Annals of the Australian Medico-Legal College

Vol.1, August 2021

Content:

Welcome from the Editor-in-Chief:

Due to the Covid epidemic, our world has changed during the last 18 months. No one alive today could recall the previous largest pandemic in the world. Emerging from Southeast Asia, it engulfed the USA and then Europe during the First World War. Because censorship prevented reporting on the disease in countries that were at war, most reporting focused on neutral Spain, and therefore the epidemic was called the “Spanish flu”. Other man-made calamities equally led to high numbers of victims, such as the Second World War and soon after, the famine emerging from China’s Great Leap Forward. The world has changed.

Medicine has also changed during the recent pandemic, where the disease for the first time covered all 6 continents. Physicians closed hospital departments and opened new ones, with new methods of diagnosis being introduced. Consultations using phone or zoom emerged and medical instructions and scripts were faxed to patients or to pharmacists. New therapeutics appeared and disappeared, the vaccine took time to be developed and administered, in some cases leading to either cerebral thrombosis, Guillain-Barre syndrome, myocarditis, or fatalities.

Physicians were the heroes, together with the rest of the para-medical staff, all trying to save the lives of the infected ones, whilst exposing themselves to the danger of contagion. The pandemic appeared initially in an acute stage, which then slowed down in some parts of the world to a lower level. Eventually, it has now become a chronic low grade clinical manifestation, with intermittent upsurges due to new variants of the virus. This development is progressing into a long-term pathological condition, affecting people both physically and psychologically, irrespective of whether they are sick themselves or just next to someone sick.

Soon, from what started as a medico-social event, a medico-legal aspect might emerge, questioning whether this illness would be, could be, or should be considered as a compensable illness if contracted during work?

The Australian Medico-Legal College is now in a process of upgrading. It emerged from a Society, and once officially recognized, it progressed into a vigorous academic organization.
The College is active in educating and assisting its members in matters relating to legislation. At this stage it is suggested that the *Annals of the Australian Medico-Legal College* should contain theoretical, historical, and ideological perspectives and present interesting clinical examples for discussion.

It is hoped that the publication of the *Annals* of the College will enhance its prestige and offer its members a forum for contributions.

George M. Weisz,

MD, FRACS (Ortho), FAMLC, BA, MA.

Adjunct Associate Professor, School of Humanities, Arts and Social Sciences, UNE and
Adjunct Senior Lecturer, School of Humanities and Languages, UNSW.

THE MAKING OF AN EXPERT

The Expert's Role is to provide a relevant Medico-Legal IME Report.

It is important to understand and critically review the letter of instruction.

It is important to appreciate when further material should be requested from the instructing lawyer or Insurer.

It is important to emphasize the report is for the Court and the essential elements required in an expert report are common to all the codes of conduct.

One has to understand the difference between

- Assumed facts
- Facts
- Opinion.

It is important to understand how an opinion is properly constructed and how the conclusions were derived.

One must appreciate the proper use of

- Language
- Syntax
- Grammar in an Expert's IME Report.

Consider all the stakeholders, the claimant, his or her solicitor and insurers. Consider the impact on the Stakeholders, especially those on the losing side:

Procedural Fairness.
Consider the Ethics, the culture, the language in the medico-legal domain avoiding rancour, non-constructive criticism ands treat the claimant with respect for their beliefs, recounting of events and subsequent disabilities.

Avoid exaggeration, hyperbole and personal rhetoric but let the facts speak for themselves in a measured, reasoned and comprehensible way: tell the story as it is and conclude it rationally for the benefit of the court.

The evidence presented to the court via an IME report must have

- Relevance
- Be probative
- Substantiated by known facts
- Be communicated in a clear manner
- Be supported by investigations, and the findings in the factual report and subsequent events.

The report should avoid

- Deliberate omission
- Heuristic skewing of matters
- Misleading
- Inconsistencies emphases, ie the report should be intuitively felt as being consistent with the mechanism of injury subsequent treatment, clinical outcomes and residual disability.
- Avoid bias, whether conscious, subconscious or in hindsight.

Causation:

- Proximal in time and place
- Reasoned mechanism of injury
- Aggravation more than negligible.

History should include Pre-existing conditions and accident details

- Ambulance report
- Police statement
- Hospital notes
- GP records
- Specialist's opinions
- Physio treatment
- OT Assessments

Physical examination

- Observe
- Move
- Measure
- Provocation tests eg Finkelstein's

Relevant Investigations

- Relevant imaging
- Bone scans/SPECT/CT
- Nerve conduction studies and EMG studies
- Medical Conditions: Thyroidism, Gout, Diabetes.

Professional Mindfulness

- Avoids forensic ferocity
- Respect opinion of others
- ABC – Always be Courteous.

AMICUS CURAE ('Friend of the Court')

You are not an advocate for either party, but your IME report is for the Court to be adduced as fair and reasonable Expert Evidence.

Independence and the Medico-legal Expert

Fundamental to the integrity and the probative value of the medico-legal expert's forensic role is their independence. This article does not address the well-reheared concerns about expert partisanship and bias in the context of independence. Instead, it focuses upon issues of conflict of interest, draft reports, contact between experts and legal representatives before finalisation of forensic reports, and the role of lawyers in "settling" expert reports. It argues that there is a need for medico-legal experts to guard these aspects of their independence jealously - both its reality, and how it may be perceived – so as avoid ethical pitfalls which can have adverse consequences for experts' forensic reputations and also for the probative value attributed to their evidence by courts.

"True independence and freedom can only exist in doing what's right."
Brigham Young (1801-1877)

Introduction:

The independence of a medical practitioner who plays a forensic role by writing a report or giving expert opinion evidence in a court or tribunal is fundamental to their credibility and the probative value which decision-makers are likely to attach to their views, whether expressed in writing or in viva voce evidence.

However, there are a number of different aspects to the independence of a forensic expertise. Most prominent is where an expert slants their views, using problematic methodology, ignoring contrary evidence or failing to advert to other reasonable interpretations of data, in such a way as to favour the party paying for their views.[1] A number of studies have documented concerns about such matters, variously described as expert witness bias and partisanship.[2] This article addresses a range of other considerations relevant to the independence of medic-legal experts, reflecting on conflict of interest on the part of forensic practitioners, problematic acceptance of "guidance" from lawyers in the writing of reports, engagement in conferences prior to the finalisation of reports, and the suppression of forensic reports. It argues that medico-legal experts need to be attentive to ethical proprieties in

[1] See Ian Freckelton, *The Trial of the Expert* (OUP, 1987); Margaret Hagen, *Whores of the Court: The Fraud of Psychiatric Testimony and the Rape of American Justice* (Harper Collins, 1997); Alan Gold, *Expert Evidence in Criminal Law: The Scientific Approach* (Irwin Law, 2009); Paul Roberts and Michael Stockdale, *Forensic Science Evidence and Expert Witness Testimony: Reliability Through Reform?* (Edward Elgar, 2018)
[2] See eg Ian Freckelton, Prasuna Reddy and Hugh Selby, *Australian Judicial Perspectives on Expert Evidence: An Empirical Study* (AIJA, 1999); Ian Freckelton, Prasuna Reddy and Hugh Selby, *Australian Magistrates' Perspectives on Expert Evidence: A Comparative Study* (AIJA, 2001); Ian Freckelton, Jane Goodman-Dealunty, Jacqueline Horan and Blake McKimmie, *Expert Evidence and Criminal Jury Trials* (OUP, 2016).

respect of such matters and robust in their assertions and maintenance of independence from the party commissioning their assessments.

Independence of Expert Views:

There is a significant jurisprudence in relation to expert witness independence, dating back at least four decades in England and Australia.

In *Whitehouse v Jordan*[3], for instance, Lord Wilberforce held that: "Expert evidence presented to the Court should be, and should be seen to be, the independent product of the expert, uninfluenced as to form or content by the exigencies of litigation." Similarly in the guidance provided for expert evidence in *The Ikarian Reefer*[4] by Cresswell J, which gave rise to the subsequent formulations of experts' codes of conduct, independence was again stressed:

> 1. Expert evidence presented to the Court should be, and should be seen to be, the *independent product of the expert uninfluenced as to form or content by the exigencies of litigation*.
>
> 2. An expert witness should provide *independent assistance to the Court* by way of objective unbiased opinion in relation to matters within his expertise. An expert witness in the High Court should never assume the role of an advocate.
>
> 3. An expert witness should state the facts or assumptions upon which his opinion is based. He should not omit to consider material facts which could detract from his concluded opinion.
>
> 4. An expert witness should make it clear when a particular question or issue falls outside his expertise.
>
> 5. If an expert's opinion is not properly researched because he considers that insufficient data is available, then this must be stated with an indication that the opinion is no more than a provisional one. In cases where an expert witness who has prepared a report could not assert that the report contained the truth, the whole truth and nothing but the truth without some qualification, that qualification should be stated in the report.
>
> 6. If, after exchange of reports, an expert witness changes his view on a material matter having read the other side's expert's report or for any other reason, such change of view should be communicated (through legal representatives) to the other side without delay and when appropriate to the Court.
>
> 7. Where expert evidence refers to photographs, plans, calculations, analyses, measurements, survey reports or other similar documents, these must be provided to the opposite party at the same time as the exchange of reports.

