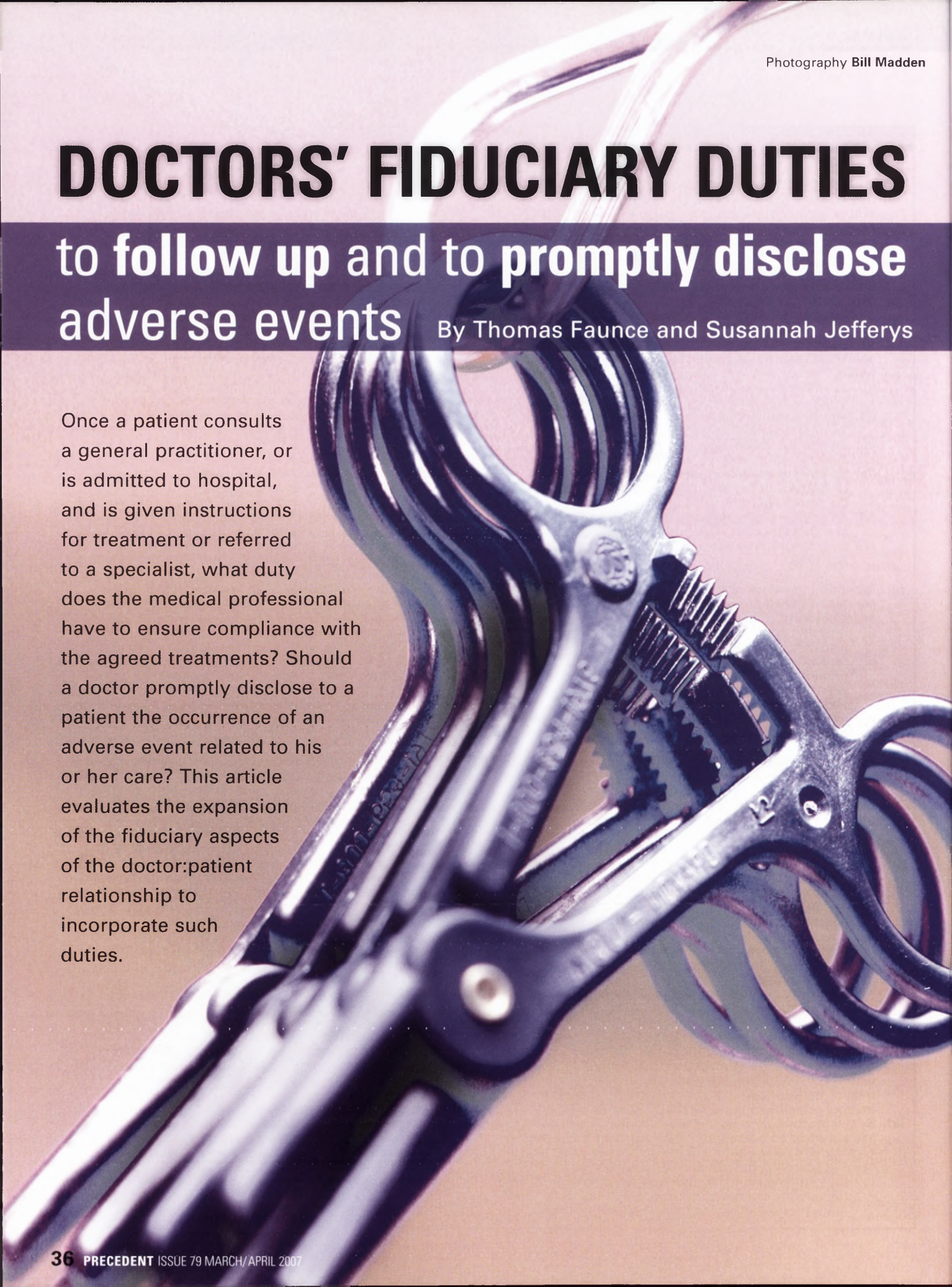
Photography **Bill Madden**

DOCTORS' FIDUCIARY DUTIES

to **follow up** and to **promptly disclose** adverse events

By Thomas Faunce and Susannah Jefferys



Once a patient consults a general practitioner, or is admitted to hospital, and is given instructions for treatment or referred to a specialist, what duty does the medical professional have to ensure compliance with the agreed treatments? Should a doctor promptly disclose to a patient the occurrence of an adverse event related to his or her care? This article evaluates the expansion of the fiduciary aspects of the doctor:patient relationship to incorporate such duties.

