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General practitioner successfully appeals negligence finding

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Abstract

A Sydney-based general practitioner has successfully appealed a finding of negligence based on an alleged failure to refer a patient for specialist treatment in the context of particular pathology results (which predated his involvement in the patient's care) on a background of a chronic and prolonged health condition.

District Court proceedings[1]

Mr Elysee was a patient at Bankstown Medical Practice (BMC) over a period of roughly 10 years commencing in March 2002, over which time he had a complex combination of conditions including psoriasis, Hepatitis C, high blood pressure and renal complications for which he saw a number of practitioners, both at BMC and other practices.[2] Relevantly, Dr Ngo commenced treating Mr Elysee in July 2009.[3]

Mr Elysee initially sued seven general practitioners in two separate general practices for failing to monitor and manage his renal and kidney disease, resulting in sub-optimal control of his diabetes and hypertension and a requirement for dialysis at some time in the future.[4] During the hearing, Mr Elysee revised his allegation of negligence against Dr Ngo to causing an "acceleration" of the kidney disease (the progression of which was inevitable) and depression.[5] This was on the basis of an alleged "concession" by the defendant's renal expert, A/Prof Burke, given during the liability conclave joint report in which he expressed the opinion that, had earlier referral been made to a renal physician, "it *may have slowed it a bit* but it was set in place that he was going to progress to end stage renal failure anyway".[6]

Evidence adduced during the course of the litigation and during the hearing suggested that Mr Elysee intentionally doctor-shopped and ignored treatment advice provided by his treating practitioners, including specialist practitioners.[7] It was commonly agreed among the experts that this contributed to the progression of his illness.[8] He consulted countless general practitioners across no less than four practices and did not inform or divulge this fact to any one of them. This meant that no practitioner was able to get a complete clinical picture of Mr Elysee's condition, nor control his ultimate outcome.

Shortly prior to the hearing, a number of expert conclaves were convened and separate joint reports going to liability and causation were provided to the court. The liability report, served on the first day of hearing, led to judgment in favour of two defendants by consent.[9] The causation report prompted the remaining defendants, with the exception of Dr Ngo, to make a collective application for summary dismissal[10] on the basis that the experts unanimously held that no act or omission of any defendant caused or materially contributed to the plaintiff's condition. The argument was that this necessarily negates the importance of the question as to breach of duty.[11] In reaching this conclusion, the plaintiff's endocrinologist, Dr Thornley, changed his original opinion following provision of a fulsome clinical history and co-morbidities, which had not been known to him at the time of preparing his report.[12] Mr Elysee settled his claim against the applicant defendants in their favour.

The case proceeded against Dr Ngo, who at the outset made an identical application for summary dismissal, which was refused. After 7 days of hearing, the primary judge ultimately found that Dr Ngo was negligent in failing to refer Mr Elysee for "specialist medical treatment when the test results indicated that such a course was required".[13] The tests to which the plaintiff and his Honour referred to as the critical time for referral were those reported on 16 April 2009,[14] some 3 months prior to Dr Ngo's involvement in his care. These tests allegedly showed signs of "chronic kidney failure"[15] by way of renal markers.[16] Expert evidence provided by a renal physician and endocrinologist separately agreed that the results were borderline normal and diagnostically unreliable, such that a further blood test should have been arranged.[17] Unbeknown to any practitioner at BMC, this was in fact done at another medical practice a fortnight later and the results were within the normal reference range.[18] The patient's renal markers remained this way for 2010 and into 2012.[19]

Despite this expert evidence (including the change in the opinion of the plaintiff's causation expert), his Honour found[20] that, absent such referral, Mr Elysee's need for dialysis may have been accelerated by 2 years.