[3] [1981] 1 WLR 246.
[4] [1993] 2 Lloyd's Rep 63 at 81, citations omitted.

> Judge Toulmin in the case of *Anglo Group plc v Winther Brown & Co Ltd and BML (Office Computers) Ltd* (2000) 72 Con LR 118 added two further rules that experts should consider:
>
> 8. The expert witness should not give evidence or opinions as to what the expert himself would have done in similar circumstances or otherwise seek to usurp the role of the judge.
>
> 9. [The expert] should co-operate with the expert of the other party or parties in attempting to narrow the technical issues in dispute at the earliest possible stage of the procedure and to eliminate or place in context any peripheral issues. He should co-operate with the other expert(s) in attending without-prejudice meetings as necessary and in seeking to find areas of agreement and to define precisely areas of disagreement to be set out in the joint statement of experts ordered by the court. [emphasis added]

In *Vernon v Bosley (expert evidence)*[5] Thorpe LJ used a vivid metaphor to describe the expert's duty of independence:

> The area of expertise in any case may be likened to a broad street with the plaintiff walking on one pavement and the defendant walking on the opposite one. Somehow the expert must be ever-mindful of the need to walk straight down the middle of the road and to resist *the temptation to join the party* from whom his instructions come on the pavement. [emphasis added]

In the United Kingdom Practice Direction 35 issued pursuant to the Civil Procedure Rules provides that:

> 2.1 Expert evidence should be *the independent product of the expert uninfluenced by the pressures of litigation*.
> 2.2 Experts should assist the court by providing objective, unbiased opinions on matters within their expertise, and should no assume the role of an advocate.
> 2.3 Experts should consider all material facts, including those which might detract from their opinions.
> 2.4 Experts should make it clear –
> (a) when a question or issue falls outside their expertise; and
> (b) when they are not able to reach a definite opinion, for example because they have insufficient information.
> 2.5. If, after producing a report, an expert's view changes on any material matter, such change of view should be communicated to all the parties without delay, and when appropriate to the court. [emphasis added]

Comparable provisions exist in court rules and codes of practice for expert witnesses in Australia. For instance, the Federal Court of Australia[6] requires of expert witnesses giving evidence to the Court to read and agree to be bound by the "Harmonised Expert Witness Code of Conduct" which provides as a threshold issue that: "An expert witness is not an advocate for a party and has a paramount duty, overriding any duty to the party 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" and more specifically that:

---

[5] [1998] 1 FLR 297.
[6] Federal Court of Australia, "Expert Evidence Practice Note", 25 October 2016: < https://www.fedcourt.gov.au/law-and-practice/practice-documents/practice-notes/gpn-expt#AnnexureA> .

> Every report prepared by an expert witness for use in Court shall clearly state the opinion or opinions of the expert and shall state, specify or provide:
>
> (a) the name and address of the expert;
>
> (b) an acknowledgment that the expert has read this code and agrees to be bound by it;
>
> (c) the qualifications of the expert to prepare the report;
>
> (d) the assumptions and material facts on which each opinion expressed in the report is based [a letter of instructions may be annexed];
>
> (e) the reasons for and any literature or other materials utilised in support of such opinion;
>
> (f) (if applicable) that a particular question, issue or matter falls outside the expert's field of expertise;
>
> (g) any examinations, tests or other investigations on which the expert has relied, identifying the person who carried them out and that person's qualifications;
>
> (h) the extent to which any opinion which the expert has expressed involves the acceptance of another person's opinion, the identification of that other person and the opinion expressed by that other person;
>
> (i) a declaration that the expert has made all the inquiries which the expert believes are desirable and appropriate (save for any matters identified explicitly in the report), and that no matters of significance which the expert regards as relevant have, to the knowledge of the expert, been withheld from the Court;
>
> (j) any qualifications on an opinion expressed in the report without which the report is or may be incomplete or inaccurate;
>
> (k) whether any opinion expressed in the report is not a concluded opinion because of insufficient research or insufficient data or for any other reason; and
>
> (l) where the report is lengthy or complex, a brief summary of the report at the beginning of the report.[7]

Unsurprisingly, then, it has been held to be "axiomatic" that the evidence of an expert be "independent, unbiased and objective"[8], although generally a lack of independence is not fatal in Australia for the admissibility of their evidence.[9] By contrast, in a unanimous Supreme Court decision in Canada it has been held that at least in some circumstances

---

[7] Harmonised Expert Witness Code of Conduct, approved by the Council of Chief Justices' Rules Harmonisation Committee: https://www.fedcourt.gov.au/law-and-practice/practice-documents/practice-notes/gpn-expt#AnnexureA

[8] *Bux v The General Medical Council* [2021] EWHC 762 (Admin) at [17].

[9] See *Idoport Pty Ltd v National Australia Bank Ltd* [1999] NSWSC 828 at [275; *FGT Custodians Pty Ltd (formerly Feingold Partners Pty Ltd) v Fagenblat* [2003] VSCA 33; *Collins Thomson Pty Ltd v Clayton* [2002] NSWSC 366; *Kirch Communications Pty Ltd v Gene Engineering Pty Ltd* [2002] NSWSC 485; *SmithKline Beecham (Australia) Pty Ltd v Chipman* (2003) 131 FCR 500; [2003] FCA 796.

concerns about independence or impartiality of an expert witness' evidence can result in its being held to fall at the first threshold – to be inadmissible.[10] In the United Kingdon, Australia and Canada compromise to an expert's independence is likely at least to have an adverse impact upon the weight given to their views.

Conflict of Interest:

A number of other considerations can erode the value of expert witnesses' opinions. For instance, it is fundamental that forensic expert should avoid actual conflict of interest and circumstances that might reasonably give rise to a perception of conflict of interest. It has been held that a relevant conflict of interest can arise in relation to the work of a forensic expert when an expert witness' opinions are either actually influenced or are capable of being influenced, by his or her personal interests: "The former state is obviously rare and where done consciously involves considerable moral turpitude. The latter state is more common and involves no wrongdoing."[11] For example, when an expert accepts instructions to give evidence for a litigant with whom he or she is having a relationship, that is an actual conflict, whereas if the relationship had ended many years later there would be a potential conflict of interest. In the 2021 decision of *Bux v The General Medical Council* Mostyn J provided a further example of a potential conflict of interest:

> … a solicitor wishes to instruct a top expert in a piece of litigation. However, the previous summer, as part of her firm's marketing strategy, the solicitor had taken the expert to Wimbledon for the day with full hospitality. That largesse would not mean that a state of actual conflict of interest existed between the solicitor and the expert. However, there would be a potential conflict of interest which would need to be disclosed …[12]

Forms of conflict of interest include where the expert has, or may have, an interest in the litigation; where the expert has, or may have a conflicting duty; and where the expert has, or may have, a personal or other connection with a party which might consciously or subconsciously influence or bias the expert's evidence.[13] The General Medical Council Guidance on Acting as a Witness in Legal Proceedings instances the position where "you have been professionally or personally involved with one of the people involved in the case in the past, or you have a personal interest in the case."[14] The General Medical Council Guidance on Financial and Commercial Arrangements and Conflicts of Interest also identifies that: "Conflicts of interest may arise in a range of situations. They are not confined to financial interests, and may also include other personal interests."[15]

---

[10] *White Burgess Langille Inman v Abbott and Haliburton Co* [2015] 2 SCR 182. See Ian Freckelton, *Expert Evidence: Law, Practice, Procedure and Advocacy* (6th edn, Thomson Reuters, 2019) at 2.05.150.
[11] *Bux v The General Medical Council* [2021] EWHC 762 (Admin) at [23].
[12] *[2021] EWHC 762 (Admin) at [28]*
[13] *See Rowley v Dunlop* [2014] EWHC 1995 (Ch) at [21].
[14] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/acting-as-a-witness/acting-as-a-witness-in-legal-proceedings
[15] https://www.sra.org.uk/solicitors/guidance/conflicts-interest

In civil proceedings, if a medico-legal (or other) expert has a conflict of interest this generally does not disqualify him or her from giving evidence; it is usually a matter of the diminished weight which the expert's evidence will command. In the United Kingdom Lord Phillips MR stated in *Factortame (No 8)*[16]*:*

> Expert evidence comes in many forms and in relation to many different types of issue. It is always desirable that an expert should have no actual or apparent interest in the outcome of the proceedings in which he gives evidence, but such disinterest is not automatically a pre-condition to the admissibility of his evidence. Where an expert has an interest of one kind or another in the outcome of the case, this fact should be made known to the Court as soon as possible. The question of whether the proposed expert should be permitted to give evidence should then be determined in the course of case management. In considering that question the judge will have to weigh the alternative choices open if the expert's evidence is excluded, having regard to the overriding objective of the Civil Procedure Rules."