Defining the beginning and end of the doctor: patient relationship has traditionally been a means of circumscribing the responsibilities of medical professionals. At common law, a doctor:patient relationship begins with the proven acceptance of clinical responsibility by a duly registered doctor. The basic legal responsibility of a doctor is to exercise reasonable care and skill in the provision of advice and treatment to a patient who has requested or been allocated his or her professional services.[1]

The doctor:patient relationship is generally deemed to have commenced at common law even if it came about as a result of clinical research, or the demands of a third party (such as an insurer, the police, an employer, or public health official).[2] Once the doctor:patient relationship has begun, a myriad of ethical, common law, legislative and international human rights obligations apply.

Irrespective of which party wants to terminate the doctor: patient relationship, reasonable notice must be given in order for a doctor to ensure continuity of care.[3] Recent Australian decisions, however, appear to be redefining legal responsibilities at what used to be considered the 'tail end' of the doctor:patient relationship.[4] One of the most important changes involves the expansion of the doctor's duty of care in relation to follow-up.[5] It has also been argued that doctors' fiduciary obligations should be expanded to include a related duty to promptly (at least before hospital discharge) disclose to patients adverse medical events related to their own treatment.[6]

Some commentators contend that such redefinitions may have a significant impact on the practice of medicine in Australia, creating increased costs from over-servicing, or 'defensive medicine'.[7] Others believe that such duties represent a return to paternalism in medical decision-making, which is unwanted and unwarranted at a time when patients are increasingly seen as 'consumers' who are allegedly willing to trade universal access to basic care for freedom of choice and responsibility to pay.[8] A 'consumerist' right of self-determination, according to this view, opposes the duty to follow up, because it accords the doctor the power to give commands, rather than being an entrepreneurial provider of discretionary advice.[9]

FOLLOW-UP: A FIDUCIARY DUTY?

In *Breen v Williams*, the High Court did not consider the doctor:patient relationship to be comprehensively covered by legal rules of fiduciary responsibility.[10] The Court emphasised that the primary legal duty of the doctor was to exercise reasonable care and skill in the provision of advice and treatment. It was not to act 'on behalf of' a patient, or with 'undivided'[11] or 'uncompromising'[12] loyalty, so as to avoid any conflict of interest whatsoever, or to warrant that treatment would be successful.[13]

The justices found only fiduciary 'elements' in the relationship. These fidicuary elements evolved from the sensitive and intimate nature of patient reliance, the patient's need for bodily exposure and to divulge confidential information, and his or her presumed inability to fully protect personal economic interests.[14] Such restricted 'fiduciary elements' were expressed as legal rules requiring that doctors keep patient information confidential, receive no more than proper remuneration and not procure gifts, nor sexually intimidate or abuse the patient.[15] The Court was careful to leave open the capacity of the fiduciary concept to 'monitor the abuse of loyalty reposed in the medical practitioner by a patient', particularly where the doctor has obtained commercial benefit or financial gain from the patient beyond the agreed fee.[16]

In a privatised healthcare system, however, contractual obligations may become the starting point for a discussion of any medical duty to follow up. Another option would be to extend the tortious duty of care in medical negligence, as occurred in *Rogers v Whitaker*[17] and *Lowns v Woods*.[18] The High Court, however, has been exceedingly reluctant to pursue justice by finding new tortious duties of care given the raft of state and federal legislation[19] that followed the medical indemnity 'crisis' and consequent Ipp Committee Report.[20]

