, at [35].
5. Above n 1, at [7].
6. Above n 1, at [9].
7. Above n 1, at [173].
8. Above n 1, at [8].
9. ST elevation refers to a specific part of an electrocardiogram between the J point of the graph ending with the T wave. The ST segment is the plateau phase which is isoelectric as there is no voltage passing across the cardiac muscle cell membranes during this state.
10. Above n 1, at [9].
11. Above n 1, at [12].
12. Above n 1, at [13].
13. Above n 1, at [14].
14. Above n 1, at [15].
15. Above n 1, at [16].
16. Above n 1, at [17].
17. Above n 1, at [31].
18. *McKenna v Hunter & New England Local Health District* [2013] NSWCA 476; BC201316604.
19. Above n 1, at [69].
20. Above n 1, at [70].
21. Above n 1, at [73].
22. Above n 1, at [77].
23. Above n 1, at [77].
24. Above n 1, at [33].
25. Above n 1, at [57].
26. Above n 1, at [54].
27. Above n 1, at [43]–[47].
28. Above n 1, at [62].
29. Above n 1, at [60].
30. Above n 1, at [63].
31. Above n 1, at [80].
32. Above n 1, at [82]–[84].
33. Above n 1, at [85]–[86].
34. Above n 1, at [87]–[89].
35. Above n 1, at [90]–[99].
36. Above n 1, at [127].
37. Above n 1, at [128].
38. Above n 1, at [147]–[148].
39. Above n 1, at [156].
40. Above n 1, at [167].
41. Above n 1, at [171].
42. Above n 1, at [172].
43. Above n 1, at [185].
44. Above n 1, at [187].

45. Above n 1, at [188].
46. *King v Philcox* (2015) 255 CLR 304; 147 ALD 59; [2015] HCA 19; BC201504903.
47. *Gifford v Strang Patrick Stevedoring Pty Ltd* (2003) 214 CLR 269; 198 ALR 100; [2003] HCA 33; BC200303072 (*Gifford*); above n 1, at [103].
48. Above n 1, at [104].
49. Above n 1, at [107].
50. Above n 1, at [109].
51. Referring to *Wicks v State Rail Authority of New South Wales; Sheehan v State Rail Authority of New South Wales* (2010) 241 CLR 60; 267 ALR 23; [2010] HCA 22; BC201004005 (*Wicks*); above n 1, at [111].
52. Above n 1, at [113]–[114].
53. *Wicks*, above n 51.
54. As found in the Act, s 32(2)(a).
55. Above n 1, at [112]–[113].
56. Above n 1, at [113]. It was also noted that in *Tame v New South Wales*; *Annetts v Australian Stations Pty Ltd* (2002) 211 CLR 317; 191 ALR 449; [2002] HCA 35; BC200205111 (*Annetts*) that there was equally no implicit requirement of direct perception of the death, injury or being put in peril.
57. See *Gifford*, above n 47, at [48]–[49].
58. Above n 1, at [115].
59. See *Annetts*, above n 56.
60. Within s 32(2) of the Act.
61. Above n 1, at [193].
62. Above n 1, at [69].
63. Above n 1, at [36]–[65].
64. Above n 1, at [27].
65. Also see Uniform Civil Procedure Rules, r 31.23.

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