However, there is a duty for the party who wishes to call an expert who has an actual or potential conflict of interest to disclose the details of the conflict at as early a stage in the proceedings as possible so that the court and other parties are placed in a position to assess it.[17] Justice Mostyn has summarised the position for forensic experts, holding that:

> there is a high duty of candid disclosure imposed on an expert witness who has any degree of belief (other than a belief which is unreasonable or de minimis) that he may be under a conflict of interest. He must disclose details of a potential conflict of interest at as early a stage in the proceedings as possible. He must disclose any associations or loyalties which might give rise to a conflict. He must disclose any material that is suggestive of a conflict of interests, and will not be pardoned, if he fails to do so, by a later finding that there is no conflict of interest.[18]

He noted that a failure on the part of a forensic expert to make proper and candid disclosure is likely to have very serious consequences – public criticism of the expert in a judgment, disqualification as a witness, or determination that the evidence they give is either inadmissible or of no weight – while in regulatory proceedings a "disciplinary tribunal will no doubt examine with great care what motivated the expert witness to conceal the conflict of interest. If it concludes that it was done for an improper motive, such as to obtain a financial advantage, then this may well lead to a finding of dishonesty, which in turn would inevitably lead to an order for erasure from the register."[19]

The Decision in *Bux v The General Medical Council:*

---

[16] [2002] 3 WLR 1104 at [70.
[17] See *Toth v Jarman* [2006] EWCA Civ 1028 at [102], [108], [112]; *Rowley v Dunlop* [2014] EWHC 1995 (Ch) at [29]; *EXP v Barker* [2017] EWCA Civ 63 at [51]; *Bux v The General Medical* Council [2021] EWHC 762 (Admin) at [35]-[38].
[18] *Bux v The General Medical* Council [2021] EWHC 762 (Admin) at [38].
[19] *Bux v The General Medical* Council [2021] EWHC 762 (Admin) at [45]-[46].

The 2021 High Court decision of Mostyn J in *Bux v The General Medical Council* provides an extreme example of conflict of interest and an illustration of the disciplinary consequences that are liable to attend it.

There were a number of complaints against Dr Bux against a tawdry background. In 2008 Dr Bux had started writing medico-legal reports in relation to holiday sickness claims through an agent, Medico Legal and Litigation Service Ltd ("MLLS") for a firm of solicitors (AMS Solicitors Limited ("AMS") in which his wife was a salaried partner. Between 2016 and 2017 he wrote reports in 684 cases accepting instructions solely from AMS via MLLS. Thereafter, he produced expert medical reports at what Mostyn J classified as "an industrial scale". They generated a substantial part of his income. For each report he was paid £180 plus VAT. Therefore for those reports he received £123,120 plus VAT. These fees were paid into a service company, Bux Incorporated Ltd, of which he held 55% of the shares and his wife 45%. His reports were written on what was described by Mostyn J as:

> a boilerplate basis. They were superficial, unanalytical, devoid of any differential diagnoses, and were invariably supportive of the claim. They would generally conclude with the words (or words to the same effect): "I am of the opinion that the symptoms are due to infective gastroenteritis as a consequence of food poisoning. On the balance of probabilities, this was due to inadequate food preparation and food handling at the hotel..." [20]

There was no suggestion that that even once Dr Bux wrote a report which was unfavourable to a claimant. Once written, the report would be sent to the defendant travel company, which would pass it on to its insurers. In almost all cases the insurers would accept the claim, and would pay up the relatively small amount of damages sought. As Mostyn J observed, "The success of the system depended critically on production of a favourable medical report supportive of the claim."[21]

If a report had been written which disclosed that Dr Bux was married to a salaried partner of the firm of solicitors that instructed him, it was highly likely that the insurance company would challenge its conclusions and seek to disqualify the expert. Thus there was a strong financial motive for Dr Bux to remain silent about the relationship with the firm of solicitors "in order to keep up the lucrative throughput of uncontested claims."[22]

Ultimately, suspicions came to light as to the scheme "which had all the hallmarks of corrupt practice"[23] and in the course of litigation questions were sent by the solicitors for the dfendant travel company to Dr Bux pursuant to the Civil Procedure Rules, including:

---

[20] *Bux v The General Medical* Council [2021] EWHC 762 (Admin) at [8].
[21] *Bux v The General Medical* Council [2021] EWHC 762 (Admin) at [10].
[22] *Bux v The General Medical* Council [2021] EWHC 762 (Admin) at [12].
[23] *Bux v The General Medical* Council [2021] EWHC 762 (Admin) at [13].

> "1. To what extent is there a connection between you, and Sehana Bux one of the two Partners of AMS Solicitors, the firm representing the Claimant?
> 2. If there is a connection why haven't you mentioned it in the medico-legal report produced by you in this case?"

The answer (endorsed with a statement of truth), was:

> 1. Mrs Sehana Bux is my wife of just under nineteen years.
> 2. I have been doing medico-legal work for over ten years. I receive instructions to prepare reports from various different solicitors, mainly in the North-West of England. Included in this, I receive instructions to prepare reports from MLLS. Often the instructions are to provide reports for AMS solicitors. However, to maintain my professional independence and integrity, I do not deal with any cases involving Mrs. Sehana Bux. All instructions that I receive have no involvement with her whatsoever. There is a relative (sic) Chinese wall created by her firm so that there is no discussion of cases in which I am involved. Clearly from my point of view (and from hers as well) confidentiality and our reputation is of the utmost importance. Therefore, no cases are discussed between us. My job is to produce a report following consultation with the patient. It is an independent report for the purposes of the court through which I present my professional opinion, using the sources of information made available to me by MLLS. The fees that I receive for the report are independent of the outcome of the case.
>
> To clarify matters further, as I have been asked this question before, when I originally started doing medicals many years ago, I sought clarification from the GMC, who then referred me to my defence union (MDU) for further clarification. They advised me that I am following the GMC guidelines and also those provided by the MDU. Also, for further clarification, as I understand it, AMS Solicitors have an inclusion in their Terms and Conditions about the relationship between myself and Mrs Bux.

However, this was at variance with what Dr Bux said when cross-examined and he was not able to “dig up” the correspondence which he claimed existed. The Medical Practitioners Tribunal (“MPT”) made a series of decisions that were adverse to Dr Bux, including that he had acted in a state of conflict of interest, dishonestly and for financial gain. It directed that he be erased from the Medial Register. Dr Bux appealed to the High Court but Mostyn J upheld the finding of the MPT that Dr Bux had engaged in an actual conflict of interest and held that the MPT had abundant evidence which demonstrated that:

> i) As an expert witness [Dr Bux] owed to the court a duty of independence and objectivity.
>
> ii) On the other hand, [Dr Bux] had a personal interest in keeping up to speed the lucrative throughput of medical reports the benefit from which accrued not only to himself but also to his wife. She was a co-shareholder in the company to which the proceeds of the work were paid, and was a partner in the firm of solicitors providing him with the work.
>
> iii) In 2016 it was abundantly clear to [Dr Bux] that he had to disclose his marital relationship not only to the defendant's insurers but also to the court. This was clear to [Dr Bux] not only from the terms of the codes of guidance to which he was subject,

> but also as a result of the letter written in 2011 by the MDU. But he made no disclosure.
>
> iv) [Dr Bux] had on 12 May 2017 signed replies to CPR 35.6 questions, endorsed with a statement of truth, which were completely false.[24]

He concluded that with good cause the MPT found that Dr Bux had deliberately decided to write formulaic reports that diagnosed food poisoning alone. The MPT held that he did so "considering that it was the best way of continuing to provide the lucrative stream of income for his wife's firm and himself." Justice Mostyn J endorsed the MPT's analysis of Dr Bux's untruthful replies to the Part 35.6 questions. He found no error in the MPT's decision that Dr Bux knew exactly what he was doing and rejected the argument on behalf of Dr Bux that he had simply made a "stupid mistake". He found no error in the MPT's observation that ordinary decent people would consider Dr Bux's conduct dishonest and that it was financially motivated: "This was a cut and dried decision" and given that this constituted a finding of dishonesty and a finding of impairment of fitness to practise and the sanction of erasure were inevitable.[25] Thus, the ultimate consequence that the MPT had imposed on the registration of Dr Bux, who had engaged in such an egregious conflict of interest in his forensic work was affirmed in the High Court.