In *Harriton v Stephens*,[21] for example, a majority of the High Court refused to find an actionable duty of care to a child born with catastrophic disabilities as a result of her mother's doctor failing to correctly order, interpret and communicate routinely ordered diagnostic tests for rubella, in order to give the parents the choice of termination. Kirby J, in dissent, agreed with the dissent of Mason P in the Supreme Court, and held that the tortious claim in this instance involved >>

physical damage (the disability), which was reasonably foreseeable and preventable and caused by the doctor's failure to diagnose and give advice. Both judges disagreed with the concern of their respective majority brethren about the 'keep out' signs erected by numerous state parliaments in recent legislation restricting tortious liability. As Mason P held: 'I know of no principle that directs the common law to pause or go into reverse simply because of the accumulation of miscellaneous statutory overrides.'[22]

Other Australian courts, however, have held that – at very least, in the case of patients with serious conditions – doctors have a responsibility, which may be based either in fiduciary duty or negligence, to send reminders in the event of missed appointments.[23] These standards have to some extent been incorporated in guidelines prepared by the Australian Medical Association and the Royal Australian College of General Practitioners.[24] These guidelines are carefully worded to place only an ethical rather than a legal obligation on medical practitioners.

The question considered here is whether an expansion of fiduciary duty is more likely to be accepted as the common ground for claims related to issues of obtaining or communicating follow up, or of promptly disclosing adverse events.[25]

Burnett v Kalokerinos[26]

Ms Burnett (the plaintiff) complained of nausea, fainting spells, a lack of energy, and vaginal bleeding to the defendant GP, Dr Kalokerinos. He made an appointment for her with a specialist gynaecologist in Tamworth.

It was accepted by the court that Ms Burnett returned (in an unrecorded visit) to the defendant's practice later in the day. She then allegedly informed him that, due to family, financial and transportation problems, she could not keep the specialist appointment. She requested a referral to the nearby town of Inverell. The defendant allegedly replied that he did not 'deal with anyone in Inverell' and that it was her choice whether she kept the Tamworth appointment. Ms Burnett emphasized that she could not make it to the specialist, to which Dr Kalokerinos allegedly responded (under oath he denied any recollection of the event): 'just see how it goes and it might settle down'. Given this reassurance, Ms Burnett sought no further treatment for the next 12 months.

She was later diagnosed with cervical cancer and underwent radical surgery (including hysterectomy) and radiation treatment. Ultimately, this was a case in which an earlier diagnosis would have avoided, or at the very least reduced, the adverse consequences of treating Ms Burnett's metastasising cervical cancer. She was awarded the full amount of her loss, which was later reduced on appeal.

While discussing contributory negligence, Spender AJ referred to the fiduciary nature of the doctor:patient relationship, with its inherent imbalance of power and knowledge.[27] On appeal, however, the plaintiff was found to have been liable for contributory negligence (her damages were reduced by 20%), as she should have acted in response to the worsening of her condition.[28] This case raises a relevant broader issue. Liability for failure to follow up is a serious fiduciary concern for doctors in regional areas, where patients often need to travel great distances to obtain specialist treatments.

Wang v Central Sydney Area Health Service

In this case,[29] Justice Hidden held that a duty to follow up extended to the care of a patient with head injuries in a hospital emergency department who sought release against medical advice. Hidden J indicated that the Central Sydney Area Health Service, as the statutory authority, was under a duty to provide reasonable care for the plaintiff's well-being to the reasonable limit of its resources.[30]

Kite v Malycha

In *Kite v Malycha*,[31] Dr Malycha biopsied a lump in Mrs Kite's breast and sent the specimen away for testing. This procedure was not recorded in Dr Malycha's notes. Mrs Kite was told that she needed to call to obtain the results, and a follow-up appointment was made and recorded on a card given to Mrs Kite.[32] The specimen was analysed, found to be 'highly suspicious of carcinoma' and the results were faxed back to Dr Malycha's office. He denied that he had received the results, but the Court found that his office had received a fax, although it accepted that Dr Malycha had never seen it.[33]

