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ACT Court of Appeal overturns onerous duty finding confirming that there is no general duty on a GP to follow-up or escalate referrals

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The ACT Court of Appeal has overturned the decision of *Rubino v Ziaee*[1] in which the Supreme Court of the ACT imposed a more burdensome duty of care on a general practitioner (GP). The GP was found to be in breach of his duty by failing to follow-up referrals to a general surgeon at the Canberra Hospital to ensure that the intended treatment path was effective, and that the treatment plan devised by the referrer had not gone awry.

The Court of Appeal[2] reasoned that while there is no difference in the standard expected of a practitioner between jurisdictions or locations within Australia, the calculus of precautions[3] may differ based on the practical realities affecting an institution, organisation or facility, thereby making certain actions more onerous or less likely to effectively guard against the materialisation of an identified risk. The Court of Appeal commented that:

> Where a particular precaution against risk is readily taken and effective, failing to take that precaution may well constitute negligence. The calculus is different, however, if the circumstances of the case make that precaution more onerous or less likely to guard effectively against the identified risk.[4]

A patient who follows a normal and expected treatment path is not necessarily indicative of any negligence, even if progress is slow.

Background

The patient, Mr Rubino (the respondent), sued his former general practitioner, Dr Ziaee (the appellant), in relation to the treatment he received for hyperkeratosis on his right foot (commonly known as a corn) over a 3-year period. Though this condition is usually benign, Mr Rubino's condition progressively worsened, resulting in pain, limited mobility, and eventually, an infection that required emergency surgery.[5]

During the treatment period, which spanned 24 July 2013 to 9 August 2016, Mr Rubino attended on Dr Ziaee on 19 occasions. Dr Ziaee referred the patient to a general surgeon at the Canberra Hospital (which is part of the ACT's public health system) for evaluation and management in March and May of 2014, but received no response to either referral. For over 2 years, the patient's condition was mainly managed through prescribed painkillers, which the trial judge described as the "holding pattern."[6]

While the litigation was based on the laws of the ACT, including as to the standard of care, precautions against risk, and general principles of causation,[7] the tests are not so dissimilar to other jurisdictions[8] in other states and territories in Australia, and therefore are broadly applicable generally to medical and legal professionals.

First instance decision

The primary decision has been previously reported in an earlier article of the *Australian Health Law Bulletin*, which included detailed commentary on the respective case formulations, relevant legislative tests, and resultant judicial findings of the trial judge, his Honour McWilliam AJ.[9]

In broad terms, Mr Rubino alleged that his GP, Dr Ziaee, had been negligent in not better managing his condition. That claim turned on the alleged failure to follow-up his referrals to the Canberra Hospital.[10] Had he done so, Mr Rubino claimed that he would have received treatment at a materially earlier time, thereby avoiding injuries.

The trial judge found that Dr Ziaee's failure to follow-up on the referral within a reasonable time was a breach of his duty of care. His Honour found that a reasonable practitioner would have taken action to follow-up or escalate the surgical referral. In the circumstances of a non-urgent patient in the public system, that precaution should have been taken within 1 month[11] to ensure that the intended pathway was "effective" and achieved the specialist advice that the GP considered necessary or desirable.[12]

In doing so, an ordinary general practitioner acting reasonably would have followed up with the Hospital by "phone call or some other attempt at communication"[13]

to ensure that their patient had been "processed through the system and placed on the relevant list for surgery, perhaps with some idea of approximate wait times."[14] In contrast, Dr Ziaee was found to have done nothing to satisfy himself of his patient's progress,[15] nor did he provide any treatment other than pain management despite frequent attendances and escalating complaints.[16]

At first instance, the expert evidence presented by Associate Professor Clyne, retained by the patient, suggested that a GP has a duty to do their best for their patient, referred to as a "duty to try."[17] On the other hand, Dr Goodling, an expert witness retained by the GP, with firsthand knowledge of the subject public system, provided an opinion that no matter the means or frequency of follow-up, the patient would not have progressed through the overloaded system, which was working normally based on the non-urgent categorisation and in the absence of a significantly serious and acute change in his condition.[18]

Ultimately, the trial judge found that, by December 2014 or at least by May 2015, the GP had breached his duty of care by failing to progress the referrals to a resolution[19] and this was a necessary condition of the 12-month delay in the patient receiving definitive and effective treatment, resulting in more extensive injury and impairment.[20] Mr Rubino was awarded damages in excess of $185,000.[21]

Appeal

The GP lodged an appeal against the primary decision and presented four grounds for appeal which focused on two main issues: the trial judge's definition and application of the required standard of care and whether it had been breached, and issues of causation.[22] Ultimately, Ground 3, relating to the standard of care and duty to follow-up a surgical referral was successful. This concerned the threshold duty test, making the other grounds less important.[23] That ground challenged the trial judge's ruling that the GP had a duty to follow-up or escalate a surgical referral, as the evidence did not support the conclusion that a reasonable person in the GP's position would have taken those steps, as they would have been futile in the absence of a significant deterioration in the patient's condition.[24]

Unpacking the Appeal

There are four notable aspects of the Court of Appeal decision that noted errors made by the trial judge.