Suppression of Reports:

On a number of occasions wasted costs orders have been made by courts against experts to manifest their displeasure about problematic conduct by expert report writers and witnesses.[26] The failure by senior counsel, a solicitor and a forensic expert in a 2014 case in the Victorian Supreme Court to make disclosure of a report that had been commissioned from a forensic engineer is a salutary example of where less than straightforward conduct can be found in breach of overarching obligations to a court.

In *Hudspeth v Scholastic Cleaning and Consultancy Services Pty Ltd* (No 8)[27] Dixon J dismissed as "fatuous" the argument that the expert had not been in breach of his obligations to the court and the other party in failing to identify the existence of a third report that had not been served on the other parties or filed with the court. He found the expert's evidence to be misleading and deceptive and, particularly problematically, to have led the court into the error of assuming that there was not a third report by remaining silent about having signed

---

[24] *Bux v The General Medical* Council [2021] EWHC 762 (Admin) at [13].
[25] See *Bux v The General Medical* Council [2021] EWHC 762 (Admin) at [91], applying *Bolton v The Law Society* [1993] EWCA Civ 22 at [12]-[16]; *Tait v Royal College of Veterinary Surgeo*ns [2003] UKPC 34 at [13].
[26] See Ian Freckelton, "The Award of Wasted Costs Arising from Defective Expert Evidence" (2016) 25 *Journal of Judicial Administration 113; Ian Freckelton,* Expert Evidence: Law, Practice, Procedure and Advocacy (6th edn, Thomson Reuters, 2019), ch 5.15.
[27] [2014] VSC 567 at [123].

and sent the report to the plaintiff's legal team. He found the expert to have perpetuated this error during his examination-in-chief by failing to inform the court of the new report.[28] In response to the argument by the expert that it was not for him to mention the report, Dixon J concluded that the expert's conduct constituted a breach of the Expert Code of Conduct in that the expert was not assisting the court impartially on maters relevant to his expertise and was acting as an advocate for the plaintiff by acquiescing in the tactics of senior counsel – he had his own independent responsibilities.[29] Justice Dixon ordered him to pay costs.[30]

The H*udspeth* ruling signals clearly the expectation that an expert will take steps to be candid with a court about reports that they have written. If they do not, they are likely to be found to have breached their overarching obligations to the court, to have been misleading and deceptive and to have breached the Code of Conduct to which they are obliged to subscribe in their reports. At the heart of their conduct is a repudiation of their obligation to be independent and engagement in improper advocacy for the party paying their fees.

Permitting Lawyers to Play an Excessive Role in Forensic Reports: There is extensive case law on the constraints that should apply to lawyers' involvement in "settling" expert reports. As long ago as 1981 in *Whitehouse v Jordan*[31] Lord Wilberforce made a pointed warning about excessive lawyer involvement:

> While some degree of consultation between experts and legal advisers is entirely proper, it is necessary that expert evidence presented to the court should be, and should be seen to be, the independent product of the expert, uninfluenced as to form or content by the exigencies of litigation. To the extent that it is not, the evidence is likely to be not only incorrect, but self-defeating

Similar sentiments were later expressed by Brooking J in the Victorian decision of *Phosphate*

Co-operative Co of Aust Pty Ltd v Shears[32]:

> It is impossible to lay down specific rules dealing with communications between the expert, on the one hand, and the company and those representing it, on the other: everything depends on the circumstances. The guiding principle must be that care should be taken to avoid any communication which may undermine, or appear to undermine, the independence of the expert.

Conventionally, the distinction drawn is between lawyers assisting with the form of expert reports, including in relation to matters that go to their admissibility, as against playing any role in their substance.[33] It is important that medico-legal experts resist any overtures by legal practitioners to intrude in any significant way into the reasoning or the ultimate views that

---

[28] [2014] VSC 567 at [206]
[29] [2014] VSC 569.
[30] *Hudspeth v Scholastic Cleaning and Consultancy Services Pty Ltd (Ruling no 9)* [2014] VSC 622.
[31] [1981] 1 WLR 246 at 276
[32] [1989] VR 665 at 683
[33] See eg *Harrington-Smith v Western Australia (No 7*) (2003) 130 FCR 424 at [19]; see also *Moore v Getahun* (2015) 381 DLR (4th) 471.

they are minded to express. Any other response abrogates forensic responsibility from the expert to the legal advocates and is unethical and such as to erode profoundly the integrity of the expert's opinions by reason of compromising the expert's independence from the party commissioning their opinions.

Draft Reports: The status of draft reports in terms of whether and, if so, the extent to which, they are protected by legal professional privilege remains to be finally determined under Australian law.[34] A line of authority from the Federal Court suggests they are not privileged as they are neither communications nor do they expose communications[35], while a New South Wales line of authority suggests that their status depends on the intention underlying the creation of the draft report[36] – if, as is standard, the report was created in order to set out the evidence intended to be provided in the final report and in court by the expert, privilege will not apply.[37]

What can be said with confidence is that when drafts are sent by an expert to legal practitioners, it is prudent for both the experts and the lawyers to make the assumption that legal professional privilege will not apply to them. This means that any communications giving rise to the report and any feedback from legal practitioners to the expert before production of the final report should be treated as though it may become available to the other side in litigation and may form the basis for cross-examination.

Orthodox cross-examination on the basis of draft reports scrutinises the changes between the draft and the final report, looking to whether sinister influences have been brought to bear upon the expert which have been responsible for any shift in position. This lays the basis for the suggestion that the expert has come to function as an advocate and that their views are no such as to be regarded as the product of an independent analysis of the available information.

The ramifications for legal practitioners are that they need to be very cautious in relation to their input in relation to draft reports, retaining notes of any communications and assuming that any written feedback that they provide will become available to the other side in

---

[34] See Paul Mendelow, "Expert Evidence: Legal Professional Privilege and Experts' Reports" (2001) 75 *Australian Law Journal* 258; Derek Hand, "Expert Reports and Client Legal Privilege under the Uniform Evidence Act", CLE Seminar, 30 August 2017; Ian Freckelton, *Expert Evidence: Law, Practice, Procedure and Advocacy* (6th edn, Thomson Reuters, 2019) at 2.05.150.

[35] See eg *Australian Securities and Investments Commission v Southcorp Ltd* [2003] FCA 804 at [21].

[36] See eg *New Cap Reinsurance Corporation Ltd (in Liq) v Renaissance Reinsu*rance [2007] NSWSC 258 at [30]. See also, subsequently, *Shea v TruEnergy Services Pty Ltd (No 5)* [2013] FCA 937 at [56]-[6] per Dodds-Streeton J.

[37] *Sprayworx Pty Ltd v Homag Pty Ltd* [2014] NSWSC 833.

litigation. For medico-legal practitioners, the corollary is that they need to be circumspect of participating in communications, including on the telephone, about the content their draft reports. By reason of the boon that draft reports provide for the cross-examiner[38], the question should always be asked of whether from a perspective of advantages and disadvantages it is prudent for a forensic expert to provide a draft report to solicitors for counsel and, if feedback is to be provided, what should be the parameters within which such feedback is provided.

Contact with Lawyers Prior to Finalisation of a Report:

An issue associated with the risks attaching to draft reports is the contact that takes place between an expert and a commissioning solicitor or barrister prior to finalisation of a report. There is the potential for the reality or appearance of the exercise of influence by lawyers over the content of the expert's report and therefore of compromise to the expert's independence.