Mrs Kite assumed that, as she had not heard anything further from Dr Malycha, there was no cause for concern. Nine months later, she consulted Dr Malycha and was diagnosed with metastatic breast carcinoma. Dr Malycha was found liable for not following up on the test results, and in failing to have a reminder system to check whether such reports had been returned.[34] An important issue in this case was whether the patient has a duty to take reasonable care for his or her own safety and wellbeing.[35] Such a finding would have mitigated the claim in damages against the doctor. On this point, Perry J highlighted the vulnerability of the patient:

> 'I do not think that the courts should be quick to find contributory negligence on the part of patients who have put themselves in the hands of competent medical practitioners for advice and treatment.'[36]

The then South Australian AMA President, Dr Rodney Pearce, asserted that 'until [*Kite v Malycha*] we believed the patient-doctor relationship involved joint obligations'.[37]

Tai v Hatzistavrou

In this case,[38] the plaintiff (Mrs Hatzistavrou) consulted the defendant (Dr Tai), a specialist gynaecologist, complaining of post-menopausal bleeding. A physical examination did not reveal anything abnormal, so Dr Tai decided that a dilation and curette (D&C) procedure was necessary to rule out the possibility of cancer. It was normal procedure for Dr Tai to fill out an admission form for surgery and allow the patient to submit it directly to the hospital. Mrs Hatzistavrou submitted the form on the same day. She then waited for the hospital to contact her and Dr Tai with the date for the procedure.

The form was lost in hospital administration and the date for the procedure was never set. Dr Tai did not follow up. Ten months later, the plaintiff returned for a

consultation with Dr Tai, complaining of further bleeding. He immediately booked her in for a D&C procedure, which led to the discovery of ovarian cancer that had spread to the uterus.

It was held by the NSW Court of Appeal that Dr Tai was negligent in not better monitoring the plaintiff's progress. Preistley JA stated:

> '[if] the doctor thinks it necessary, even for only prudential reasons, that the patient should submit to a particular surgical procedure, then the doctor has a continuing duty to advise the patient to submit to the surgical procedure, so long as the doctor/patient relationship is on foot.'[39]

Powell JA saw no need to extend the duty, as articulated in *Rogers v Whitaker*,[40] to cover the facts of the present case. He cited with approval Perry J's decision in *Kite v Malycha*, and held that Dr Tai was negligent through:

> 'what appears to have been inadequacies in his own system, [he] failed to ensure that the procedure which he considered necessary in the respondent's interest was carried out, the results obtained and the respondent advised accordingly'.[41]

Together, the cases of *Burnett v Kalokerinos*, *Kite v Malycha*, *Tai v Hatzistavrou* and *Wang v Central Sydney Area Health Service* suggest that courts (particularly in NSW) are placing a higher onus on healthcare practitioners and hospitals not only to provide treatment but also to take responsibility for those patients who fail to return for treatment or results.[42] The basis of liability involved elements of tortious negligence, fiduciary duty and statutory liability.

In a recent study, an overwhelming majority of patients surveyed (94.1%) expected doctors to follow up even on their missed appointments.[43] It is likely, then, that most patients still view the doctor:patient relationship as one in which they can safely rely on their doctor to give appropriate medical *instructions* (rather than 'consumer advice').

A FIDUCIARY OBLIGATION TO PROMPTLY DISCLOSE ADVERSE EVENTS

In Australia, there is no legal obligation on medical practitioners to disclose to a patient any adverse event that they know or suspect they have caused. In some jurisdictions, professional obligations require reporting incompetent conduct by a colleague to the Medical Boards.[44] Yet, giving information to a patient about core aspects of their treatment and any consequences, adverse or not, is recognised as a core component of fundamental professional virtues, ethical principles and norms of health law and international human rights.[45] It is also recognised as central to medical fiduciary obligations.[46]

Where patients have suffered an adverse event, surely this heightens their vulnerability? The equitable case for attaching a fiduciary duty to relevant aspects of the doctor:patient relationship is undoubtedly persuasive in such circumstances. Increasingly, hospital guidelines are requiring hospital staff to report as many adverse events as possible, including 'near-miss' events. The reporting, however, is usually done to regulatory authorities as part of anonymous sentinel event incident monitoring studies. Often hospital guidelines mention an ethical obligation to inform the patient of the event. Occasionally, they mention that this is actually important in heading off the possibility of subsequent litigation.