1. The appropriate framing of legislative tests, which should be constrained in scope and not general

The Court of Appeal confirmed that the critical question, when properly applying the legislative tests,[25] was whether a reasonable general practitioner in Canberra between 2014 and 2016[26] would have recognised "making inquiries", "following up" or "escalating" a referral to a specialist in the public hospital system[27] as actions that had some reasonable prospect of shortening the time in which the respondent would receive attention[28] (and advice or treatment) from that specialist.[29] This is necessarily a more specific way to formulate the content of the duty of care than the generality apparent in the primary judgment.

The reasonable person is a hypothetical, but a proper consideration of their actions must have regard to whether the taking of a precaution would render any material result in the circumstances of the case. A person cannot be supposed to have taken a particular precaution against harm if they would have known or believed that the precaution would make no difference to the probability of the harm arising.[30]

The Court of Appeal confirmed that a GP's duty to follow-up on a referral did not reflect the legislated standard of care or the general law of negligence imposed on a medical practitioner. Rather, the critical question when applying the legislative tests is whether a reasonable general practitioner in a particular area and time would have recognised specific actions as having a reasonable prospect of shortening the time before the patient would receive attention from a specialist.[31]

2. The weight given to expert evidence and the elevation of opinions that are more general in nature

All the evidence as to the effectiveness of the alleged reasonable precautions was led by the appellant,[32] but ultimately not accepted.

The Court of Appeal preferred the evidence of Dr Goodling, on behalf of the GP, ie, that patients with non-urgent but painful conditions are not escalated through the public system absent some acute deterioration or change in patient's condition. The Court of Appeal recognised that Dr Goodling was a full-time general practitioner and medical director at a practice in Canberra, having worked there since 2012. He therefore had experience of conditions in Canberra[33] at the time the referrals were made, and while they remained on foot.[34] According to the evidence of Dr Goodling, most patients wait well in excess of 12 months for surgical intervention and calls to outpatient's clinics are "highly unlikely" to trigger progress absent additional information to warrant such change.[35] While slow, the system in the public hospital was working normally and expected having regard to the specific pressures it was under.[36]

Dr Ziaee himself gave evidence that some patients in his care have had to wait up to 4 years for surgery and he had "no way of influencing" when a patient would be

seen by the Hospital.[37] Further, he gave oral evidence that the measures proposed by A/Prof Clyne (such as asking private surgeons to take on his public patients) carried the real risk that no surgeon would ever take his call again,[38] the inference being that such measures were impractical and would jeopardise patient care generally.

Having regard to the contrast in the expert evidence and their respective insights as to the Canberran health system, the Appeal found that:

> it was not open to the primary judge to find that a reasonable GP in the Territory in 2014 and 2016 would have regarded contacting the Canberra Hospital to follow up a referral as a useful or appropriate way to advance their patient's interests.[39]

The Court of Appeal concluded that the evidence of Dr Goodling and the appellant provided a sound guide as to what would have occurred had Dr Ziaee followed up or escalated the referral within the public hospital system", ie, nothing, as it was most unlikely that esclation would have changed the categorisation given to the patient by the hospital and therefore would not have resulted in any review earlier in time than that which occurred when his condition became urgent in August 2016.[40]

Further, the Court of Appeal confirmed that the more expansive "duty to try" articulated by A/Prof Clyne did not reflect the legislated standard of care or the general law of negligence imposed on a medical practitioner.[41]

3. The erroneous factual finding as to the status of referrals, which were not lost but were progressing in accordance with their categorization

Critical to the trial judge's findings on causation, was a finding that the referrals to the Hospital had gone "awry" or that the patient had got "lost in the system"[42] on the basis that no action had been taken by the Hospital.[43] The Court of Appeal clearly commented that, if this did actually occur, it was relevant only to causation and was "outside the knowledge" of Dr Ziaee, and any proposition that "some form of administrative glitch had occurred at the Canberra Hospital", did not affect any analysis of whether there had been a breach of Dr Ziaee's duty of care to his patient.[44]