An instance that illustrates the problem occurred in the course of the Barwon Children litigation.[39] A solicitor for the children commissioned a child and adolescent psychiatrist to provide a report in relation to the unsuitability of a high security adult prison for the housing of children. The psychiatrist acknowledged that he received source material for his reports from the solicitor who encouraged him to give "more thought" to parts of his reports that portrayed the unit in a more favourable light and to consider whether certain parts could be deleted. Ultimately the expert conceded that his conversations with the solicitor contributed to the content of his reports, influencing the final product. However, his second report did not reveal that its content was influenced by a conversation with the solicitor, as should have occurred if there had been compliance with the Expert Witness Code which required him to state the facts, matters and assumptions on which each opinion expressed in his report was based. Justice (John) Dixon pointedly commented that: "it is regrettable that [the solicitor], who ought to well understand the requirements of the Expert Witness Code, did not ensure, when participating in a process of settling the content of the expert reports that [the expert] fully complied with the Code."[40] Once again, the issue was as to the extent to which the forensic expert's independence as a witness was qualified by his preparedness to receive and act upon critiques of his report from a solicitor.

[38] See Law Society of New South Wales, Young Lawyers, *The Practitioner's Guide to Briefing Experts* (MSW Young Lawyers, 2017).
[39] *Certain Children v Minister for Families and Children (No 2*) [2017] VSC 251.
[40] *Certain Children v Minister for Families and Children (No 2*) [2017] VSC 251 at [404].

Concluding Observations:

This article has reflected on a variety of ways in which there is the potential for an expert's independence and their integrity to be eroded by inappropriate influences. While the conduct of the medico-legal expert in *Bux v General Medical Council* was egregiously unethical, and even corrupt, the judgment of Mostyn J is important in an enduring sense because of its enunciation of circumstances of conflict of interest which put at risk an expert's credibility – both in respect of potential as well as actual conflict.

In other circumstances too influences can adversely affect, or be interpreted to have adversely affected, the independence of a medico-legal expert. Draft reports open up the potential for inferences to be drawn that an expert has moved into the proscribed role of an advocate because of the discrepancies that inevitably will exist between them and a final report. Similarly inappropriate involvement by lawyers in "settling" expert reports or in communications with experts while reports are being drafted put at risk the arms-length relationship and transparency of interaction that ought to exist between experts and commissioning lawyers. While the factual situation that existed in the *Hudspeth* litigation was again somewhat extreme (and unusual), the decision of Dixon J provides salutary guidance as to the responsibilities of experts to avoid scenarios in which anything other than a straightforward and accurate representation of the expert's views, as reduced to forensic reports, is presented to the courts. Each of the scenarios adverted to in this article highlights the risks of any form of blurring of, or compromise to, the expert's independence in the writing of forensic reports or the influence exerted on a medico-legal expert's opinions. Awareness of these risks should provide constructive guidance to medico-legal experts and legal practitioners alike.

I.Freckelton@vicbar.com.au

Conflict of interest declaration: No conflict exists, other than the involvement of the author in the *Certain Children* litigation.

Trust and Friendship in the Doctor-Patient Relationship.

Introduction: Since the middle of the twentieth century, codes of medical ethics have stressed the doctor's obligations toward the patient – and understandably so, given the medical atrocities committed just before and during World War Two. As a result, issues such as patient autonomy and informed consent are now central to both medical practice and medical research. Without in any way wishing to diminish the ethical importance of this aspect of the doctor-patient relationship, it is nevertheless worth pointing out that in earlier times the question of the patient's obligations toward the doctor was also regarded as ethically significant.

The Patient's Obligations: From antiquity to the nineteenth century both laypersons and medical writers in Western societies gave their attention to this question, with varying degrees of emphasis. In ancient Greece, for example, the earliest Hippocratic authors considered healing to be a cooperative enterprise in which the physician acted as guide and the patient together with attendants and external contingencies all had to make their appropriate contributions. [1]

This view continued in the medical thought of the Middle Ages and the succeeding Renaissance period, where the patient was considered 'an actor of equal standing with the doctor, albeit in a position with different characteristics.' [2, p.67] These characteristics included the patient's obligation to follow the doctor's instructions, not because of passive submission but because a relationship of trust had been established between the sick person and the healer.

> Trust was considered an imperative, in the sense of being a precondition that founded, almost created, the doctor-patient relationship. This in fact was not just trust in the doctor's professional abilities: also involved was a reciprocal recognition as human beings that reduced the asymmetry inherent in the doctor-patient relationship. [2, pp. 64-65]

So the sick person had to have trust in their doctor not only as a competent medical professional but also as a humane and caring individual, before accepting the patient's role and the obligations toward the doctor that went with it. Similarly, when entering the doctor-patient relationship 'the doctor had to trust the patient to perform his or her role as well as possible,' which included following the doctor's instructions with a genuine 'hope and desire to recover', [2, p. 66] and willingness to honour whatever agreement for remuneration had been entered into.

Trust as a Therapeutic Instrument

Medieval and Renaissance remedies had very limited therapeutic efficacy, but physicians naturally felt some degree of confidence in them, or they would not have continued to use them and patients would not have continued to accept them. Even from the modern scientific viewpoint, we should not dismiss them out of hand as nothing but placebos.

Bloodletting, for example, one of the traditional mainstays of pre-modern therapeutics, may seem today to be a pointless and barbaric procedure except in the special case of haemochromatosis. But from the 1890s to the 1930s scientific evidence was produced, now mostly forgotten, which showed that in certain circumstances bloodletting could be beneficial to patients who suffered from a range of complaints. [3]

This line of research dwindled out as other therapies showed greater promise for the conditions in question, but these findings from the turn of the 20th century do suggest that the pre-modern commitment to bloodletting probably had a real, even if misunderstood, physiological basis. Nevertheless, medieval physicians 'were well aware that one of the strongest weapons they had in therapy was the patient's attitude', [4, p. 216] and especially the patient's attitude of trust toward the doctor.

Thus the centrality of trust was not controversial in Medieval and Renaissance medical thought. It was reinforced not only in published writings but also in the 'practice journals, personal notes and letters of learned physicians' in the Renaissance. [5, pp. 1, 12] Nevertheless, it did raise the issue of how much familiarity between doctor and patient this trusting relationship should involve. The prime concern here was not, as it might be today, that over-familiarity could perhaps lead to abuses such as sexual misconduct or financial exploitation. Instead the worry was that the development of genuine friendship between the doctor and patient could actually undermine the healing relationship.

Firstly, it could impair the doctor's professional judgement by interfering with what would now be called clinical detachment. [2, p. 66] And secondly, it could reduce the patient's adherence to the doctor's instructions by placing expert medical advice on the same level as the casual advice of other friends offering well-meaning but uninformed and sometimes even harmful suggestions. [4, p. 215] So early medical writers recommended to their fellow physicians that 'in general, you should not get too friendly with your patients, [but] should maintain a certain aloofness'. [4, p. 215]

The dilemma, then, was how to characterise the appropriate amount of friendliness between doctor and patient, when both too much and too little were equally risks to the therapeutic effectiveness of the healing relationship. In the Renaissance, the great Dutch humanist scholar Erasmus of Rotterdam (1466-1536) offered a solution to this problem in 1499 when he wrote a speech in praise of medicine for his friend, the physician Ghisbertus, who treated him for about two decades. [6, p. 129]

Erasmus and the Patient's Obligations

Although not a medical man himself, Erasmus was well informed about medicine in antiquity. He was not up to date with the new medical developments of his own time, such as the beginning of systematic anatomical dissections in the medical schools, but since his topic was the overall value of medicine to humanity and not the latest advances in medical science, his dependence on classical Greek, Roman and Biblical sources was not a disadvantage.

In the speech for Ghisbertus, known as the 'Oration in praise of the art of medicine', [7] Erasmus takes up, among other topics, the ethics of the doctor-patient relationship. The reciprocal obligations of doctor and patient toward each other, as Erasmus understood them, are set out in this work with the author's typical rhetorical flair. [8]

For the physician, the defining obligations are the traditional ones of competence, beneficence and diligence. Competence is the mastery of knowledge and skill necessary to practice the healing art; beneficence is the physician's moral commitment to apply this knowledge and skill only for the benefit of the patient; and diligence is the sustained effort needed to give the patient the level of ongoing attention that will lead to the best possible outcome.

In return, the patient owes the doctor both gratitude and recompense. We will come back to these two obligations, but first let us note that Erasmus, not being a medical man himself, puts no emphasis on the patient's obligation to follow the doctor's instructions.