Tort law reform legislation has permitted doctors to make an apology without this being construed as an admission of liability.[47] The legislative definition may, in the ACT and NSW, facilitate early disclosure of an adverse event (as the background circumstances rationally contextualising the apology). It may also incorporate an acknowledgement of fault without liability, although it does not require it.[48] Thus, legislation that was designed to ease patient complaints may, in fact, be an effective means of expanding patient rights and access to information.

Allowing doctors to disclose adverse events in an apology, without risk of liability, may increase the likelihood of a patient being informed promptly when such events have occurred, perhaps before a statutory limitation period has expired. But from a patient's perspective, this may seem like an unsatisfactory result, as s/he is unable to take legal action over the adverse events revealed in an apology. Yet, without the benefit of protection from liability, medical practitioners may have little incentive to act in the public interest and promptly inform a patient of any adverse events that may have occurred, particularly in the private healthcare system where an employer or administrator may advocate non-disclosure on cost/benefit grounds.[49]

>>

Allowing the right to prompt disclosure of adverse events to be relinquished – by a consent form, for example – seems to be rarely, if ever, justifiable. One exception might be where disclosure of the information could reasonably be judged by a health professional to lead to an imminent risk of substantial harm to the patient (equivalent to therapeutic privilege under the disclosure of material risk doctrine). Another could be necessity (the need to protect a patient from some external immediate and substantial harm), though the relevant risk of harm would have to be substantial, imminent and well-documented. Consideration could be given to statutory protections from subpoena and discovery, as are enjoyed by both hospital morbidity and mortality, and research and clinical ethics committees.

Should there be legal repercussions for failing to provide open disclosure of medical mistakes, particularly if a limitation period has passed? A cause of action for negligent medical treatment generally arises when the negligent act occurs and results in loss, damage or injury. However, this can be a complex issue, especially where non-disclosure has delayed the action. Avoiding prompt disclosure may mean that a limitation period passes, denying a patient the right to compensation.[50] An extension may be granted at a court's discretion where it finds deliberate non-disclosure, strategically late disclosure or fraudulent concealment of an adverse event.[51] In Australia, changes made after the Ipp Report recommendations in NSW, Victoria, Tasmania and the Northern Territory have rendered such extensions less likely.[52] In these jurisdictions, the limitation clock runs from the date when the cause of action is discoverable.[53]

Finding that prompt disclosure of adverse events is one of the fiduciary elements in the doctor:patient relationship might have further benefits, creating an important spur for quality and safety improvements in Australian healthcare.

CONCLUSION

In Australia, injured patients must initially sue individual doctors and nurses in negligence in order to receive compensation. For health professionals, the risk of personal liability creates a conflict between their duty to relieve patient suffering and their obligation (encouraged by medical indemnity insurers and hospital contracts) to comply with health law and risk limitation guidelines.

Hospitals are no longer regarded legally as charitable, custodial institutions where staff create their own standards and regime of care, and the institution is liable only for the adequacy of their selection.[54] Vicarious liability now imposes strict liability on the hospital for the negligence of salaried staff acting within the usual course and contractual scope of their employment.[55] The non-delegable duty of care[56] (based, like fiduciary duty, on the general principle of special vulnerability and dependence of patients)[57] embraces hospital responsibility for the negligence of independent contractors, such as visiting medical officers, under a general obligation to use reasonable care in treatment. Conceptual confusion persists, however, between this non-delegable duty and a hospital's emerging direct liability[58] to patients for the failure of its system of care (which is more in accord with systems error research).[59]