On the impact of this proposition on the issue of causation, the Court of Appeal disagreed with the decision of the trial judge, and found that, following proper consideration of the documentary evidence, the records of the Canberra Hospital confirmed that the referral was not "lost", but was being triaged from time to time and progressing in accordance with the normal workings of that hospital having regard to pressures it was facing.[45] There was no reason for the evidence of Dr Goodling not to be accepted on this point, ie that the delays experienced in the present case "was not a matter for particular surprise", and was not of itself suggestive of something having gone "awry" at the Canberra Hospital.[46]

4. The erroneous reliance on case law, which was factually and materially distinguishable

The trial judge based his breach finding largely on the appellant's apparent capacity to influence the patient's progress through the public hospital system. That reasoning was based on principles relevant to a failure to treat, including a failure to follow-up a surgical referral, as elucidated in *Tai v Hatzistavrou* ("*Tai*").[47] That case concerned a gynaecologist who referred a patient to a public facility to which he had admitting rights with the intention that he himself perform the procedure. The referral form was lost and the patient ultimately suffered a delay in diagnosis of cancer.

The trial judge had uncritically cited and applied Powell JA's duty formulation[48] in *Tai,* which provided the proposition that if a patient consults a doctor for a persistent health problem, the doctor falls under a duty to examine, investigate, diagnose and treat that patient in all manner considered necessary or desirable, including to set in train steps for that treatment to be given and advise the patient on a continuing basis with relation to the treatment prescribed or proposed. If that doctor fails to carry out those steps identified by them as necessary and desirable, they have failed in their duty to their patient.[49]

When properly considered, the Court of Appeal noted that, the evidence in the present case was materially distinguishable I from the circumstances in *Tai.* In that case, the specialist making the hospital referral had "a measure of control over the prioritisation of his patients, the means to know (had he monitored matters properly) that something had gone wrong in scheduling, and the ability to do something about it."[50] In contrast with the present case, Dr Ziaee had no control over the processing of patients through a public hospital. If something had gone "awry" in the processing of the referral or scheduling of the patient, that is not a matter to which the appellants would have any knowledge or influence.[51]

Practical implications from this decision

General practitioners serve as a crucial link between patients and various medical interventions. They often refer patients to specialists or hospitals for specialized care and management. While GPs owe a well-established duty of care to their patients, there are certain situations where this duty extends to following up on referrals[52] or test results.[53] However, this is not a general duty that broadly applies in all cases of patient management and will be very impacted by the circumstances of each case.[54]

General practitioners have a duty to be mindful of their obligations regarding referrals, including the development, implementation, and monitoring of treatment plans initiated by referrals. If there is a significant change in a patient's condition, it is uncontroversial that the referring practitioner should follow-up, escalate, or otherwise inquire about an active referral. This is because such information may alter the patient's risk profile, and hence their priority in relation to other cases.

Furthermore, a changing or static condition remains subject to the medical practitioner's ongoing duty to provide advice or counsel to their patient on an interim treatment plan, regardless of the intended referral pathway. Negligence may arise if a medical practitioner fails to adopt a particular precaution, such as following up on a referral, that would likely progress the patient towards the resolution of their health condition, especially if there is a change or escalation in the patient's health condition. However, in assessing the specific nature of any duty to follow-up, a medical practitioner should also consider the specific circumstances of their practice, including their ability to influence or control any further pathway, and whether the precaution is onerous or less likely to effectively guard against the identified risk of harm to their patient. In such cases, failing to take the precaution may not necessarily constitute negligence.

This decision also has implications for legal practitioners in terms of their choice of suitable expert witnesses and how this will impact on the weight to be given to any evidence they provide It is important for lawyers to consider the unique circumstances and challenges of a particular location or facility when selecting expert witnesses. While the standard practice of choosing an expert in the same field as the case at hand may satisfy the "peer practitioner" test,[55] it's also valuable to consider experts who can provide practical and relevant opinions based on their experience in the specific or similar environment. This case serves as a reminder of the importance of retaining experts who can offer insights into the context of the case, rather than just their general expertise.