Certainly he assumes that the patient must normally cooperate with the physician, because he refers to 'the recalcitrant patient' as a problematic case. [7, p. 48]

But nowhere does he refer to the patient's duty to obey the doctor during treatment. Perhaps Erasmus was silent on this point because he was not always a compliant patient himself. Even in the course of his treatments by Ghisbertus, 'he sometimes had second thoughts about [his doctor's] medical judgements'. [6, p. 129] A refusal of complete obedience on the patient's part was not uncommon at the time. Although the ideal patient, in doctors' eyes, was one who obeyed without hesitation, notes of actual medical practice 'offer numerous instances of patients questioning or indeed rejecting the physicians' recommendations and prescriptions. [5, p. 23]

Erasmus and Friendship between Doctor and Patient

Regarding the patient's obligations of gratitude and recompense, Erasmus treats these as arising out of friendship, just as he also treats the physician's beneficence as an expression of friendship. [8, p. 37] The kind of friendship he has in mind, however, is not the sort that would interfere with the doctor's clinical judgement or the patient's regard for the doctor's advice. It is not primarily an affective relationship, but a 'philosophical' friendship as described by Aristotle in his principal work of moral philosophy, the *Nichomachean Ethics*.

Aristotle analyses several types of friendship in his *Ethics*, however the one that is relevant here is what he characterises as a friendship between unequals. The category of unequal friendship includes such cases as parents and offspring, or teachers and pupils. But the most extreme form is the one that exists between benevolent gods and pious humans. This form provides the model which all the other cases approximate in some degree.

Benevolent gods, for Aristotle, provide care and protection to humans, not with any thought of return but as an expression of their inherently good nature, while pious humans honour the gods and express their gratitude through service and sacrifices. Although this response can never repay the gods for all the benefits humans receive, it is enough if it is a sincere attempt to reciprocate within the limits of one's capacity. [8, pp. 38-39]

Erasmus refers throughout his oration to the god-like role of medicine in preserving and saving life – when he says, for example, 'if the gift of life belongs to God alone, then it must be granted that the next best thing is the art which protects and restores that life.' [7, p. 38] The physician who carries out such a role with competence, beneficence and diligence is for Erasmus the best kind of friend, one who does not desert the patient in times of adversity as fair-weather friends do, but who will stay at the bedside 'to contend with the disease for the life of the critically ill'. [7, p. 46] This last point was by no means empty rhetoric on Erasmus' part.

Not only did medical writers from this period advise the physician that 'in cases of acute or life-threatening disease … he should not leave the bedside', but '[l]etters and account books show that this was indeed standard practice.' [9, p. 111]

The friendship between doctor and patient, as presented by Erasmus, would not be symmetrical because 'no honour can be deemed too high' and 'no degree of gratitude can repay the physician for the service he has rendered'. [7, pp. 37, 46] The patient's obligation to show gratitude and to pay appropriately for the physician's services is therefore an expression of friendship within an unequal relationship, an acknowledgement by the patient of benefits received, such as 'the gift of life', which can never be fully repaid but which one can only sincerely attempt to reciprocate within the limits of one's capacity.

This form of asymmetrical friendship is not one that would be likely to impair the physician's clinical judgement because of excessive familiarity, or cause the patient to disregard the physician's medical expertise. But we must remember that Erasmus is setting out here, as often happens in Medieval and Renaissance writing, an ideal type. He describes his ideal of the appropriate friendship between doctor and patient, but he also devotes a fair amount of attention to scolding patients who fail to live up to this ideal. Similarly, he also acknowledges that there are inadequate physicians who may sometimes harm patients through incompetence, negligence, or love of gain. But he argues that 'no profession is so pure as to be without its share of rogues,' and that it would be malicious to characterise the art of medicine by its worst practitioners. [7, p. 49]

Conclusion

The friendship between doctors and patients envisaged by Erasmus, derived from an Aristotelian prototype based on the relationship between gods and humans, does not appear to be a model that would suit contemporary life, even as an ideal aspiration that is never fully achieved. But if we look past the excessively paternalistic connotations of the way in which the 'Oration' characterises medicine and its ideal practitioners as divine, we recall that Erasmus does in fact allow for patient autonomy by not treating obedience to the doctor as a moral obligation. He also speaks of the appropriateness of legislation to back up some of the obligations of both doctors and patients, so he is not entirely naive about how one translates the ideal into a reality.

Nevertheless, the main value of the 'Oration' today is not to provide a detailed model of friendship in the doctor-patient relationship, but to remind us of the importance of a personal connection in the healing relationship. Given the technical sophistication of Western medicine in the 21st century and the high levels of therapeutic efficacy it offers for many conditions, together with government efforts to contain costs which can limit the time physicians spend with their patients, the role of friendship in the doctor-patient relationship may often seem irrelevant. But it is worthwhile to remember that when this happens 'patients respond to what they perceive as the physician's lack of interest with anger and withdrawal, ultimately with malpractice suits and recourse to alternative healers.' [10, p. 792] So it is good to listen, occasionally, to writers from earlier times, like Erasmus, who remind us that the element of friendship can serve both the doctor's and the patient's best interests.

References

1. Hippocratic Corpus, Aphorisms, 1.

2. Duranti T. 'Two Actors in the Mediaeval Therapeutic Relation', in Malatesta M, ed. *Doctors and Patients: History, Representations, Communication from Antiquity to the Present*. San Francisco, University of California Medical Humanities Press, 2015, 52-80.

3. Risse G. 'The Renaissance of Bloodletting: a Chapter in Modern Therapeutics', *Journal of the History of Medicine and Allied Sciences* 1979, 34: 3-22.

4. McVaugh MR. 'Bedside Manners in the Middle Ages', *Bulletin of the History of Medicine* 1997, 71(2): 201-223.

5. Stolberg M. 'The Doctor-Patient Relationship in the Renaissance', *European Journal for the History of Medicine and Health* 2021, 1-29. Online ahead of print. doi: https://doi.org/10.1163/26667711-bja10001

6. Krivatsky P. 'Erasmus' Medical Milieu', *Bulletin of the History of Medicine* 1973, 47: 113-154.

7. Erasmus D. 'Oration in Praise of the Art of Medicine [*Encomium Medicinae*]', McGregor B, tr., in Erasmus D, *Collected Works of Erasmus*. Toronto: University of Toronto Press, 1974- (86 volumes planned), vol. 29 (1989): 31-50.

8. Albury WR and Weisz GM. 'The Medical Ethics of Erasmus and the Physician-Patient Relationship', *Journal of Medical Ethics: Medical Humanities* 2001, 27: 35-41.

9. Park K. *Doctors and Medicine in Early Renaissance Florence*. Princeton: Princeton University Press, 1985.

10. Shorter E. 'The History of the Doctor-Patient Relationship', in Bynum WF and Porter R, eds. *Companion Encyclopedia of the History of Medicine*, 2 vols. London: Routledge, 1993, vol. 2: 783-800.

Testifying in Court – A Historian's View

I am neither a lawyer nor a scientist, let alone a member of the medical profession, thus, I am not qualified to pass judgement on their expert assessments presented in court rooms. I am a historian, a retired University Professor, who once had testified in courts.

In 1976 I was appointed as chief historian of the Special Investigation Unit (SIU), Australia's short-lived War Crimes Commission, entrusted with the task to investigate war crimes allegations made against Australians and residents in Australia and to prepare cases for criminal prosecution. A total of 846 cases were investigated, only in three cases was there sufficient evidence to lay charges. The three alleged murderers were acquitted.

I also served as historical consultant for other war crimes agencies and as expert witness in trials conducted in Australia, Canada, and the United States. Seconded from the University, leaving the academic principles of freedom of teaching and research behind, I followed the clear instructions of the SIU and the Department of Public Prosecutions, the representatives of the legal profession, to be more precise, the law enforcement agencies. For each case under investigation, I searched for and evaluated historical records kept in archives, as well as judicial material transmitted in post-war war crimes investigations and trials. In other words, I was engaged in 'applied' history.

Whenever I am asked to speak of my experiences as chief historian of the SIU, I recall one episode that left an indelible mark on my memory. In 1992 I testified as expert witness for the prosecution in Australia's first and only war crimes trial. During the four days I was in the witness-box, I was frequently reminded of the strict rules of evidence. At a certain point His Honour said to me: *"Professor Kwiet, you are not here to tell us the truth or what you perceive as historical truth... You are here to express an opinion, an opinion which must comply with the rules of evidence operating in Australia. … It is important in front of the jury that the guidelines be obeyed*…."