Cases such as *Harriton* send a dangerous signal about the lack of judicial interest in professional care in the crucial area of follow-up and disclosing adverse incidents. This is particularly concerning given the growing interest of third parties such as insurance companies, health management organisations or employers in the results of genetic tests.[60]

If, however, the doctor's fiduciary obligations to the patient were extended, patients would benefit. In *Moore v Regents of University of California*,[61] the Supreme Court of California held that the legal fiduciary duties of the relevant doctors included a responsibility to disclose 'all information material to the patient's decision' to undergo treatment.[62] In *Breen v Williams*, Gummow J cited *Moore*, stating:

> 'In such cases ... the fiduciary principle would *monitor the abuse of loyalty* reposed in the medical practitioner by the patient.'[63]

An extended fiduciary duty might also require doctors, particularly in high-risk situations, to disclose to patients any inducements by private pharmaceutical companies or health management organisations that might have influenced a clinical decision.[64]

The advantages of using fiduciary law, rather than general negligence, to protect the interests of patients are not just temporal and practical; this approach is more consistent with legal theory. Good law proceeds from a commitment to fundamental professional and social virtues, such as justice and loyalty to relieving patient suffering. ■

Notes: **1** *Rogers v Whitaker* (1992) 175 CLR 479; *Breen v Williams* (1996) 186 CLR 71. In the UK, an individual becomes a patient of a GP through a legal mechanism created by the *National Health Service (General Medical Services) Regulations* 1992. **2** See *Green v Walker* 910 F 2d 291(1990); *Anderson v Glismann* 577 F Supp 1506 (1984) (medical examination ordered by court); *Matter of Johnson* 243 SE 2d 386, 36 NC App 133, app dis 267 SE 2d 686, 300 NC 373 (1980) (medical examination ordered by governmental entity). **3** *Salas v Gamboa* 760 SW 2d 838 (1988). **4** *Burnett v Kalokerinos* (unreported, NSWCA, 30/1/96); *Kite and Another v Malycha; Kite v Malycha and Another* (1998) 71 SASR 321; *Tai v Hatzistavrou* [1999] NSWCA 306. **5** *Kite v Malycha*, above note 4; *Tai v Hatzistavrou* (unreported, NSW Court of Appeal, 25 August 1999). **6** T Faunce and S Bolsin, 'Fiduciary Disclosure of Medical Mistakes: The Duty to Promptly Notify Patients of Adverse Health Care Events' (2005) 12 *Journal of Law and Medicine* 478. **7** Sally Andrews and Mary Barrett, 'Perceptions of Responsibility for Clinical Risk Management: Evidence from Orthopaedics Practitioners, Practice Managers and Patients in an Australian Capital City' (2003) 11(1) *Journal of Law and Medicine* 48, 49-50. **8** M Schultz, 'From Informed Consent to Patient Choice: A New Protected Interest' (1985) 95 *Yale Law Journal* 219 at 221. **9** Victor Harcourt, 'The Doctor's Duty to Follow Up: Legal Fiction, A Return to Paternalism or An Exercise in Risk Management?' (2001) 8 *Journal of Law and Medicine* 286 at 288. **10** *Breen v Williams* (1996) 186 CLR 71 at 108 per Gaudron and McHugh JJ. **11** *Ibid*, at 93 per Dawson and Toohey JJ. **12** *Ibid*. **13** See *Greaves v Baynham Meikle* [1975] 1 WLR 1095 at 1100. **14** *Breen v Williams*, at 135. **15** *Breen v Williams*, at 92 per Dawson and Toohey JJ; 107-109 per Gaudron and McHugh JJ; 125 per Gummow J. Informed consent does not appear to be based on the fiduciary principle in Australia: see *Rogers v Whitaker* (1992) 175 CLR 479. **16** *Breen v Williams*, at 136 per Gummow J; 112 per Gaudron and McHugh JJ; 94 per Dawson and Toohey JJ. **17** (1992) 175 CLR 479 (disclosure of material risk). **18** (1995) 36 NSWLR 344 SC (NSW); on appeal (1996) Aust Torts Reps 81-376 CA (NSW) (duty