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Footnotes

1. *Rubino v Ziaee* [2021] ACTSC 331; BC202113999.
2. *Ziaee v Rubino* [2023] ACTCA 7; BC202300807.
3. Above n 2, at [58]. The "calculus of precautions" (also known as the "negligence calculus") refers to the assessment of negligence and whether a duty of care has been breached. Broadly speaking, Australian law conceptualises negligence as having two components which requires the threshold assessment of whether a particular risk of harm was foreseeable, and if so, what precautions would a reasonable person have taken to avoid the harm which in fact materialised. The "calculus" requires weighing four factors (the probability of harm arising, the likely seriousness of that harm, the burden of taking precautions to avoid that harm; and the social utility of the risk-creating activity) against each other, as opposed to being considered individually. The calculus therefore requires a risk/benefit analysis of scientific concepts (such as probability), hypothetical deductions (as to the "reasonable person") and practice knowledge (such as foreseeability).
4. Above n 2, at [58].
5. Above n 1, at [1].
6. Above n 1, at [86]; above n 2, at [18].
7. Primarily the Civil Law (Wrongs) Act 2002 (ACT) ("the Wrongs Act"), ss 40, 42–46.
8. See generally Civil Liability Act 2002 (NSW), ss 5B, 5C, 5D; Civil Liability Act 2003 (Qld), ss 9–11, 21; Wrongs Act 1958 (Vic), ss 48–51; Civil Liability Act 2002 (Tas), ss 11–13; Civil Liability Act 2002 (WA), ss 5B, 5C.
9. See A Januszewicz and C Chosich "Rubino v Ziaee — general practitioner found negligent for failing to follow up surgical referral" (2022) 30(2) *HLB* 27.
10. Above n 1, at [21].
11. Above n 1, at [114].
12. Above n 1, at [160]; Above n 2, at [40].
13. Above n 2, at [36].
14. Above n 1, at [118].
15. Above n 1, at [141].
16. Above n 1, at [148].
17. Above n 1, at [130]; Above n 2, [30].
18. Above n 1, at [107].
19. Above n 1, at [120]; Above n 2, at [31].
20. Above n 1, at [183]–[87]; Above n 2, at [42].
21. Above n 1, at [217].
22. Above n 2, at [43].
23. Above n 2, at [61].
24. Above n 2, at [43] as framed by the appellant in the respective appeal ground.
25. Above n 2, at [48].
26. This being the Appeal's framing of the hypothetical reasonable person referred to in s 43(1)(c) of the Wrongs Act.
27. As to the apparent reasonable "Precautions" to satisfy s 43 generally: see above n 2, at [48].
28. Having regard to the Appeal's framing of the "harm" as the pain and inconvenience that flowed from his hyperkeratosis not being the subject of surgical intervention or specialist advice until it became infected and was dealt with by emergency surgery: see above n 2, at [48].

29. Above n 2, at [48].
30. Above n 2, at [48].
31. Above n 2, at [48].
32. Above n 2, at [48].
33. Above n 2, at [49]. In contrast, A/Prof Clyne is a general practitioner (working primarily in NSW) with no experience practising in the ACT and therefore was not in a position to contradict what Dr Goodling said about waiting times or the vagaries on the Territory's public health system, above, n 2 at [54].
34. This author gives credit to the Appeal's inconspicuous pun while not coming off as corny (cue applause).
35. Above n 1, at [107]; above n 2, at [49].
36. Above n 2, at [57].
37. Above n 2, at [53].
38. Above n 2, at [55].
39. Above n 2, at [56].
40. Above n 2, at [67].
41. Above n 2, at [54].
42. Above n 2, at [59].
43. Above n 1, at [157]; [140]–[41]; [160]–[61].
44. Above n 2, at [59].
45. Above n 2, at [64]–[67].
46. Above n 2, at [63].
47. *Tai v Hatzistavrou* [1999] NSWCA 306; BC9905258.
48. Above n 1, at [27], citing *Tai,* above n 47 at [101]–[02].
49. Above n 1, at [27].
50. Above n 2, at [57].
51. Above n 2, at [57].
52. Including but not limited to *Tai*, above n 47.
53. See for example: *Kite v Malycha* (1998) 71 SASR 321; 197 LSJS 138; BC9802375; *O'Gorman v Sydney South West Area Health Service* [2008] NSWSC 1127; BC200809507.
54. Above n 1, at [150].
55. Although the precise terms of the defence vary in each jurisdiction, there is a common requirement that the evidence must establish that a body of peer practitioners accepts the professional's conduct to be competent and accepted practice. See s 22 Civil Liability Act 2003 (Qld), s 5O Civil Liability Act 2002 (NSW), s 59 Wrongs Act 1958 (Vic), s 41 Civil Liability Act 1936 (SA), s 22 Civil Liability Act 2002 (Tas) and s 5PB Civil Liability Act 2002 (WA).