Following this exchange of words, my answers during cross-examination were reduced to "yes" or "no." Relevant sections of my affidavit were declared non-admissible. Later, during his cross-examination the defence lawyer pointed out to me: *"Historians and lawyers have different criteria. You might have realised that".*
It took the jury less than one hour to acquit the accused. The acquittal was not the result of the frictions or the 'battle' between the law and history. The suspect was acquitted as there was no living witness who could testify in court of having seen him committing crimes.

Serving as war crimes historians and testifying for the prosecution in court, I have learnt that rather technical legal considerations determine the progress of trials. Lawyers, rather than historians, set the tone.

It is hoped that this experience will have some impact on testimonies also in Medico-Legal trials.

References:1.Konrad Kwiet, "A Historian's View. The War Crimes Debate Down Under", in *Dapim, Studies. on the Holocaust* 24/1, (2010), 319-339.
2. David Fraser, *Daviborshch's Cart. Narrating the Holocaust in Australian War Crimes Trials.* London and Lincoln: University of Nebraska Press 2010.
3. David Bevan, A Case to Answer. The Story of the Australia's First European War Crimes Prosecution. Mile End: Wakefield Press 2018.

.

Paradoxical Embolism: From the Tibial Vein to Vertebral artery via a Patent Foramen Ovale.

Introduction: Residual patency of the inter-atrial embryonic foramen was reported to be in between 25% to 35% of the population. The incidence of vertebral artery occlusion as the cause of an infarct occurs in 1-4% of cases of strokes, with a resultant high mortality rate.

It is remarkable that most cases of Patent Foramen ovale (PFO) remain not diegnosed, asymptomatic and do not interfere with normal arterial oxygenation.

However, passage of venous thrombi into the left cardiac system causes widespread arterial embolization. Our case presents with two rare aspects of such embolization:

Case Report: 54-year-old healthy man travelling in business class landed after a14-hour transpacific flight. His activity during the long flight is unknown He was not given anti-coagulants. He collapsed on arrival at the airport and had tonic-clonic seizure, terminated by injection of midazolam before being flown to a Major Teaching Hospital. He was intubated and anti-convulsive was administered.

He was by then unconscious and remained so. He was diagnosed with a cerebellar infarct. A Doppler ultrasound test of the legs revealed deep vein thrombosis.

Subsequently a trans - oesophageal echogram showed the Patent foramen Oval with inter-atrial flow. CT angiogram diagnosed thrombosis of the vertebral /basilar artery, oedema, and a moderate sized left cerebellar infarct. He underwent a successful endovascular removal of the clot, but later required posterior cranial decompression and C1 laminectomy. All measures proved unsuccessful, and death was confirmed two days after arrival.

Discussion:

The inter-atrial foramen was known at least since Galen's time. It was reported in the French literature by Rostand and in German medical literature of the 19 Century by Cohnheim and Zahn.

The incidence of clinically silent presence of patent foramen ovale (PFO) is accepted as being present in above 30% of the general population. This opinion suggests that **paradoxical emboli may be the cause of ischemic stroke more often than it is recognised** Within the reviewed literature, the subclavian artery trajectory of the cardiac embolus was found to be less frequently encountered. In an extensive (NCBI, Google scholar), search of total of 340 papers, we rarely found mention of paradoxical embolism via vertebral artery. The passage of clots originating in the legs through the PFO after a **long-haul flight** (despite a greater mobility in business class). Is well recognised In our case thrombus occluded the left vertebral artery, causing cerebellar infarct, which further extended into the central cerebrum, eventually causing pontine ischemia and ending with thalamic herniation.

Another feature of interest in this case is the presentation of a cerebellar infarct by a tonic-clonic seizure . The question could be raised as to whether any anticoagulant therapy during flight could have prevented this fatal event.

Compensation: As the travelling overseas was work related the family was entitled to full compensation benefit.

SUMMARY: The present case of paradoxical embolism with cerebellar infarct, originating in venous thrombosis of the legs. The unusual features are:

1. the presentation with grand mal seizure.
2. embolism to vertebral artery, through previously unknown patent foramen ovale.

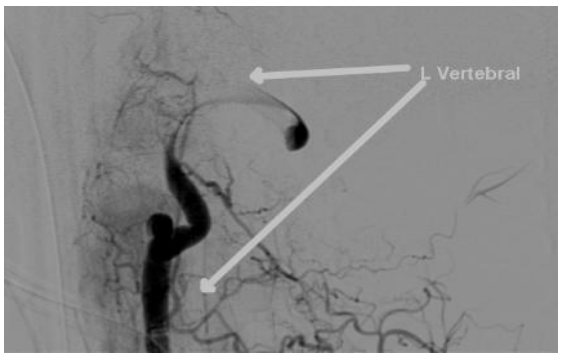

Figure 1: Vertebral artery clot prior to embolectomy

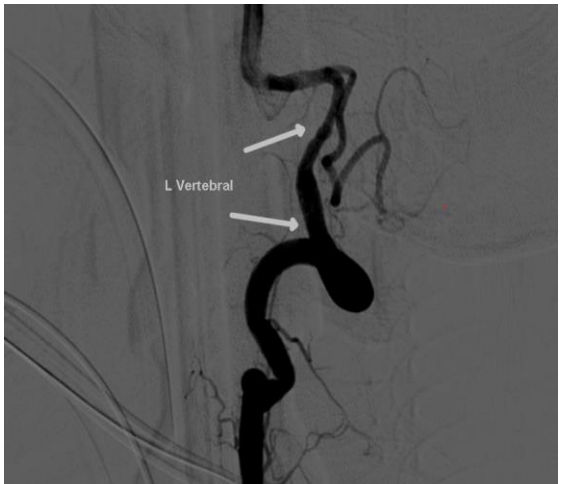

Fig.2 :Post embolectomy

Combined Orthopaedic and Neurological Injury.

A cooperative Case reports.

A 33-year-old woman worker was injured when a metal apparatus attached to the ceiling fell and struck her on the top of the left shoulder. She experienced immediate pain at the site of impact and experienced a tingling sensation in the left dominant upper extremity and the shoulder joint has dislocated on impact. The worker was able to push it back into position and she was transported from the site of the injury to the Emergency Department in a wheelchair. No additional manipulation of the shoulder joint was performed. She was not admitted.

Subsequently, she was off work for approximately three months, during which time she was aware of symptoms localised to the upper extremity which felt weak, floppy, painful and there was also a sensation of burning and tingling involving the 5^{th} and 4^{th} fingers, together with some extension of the burning and tingling extending proximally up the arm.

Soon, she also became aware that the left shoulder was hanging lower than the right and surgical procedures were performed to establish better anatomical symmetry. The first operation was followed by a second and she reported that some improvement initially occurred, however the improved position of the shoulder was not maintained. The surgical procedures involved a donation of part of one of the tendon-Achilles and its attachment to the spinous process of C6 and to the scapula to lift it to a more symmetrical position. The procedures proved ineffective.

This patient continued to experience weakness of the left upper extremity and sensory symptoms in the distribution referred to above. She was however able to resume pre-injury nursing on restricted duties. With the passage of time, no new symptoms developed in either upper extremity, trunk, or lower extremities. There was no cervical pain and no abnormality of bladder or bowel sensation or function. She was responsible for all her personal needs and activities of daily living.

As dispute between the two partied emerged a combined orthopaedics and neurological assessment was organised. The examinations were conducted approximately four years after the injury in question when she was still performing her nursing duties, on restricted duties.

The past medical history did include any other relevant medical, except recurrent shoulder dislocations, repositioned, but not approached surgically.

The initial **orthopaedic examination** detected a decreased range of movement of the left shoulder comparatively, without an assessable impairment of the cervical spine. The following opinion was expressed:

“The attached table is valid only in case of no neurological injury will be diagnosed by the reviewing neurologist and, consequently, the shoulder movements would remain as a result of re-dislocation and assessed as below”.

The orthopedic surgeon was not required to assess the upper extremity neurologically, however the suspicion of nerve damage was raised by him. He also noted the lack of original MRI scan, a clear diagnostic necessity in this case.

The main assessor on his **neurological examination** found the injured upper extremity to be dominant. The left shoulder was significantly lower than the right and there was wasting of the left trapezius, with impairment of shoulder elevation on that side.

There was also wasting of the upper arm and forearm, the measurements respectively being 26.5 cm compared to 28 cm right, 23.5 cm on the left compared to 25 cm on the right. There was mild wasting of the interossei in the right hand but no wasting of the thenar eminence. There was weakness of the biceps, triceps, supinator, flexor carpi ulnaris and flexor carpi radialis, as well as the left trapezius and interossei.