Mr Elysee was awarded in excess of $200,000 in damages. A 10% reduction was applied on the basis of contributory negligence on the grounds that Mr Elysee was unlikely to have been compliant in taking prescribed medication and attending referrals.[21]

Dr Ngo appealed the decision. The primary grounds for appeal challenged the primary findings on breach of duty and causation. On appeal, Mr Elysee wanted the finding as to contributory negligence reviewed.[22]

Appeal proceedings

The appeal was allowed and was ultimately determined in favour of Dr Ngo for want of evidence, setting aside the primary judgment without the need for remittal, having regard to the considerations in *Hare v Harmer*.[23]

In the leading judgment, her Honour Lucy McCallum JA concluded that each of the primary judge's findings were unsustainable and unsupported by the evidence. In reconciling the evidence given as against the primary judgment, her Honour considered the recitation of the evidence by the primary judge to be "confusing",[24] conflated,[25] factually incorrect[26] and "incomplete in a critical respect".[27] That critical aspect related to the fact that the primary judge, whilst finding Dr Ngo negligent for a failure to refer, made no finding as to what would have happened had a referral been made.[28] This was a particularly important issue given the evidence as to non-compliance with previous referrals and medications and the causative effects of the same, which were not addressed.

Further, her Honour identified a number of procedural issues made by the primary judge including:

- disclosure of the content of the expert conclaves absent consent of the parties, which is prohibited under r 31.24(6) of the Uniform Civil Procedure Rules 2005 (NSW) (UCPR),[29] including an inconsistent application of this rule throughout the hearing[30]
- entertaining an application for summary dismissal brought by some but not all defendants, in circumstances where judicial authority is clear that such a course must fail. In multi-defendant matters, it is likely that cross-examination of one or more defendants may inculpate others and as such, the application need not be entertained.[31]
- use of evidence given on voir dire in an interlocutory application (application for dismissal by Dr Ngo) and in circumstances where that evidence was arguably considered a "fresh" opinion[32]
- judicial suggestions directed to counsel for the plaintiff as to what evidence he might wish to adduce[33] and
- reopening of the plaintiff's case following closing submissions in spite of "powerful submissions" from counsel for Dr Ngo opposing such a course[34]

Her Honour rejected Mr Elysee's case as reframed on appeal, namely that the primary judge misinterpreted the tests which the plaintiff said should have prompted referral, being "abnormal blood pressure reading scores and diabetes [markers]" referred to as HbA1C scores rather than the kidney function tests recorded on 16 April 2009.[35] Further, the window for referral had been enlarged on appeal to some unidentified point over a 3-year period from 2009 to 2011. Even if this were to be the case, which it was not, her Honour found the finding of negligence on this basis equally unsustainable[36] with reference to the unanimous and unequivocal agreement among the experts that the actions or omissions of Dr Ngo did not cause or materially contribute to the progression of Mr Elysee's chronic kidney disease.[37]

Her Honour confirmed that the conflict in opinion (as to liability) among the experts presented no issue of reliability or credibility of those experts who were each bound by the Expert Code of Conduct.[38] That evidence, when considered in totality, did not support the conclusion that Dr Ngo was negligent for failing to refer Mr Elysee to a specialist on the strength of the renal markers recorded in April 2009. Dr Ngo had successfully demonstrated that, even if a breach of duty could be established, Mr Elysee could not prove causation of any loss.

Takeaways

This case highlights a number of legal issues and considerations for medical practitioners.

Legal issues

The importance of expert evidence obtained via conclaves

Conclaves can be notoriously time consuming to prepare for and arrange however it is critical that legal practitioners articulate, with a degree of specificity, the questions in which the experts should be directed. Should agreement not be reached as to certain questions, this should be clearly indicated to the experts and by extension, the court. Where the experts reach agreement, such as occurred in this case as to causation, practitioners should take pains to ensure this is clearly indicated to the court, including active objections to "fresh" evidence being adduced at hearing which is in conflict with that earlier position.

Knowledge of procedural rules

While this would seem to be a no-brainer, much of the reasoning on appeal focused on procedural aspects of the hearing, including the admission and course of

evidence, which was inconsistent with established rules and case law. Despite these being raised by way of objection at the time, the importance of the same was not lost on appeal.