to attend an emergency). **19** B Bennett and I Freckelton 'Life after the Ipp Reforms: Medical Negligence Law' in I Freckelton and K Petersen, *Disputes and Dilemmas in Health Law*, Federation Press (2006) 381. **20** Ipp Committee, *Review of the Law of Negligence Final Report*, Canberra, October 2002. **21** (2006) 226 ALR 391. **22** *Harriton (by her tutor Harriton) v Stephens* (2004) 59 NSWLR 694 at 722 [164]. **23** Harcourt, above note 9, at 286-301, quoted in Sara Bird, 'The Duty to Follow Up' (April 2006) 35(4) *Australian Family Physician* 251 at 252. **24** Australian Medical Association, *Position Statement on Patient Follow-up and Tracking*, 2nd ed, 2000; Royal Australian College of General Practitioners, *Draft Standards for General Practice*, 2nd ed, 2000. **25** AL Bhasale et al, 'Analysing Potential Harm in Australian General Practice: An Incident-Monitoring Study' (1998) 169 *Medical Journal of Australia* 73. **26** *Burnett v Kalokerinos* (unreported, NSWCA, 30 January 1996). **27** *Burnett v Kalokerinos* (unreported, NSWSC, 22 March 1995) per Spender AJ at 57. **28** *Kalokerinos v Burnett* (unreported, NSWCA, 30 January 1996) per Kirby P, Clarke and Powell JJA at 34-39. **29** *Wang v Central Sydney Area Health Service* [2000] NSWSC 515. **30** *Ibid*, per Hidden J at [77]. **31** *Kite and Another v Malycha; Kite v Malycha and Another* (1998) 71 SASR 321. **32** *Ibid*, at 329. **33** *Ibid*, at 330. **34** *Ibid*, at 337, 336. **35** See *March v E & M H Stramare Pty Ltd* (1991) 171 CLR 506. **36** *Kite v Malycha*, at 338. **37** R Mayne, 'Doctors Panic at Court Award', *The Bulletin*, 23 June 1998, p33. **38** *Tai v Hatzistavrou* [1999] NSWCA 306. **39** *Ibid*, at [75]. **40** (1992) 175 CLR 479 at 483. **41** *Tai v Hatzistavrou*, per Powell JA at [107]. **42** John Devereux, 'Medical Law Reporter – Negligence; *Tai v Hatzistravou*, *Wang v Central Sydney Area Health Service* and *Northridge v Central Sydney Area Health Service*' (2001) 8(4) *Journal of Law and Medicine* 377. **43** Andrews and Barrett, above note 7. **44** *Health Professionals Regulation* 2004 (ACT), r145, 'Reporting other health professionals'. The Australian Medical Association Code of Ethics, s2.1d: 'Report suspected unethical or unprofessional conduct by a colleague to the appropriate peer review body'. **45** International Covenant on Civil and Political Rights, Article 7: 'No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.' **46** *Breen v Williams* (1996) 186 CLR 71. **47** See, for example, ss12-14 *Civil Law (Wrongs) Act* 2002 (ACT); and ss67-69 *Civil Liability Act* 2002 (NSW). **48** The definition of apology in Victoria, Queensland, Tasmania, Western Australia and the Northern Territory does not allow for the admission or acknowledgement of fault. See: *Civil Liability Act* 2003 (Qld), s71; *Civil Liability Act* 2002 (Tas), s7(3); *Wrongs Act* 1958 (Vic), s14I; *Civil Liability Act* 2002 (WA), s5AF; *Personal Injuries (Liabilities and Damages) Act* 2003 (NT), s12. **49** The fear of potential malpractice liability would not only discourage participation by medical professionals in volunteer quality review committees, but would stifle candour and impair objectivity in staff evaluations. For further discussion, see