Medical practitioners

The responsibility of patients to provide adequate and complete histories to their practitioners, especially when going to multiple clinics

It is not uncommon to see patients who consult a number of medical practices for any given reason. While this may be intentional and strategic by the patient, others may be unaware that investigations, such as radiology or pathology results, are not universally accessible between practices. For medical practitioners treating a patient with a complex health issue, it may be beneficial to have this discussion with the patient while reinforcing their responsibilities to contribute to their own care.

The importance of accurate documentation and clear communication with patients

In this case, the defendants were collectively able to establish a history of non-compliance by the patient with respect to a number of health care recommendations, including failure to comply with medication and referrals to specialists. The practitioners recorded each instance of noncompliance, including any reasons given by the patient. It is clear that, for medical practitioners, whilst it is possible to consider what is the appropriate care and treatment, they cannot force a patient to comply.

Patients

Doctor shoppers

Patient who visit a number of different medical practitioners and clinics need to understand the extent to which a limited medical history, deliberate or inadvertent, can negatively impact on clinical decisions made by treating practitioners. The introduction of the "My Health Record" system, which operates under the My Health Records Act 2012 (Cth), may negate the potential for patients to doctor shop, so long as they haven't "opted out" or added access controls such to frustrate the intention of the system. The authors do not profess to understand the ins-and-outs of "My Health Record" in sufficient working detail, but acknowledge that the intended operation of the online based system includes important information such as pathology test results. Should the clinical scenario as occurred in Elysee be repeated in the future, general practitioners would presumably have access to all pathology, not just those ordered by the practice in which they consult from. Admittedly, this would not have altered the outcome in this case, however the effects that My Health Record will have on patient care and by extension, medical negligence litigation in the future is yet to be seen.

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Footnotes

1. *Elysee v Ngo* [2018] NSWDC 137; BC201840297.
2. *Ngo v Elysee* [2019] NSWCA 123; BC201904400 at [13].
3. Above, at [14].
4. Above n 2, at [14].
5. Above n 2, at [15].
6. Above n 2, at [39] — emphasis added.
7. Above n 2, at [41].
8. Above n 2, at [41].
9. Above n 2, at [42].
10. Above n 2, at [42]–[50].
11. Above n 2, at [45].
12. Above n 2, at [24].
13. Above n 1, at [93].
14. Above n 1, at [22]; [80]–[81].
15. Above n 1, at [80].
16. Renal disease is monitored, *inter alia*, by way of pathology, namely serum creatinine and eGFR measurements.
17. Above n 2, at [70]; [73]; [119].
18. Above n 2, at [80].
19. Above n 1, at [15]–table.
20. Above n 1, at [93].
21. Above n 1, at [95]–[97].
22. Above n 2, at [123].
23. Above n 2, at [110] citing *Hare v Harmer* BC200902408 at [38]–[47] per Sackville AJA.
24. Above n 2, at [53]; [96]; [106].
25. Above n 2, at [93].
26. Above n 2, at [104].
27. Above n 2, at [106].
28. Above n 2, at [109].
29. Above n 2, at [8]; [10]; [47] and [59]–[61].
30. Above n 2, at [91].

31. Above n 2, at [6] citing *Wickstead v Browne* (1992) 30 NSWLR 1at 11–12[1992] NSWCA 272; BC9203970; *Breheny v Cairncross* [2002] NSWCA 69; BC200201114; *Ford v Nagle* [2004] NSWCA 33; BC200400990.
32. Above n 2, at [3]; [44]; [48]–[49]; [54]; [57]–[59]; [84]–[86]; [88]–[89]; [104].
33. Above n 2, at [83]; [88].
34. Above n 2, at [83]; [85].
35. Above n 2, at [114]–[113].
36. Above n 2, at [128].
37. Above n 2, at [128].
38. UCPR, sch 7.