L Berlin, 'Performance Improvement and Peer-Review Activities: Are they Immune from Legal Discovery?' (September 2003) AJR 181 at 649. **50** For most of the states and territories, the limitation period is three years from the incident, or knowledge or 'discoverability' if symptoms are latent. See: *Limitation Act* 1969 (NSW), s50C; *Limitation of Actions Act* 1958 (Vic), s27D; *Limitation Act* 1985 (ACT), ss16B, 36; *Limitation of Actions Act* 1974 (Qld), s11; *Limitation Act* 1935 (WA), s38; *Limitation of Actions Act* 1936 (SA), s36; *Personal Injuries (Civil Claims) Act* 2003 (NT), s8; *Limitation Act* 1974 (Tas), s5. **51** For example, *Limitation Act* 1969 (NSW), s55; and *Limitation Act* 2006 (NT), s42. **52** B Madden and T Cockburn, 'Duty to Disclose Medical Error in Australia', 3 September 2005, accessible at: http://www.slatergordon.com.au/ourservices/medneg/docs/Madden_Cockburn_Duty_Updated_3Sept05.pdf. **53** *Limitation Act* 1969 (NSW), ss50C(1), 50D; *Limitations of Actions Act* 1958 (Vic), ss27D, 27F. Cf *Limitation Act* 1974 (Tas), s5; *Personal Injuries (Civil Claims) Act* 2003 (NT), s8. **54** *Hillyer v Gov St Bartholomew's Hospital* [1909] 2 KB 820; *Schloendorff v Soc of NY Hospital* 105 NE 92 (NY 1914). **55** *Gold v Essex County Council* [1942] 2 KB 293; *Fruit v Schrenir* 502 P 2d 133 (Alaska 1972); *Duling v Bluefield Sanitarium, Inc* 142 SE 2d 754 (W Va 1965). **56** *Cassidy v Minister of Health* [1951] 2 KB 343, *Roe v Minister of Health* [1954] 2 QB 66; *Samios v Repatriation Comm* [1960] WAR 219; *Albrighton v Royal Prince Alfred Hospital* [1979] 2 NSWLR 165; [1980] 2 NSWLR 542; *Ellis v Wallsend District Hospital* (1989) 17 NSWLR 553. **57** *Kondis v State Transport Authority* (1984) 154 CLR 672 at 687 per Mason J; *Burnie Port Authority v General Jones Pty Ltd* (1992-1994) 179 CLR 520 at 551 per Mason CJ, Deane, Dawson, Toohey and Gaudron JJ. **58** *Robertson v Nottingham Health Authority* [1997] 8 MedLR 1 (communication breakdown); *Wilsher v Essex AHA* [1986] 3 All ER 801 (inexperienced doctors). **59** J Bettle, 'Suing Hospitals Direct: Whose Tort Was It Anyhow?' (1987) 137 NLJ 573; J Montgomery, 'Suing Hospitals Direct: What Tort?' (1987) 137 NLJ 703. **60** American Medical Association, Council on Ethical and Judicial Affairs, *Code of Medical Ethics: Current Opinions with Annotations* (1997) at 25. **61** 793 P 2d 479 at 482 (1990). **62** *Ibid*, at 483. **63** (1996) 136 CLR 71 at 136, emphasis added. See also Dawson and Toohey JJ at 94; *Hodgkinson v Simms* [1994] 3 SCR 377 at 406; (1994) 117 DLR (4th) 161 at 174 per La Forest J. **64** DS Shimm, RG Spece Jr and MB DiGregorio, 'Conflicts of Interest in Relationships Between Physicians and the Pharmaceutical Industry' in RG Spece, DS Shimm and AE Buchanan, *Conflicts of Interest in Clinical Practice and Research*, New York, Oxford Uni Press, 1996.

Thomas Faunce *is a senior lecturer at the College of Law and Medical School and Director of the Globalisation and Health Project at the Australian National University.*
PHONE *(02) 6125 3563* **EMAIL** *FaunceT@law.anu.edu.au*
Susannah Jefferys *is a research associate with the Globalisation and Health Project, ANU.* **PHONE** *(02) 6125 8438*
EMAIL *JefferysS@law.anu.edu.au*