There was subjective alteration of sensation to light touch involving the outer aspect of the upper arm on the left and the proximal and middle thirds of the forearm. There was a consistent alteration of sensation in the above distribution and no objective sensory loss. There was objective sensory loss involving the 5^{th} and 4^{th} fingers of the left hand. The left supinator jerk was significantly reduced compared with the right, whilst the other deep tendon reflexes were symmetrical.
Cervical movements were full and unimpaired, and no Horner's syndrome was identified on the either side. Otherwise, there were no long tract or segmental signs.

Comment: The final assessment remained based on neurological injury and the explanation is as follows:
The historical matters of particular neurological significance are the site and details of the impact and the associated dislocation of the shoulder in the absence of symptoms involving cervical pain in proximity to the injury.

The clinical findings more than four years after the injury included no evidence of cervical spine impairment and widespread distribution of muscle wasting, weakness and sensory impairment pointed to a brachial plexus injury. The wasting and impairment of the trapezius muscle was not caused by the brachial plexus lesion.

It is noted that the surgical procedure that was undertaken on two occasions involved attachment of a donation from the Achilles tendon to the spinous process at C6. The absence of evidence of weakness of the sternomastoid muscle indicated that a distal injury probably occurred to the accessory nerve by the impact from above. It is also likely that some additional contribution to the existing trapezius wasting, and asymmetry arose because of the two unsuccessful surgical procedures performed subsequent to the initial injury.

The pattern of the motor impairment indicates trauma to the brachial plexus involving mainly the upper cord, with lesser involvement of the middle and lower cords. The pattern of motor impairment involves fibers from C5, C6, C7 and C8, involvement of the left supinator jerk also at a C5/6 anatomical level, and the interossei and sensory impairment at the C8 segment.

The sensory impairment in the left upper extremity corresponds to involvement of a sensory component of the axillary nerve without evidence of wasting of deltoid and involvement of the lateral antebrachial cutaneous branch of the musculocutaneous nerve associated with motor involvement of the biceps brachii (C5/6). Wasting of the triceps indicates fibers mediated by the radial nerve (C6/7) are also involved (middle cord of the brachial plexus)

whilst the wasting of the interossei and the objective sensory loss in the ulnar nerve territory (C8/T1) indicates involvement of the lower cord of the brachial plexus.

The brachial plexus lesions are commonly patchy because of the complicated anatomy of the plexus which arises from coalescing fibers of nerve roots from C5 down to T1.

In the overwhelming proportion of cases of brachial plexus injury, a sudden downward force or pull injury is identified closely in keeping with the injury occurring here and the associated shoulder dislocation.

On occasions with lesions involving predominantly the lower cords of the brachial plexus, ptosis, miosis and enophthalmos may be present on the ipsilateral side because of a Horner's syndrome. An MRI of the brachial plexus done near to the time of the injury may have identified evidence of the injury radiologically.

The neurological findings anticipated by my orthopaedic colleague was referred to in his assessment, when he anticipated a neurological injury and he indicated that any relevant neurological finding could not be combined with the assessable impaired range of shoulder movement that he had identified. The final assessment of 16% WPI for the upper extremity was not contested by either party.

Medicine and the Law: Ongoing Cognitive Dissonance.

One of the major problems for Medical Assessors is how the doctor makes a deduction for a pre-existing condition. This is referred to in the NSW workers compensation guidelines, as *'the deductible proportion'.* (Fourth ed., pg.6, item 1.28).

Generally, from a medical point of view, the issues may seem very straightforward. However, these determinations must be considered under the law as it stands. And the law takes precedence. Unfortunately, non-medical people do not see things in the same light as do doctors.

The following is an example of how differently the medical and legal professions see things.

At a presentation given to a group of specialists by a Senior lawyer, when trying to reconcile differences between the two groups regarding deductions for pre-existing conditions, and after much heated discussion, the following extreme example was suggested.

A lady doing office work gets up and walks along a carpeted surface. Suddenly she collapses in agony and is rushed to hospital where she is found to have a pathological fracture of her femur.

To address the issue of a deductible proportion it is first necessary to decide whether the injury should be regarded as a worker's compensation injury. From a medical point of view the opinion was that the incident was not a work-related injury. The legal authority however insisted that this was a work-related injury.

As suggested, this is an extreme case. What about all those cases that are not as clear cut? For example, the typist who has typed for five hours a day, five days a week for five years, and develops carpal tunnel syndrome? Or the person with significant osteoporosis who is struck on the arm by a falling cupboard and sustains a fracture of the humerus? Or the man who has done heavy labouring work for 20 years and develops osteoarthritis of his knees without any history of injury?

Another example is that of a labourer doing heavy manual work for fifteen years, who develops bilateral osteoarthritis of his hips with no history of injury or precipitating factor. The worker eventually came to bilateral hip replacements, with a very satisfactory result and was able to get back to unrestricted duties, including driving.

He was assessed by an orthopaedic surgeon as having a good result on each side. The surgeon then made a 9/10th deduction for pre-existing condition, namely idiopathic osteoarthritis of the hips requiring total hip replacement. The 1/10th awarded was for any aggravation that might have occurred because of his employment. On review it was pointed out that legally no deduction should have been made, as there was nothing to suggest that there was a pre-existing condition prior to joining the work force.

How then does one go about making a deductible proportion in these cases?

We do not have the answer to these questions. The best thing that the doctor making these decisions can do, is to treat each case on an individual basis and then give as many explanatory reasons as possible to justify the decision that has been made.

To do this the doctor needs to consider several issues. These include the nature and conditions of the patient's work, and the length of time they had been doing that work; most importantly, the extent/force of the injury at the time; the extent of any pre-existing condition or abnormality; the immediate post-injury status (did the patient continue working or need to be taken to hospital by ambulance) and so on.

Currently then, and in the foreseeable future, deduction for a pre-existing condition remains one of the most difficult issues that doctors must deal with when assessing impairment.

It would be wonderful if there was greater consensus regarding the relevant legal and medical issues in this regard!

Incorrect cancer diagnosis: Who shares responsibility? What is the monetary worth of a stomach and of two breasts?

ABSTRACT:

Two cases of incorrect diagnoses of cancer are presented, both resulting in significant morbidity from inappropriate surgical treatment. Both diagnoses were likely due to a combination of inattention by the pathologists combined with a lack of critical analytical questioning by the surgeons.

Case 1:

A 74 years old man underwent gastroscopy for symptoms of heartburn and indigestion. At gastroscopy there were multiple haemmorhagic erosions as well as a large ulcer from which a tissue sample was taken. That sample was reported as showing the presence of signet ring cell carcinoma. The patient was referred to a specialist surgeon attached to a major tertiary referral teaching hospital where he was operated on one month later. Initially a subtotal gastrectomy of the antrum was performed, the site of the reported cancer. However, no clinical signs of carcinoma were seen in the resected stomach segment during the operation and therefore it was decided to perform a total gastrectomy. Total histological examination of the resected stomach failed to find any cancer. On review of the original biopsy no cancer was found in that specimen. A small number of histiocytes on the surface of a peptic ulcer were misinterpreted as cancer cells. The absence of cancer in the initial diagnostic biopsy was further confirmed through immune staining which revealed a normal architectural pattern of the gastric mucosa, with no disordered infiltrative growth.

Case 2:

A 69 years old woman, living in a country town with an approximate population of 100,000 underwent routine breast reduction surgery. 8 years later, while taking a shower, she felt a lump in one breast, consulted her GP and underwent mammography. The mammogram was reported as showing a spiculated mass, worrying for the presence of cancer.

She underwent a core biopsy which was reported as showing triple negative invasive lobular carcinoma. Up to about 20% of lobular carcinomas occur in both breasts either simultaneously are asynchronously[1] and the triple negative variant responds poorly to drug treatment.

Following discussion with her local surgeon, the patient underwent double mastectomy. No cancer was found in either breast. On review of the initial core biopsy on which the cancer diagnosis was based, it contained no cancer cells. It did contain histiocytes, possibly consequent on and residual from her breast reduction surgery eight years previously, and those benign cells were mistaken as cancer cells.

DISCUSSION:

In both cases an incorrect diagnosis of cancer was made through mistaking the presence of histiocytes for cancer cells.

The histiocyte is a normal cell found in almost all parts of the body. They tend to congregate in areas of inflammation and tissue damage, where they remove dead or damaged cells in the process of repairing the effects of injury. In those instances they may be present in large numbers and have an appearance similar to carcinoma cells as illustrated in figure 1.

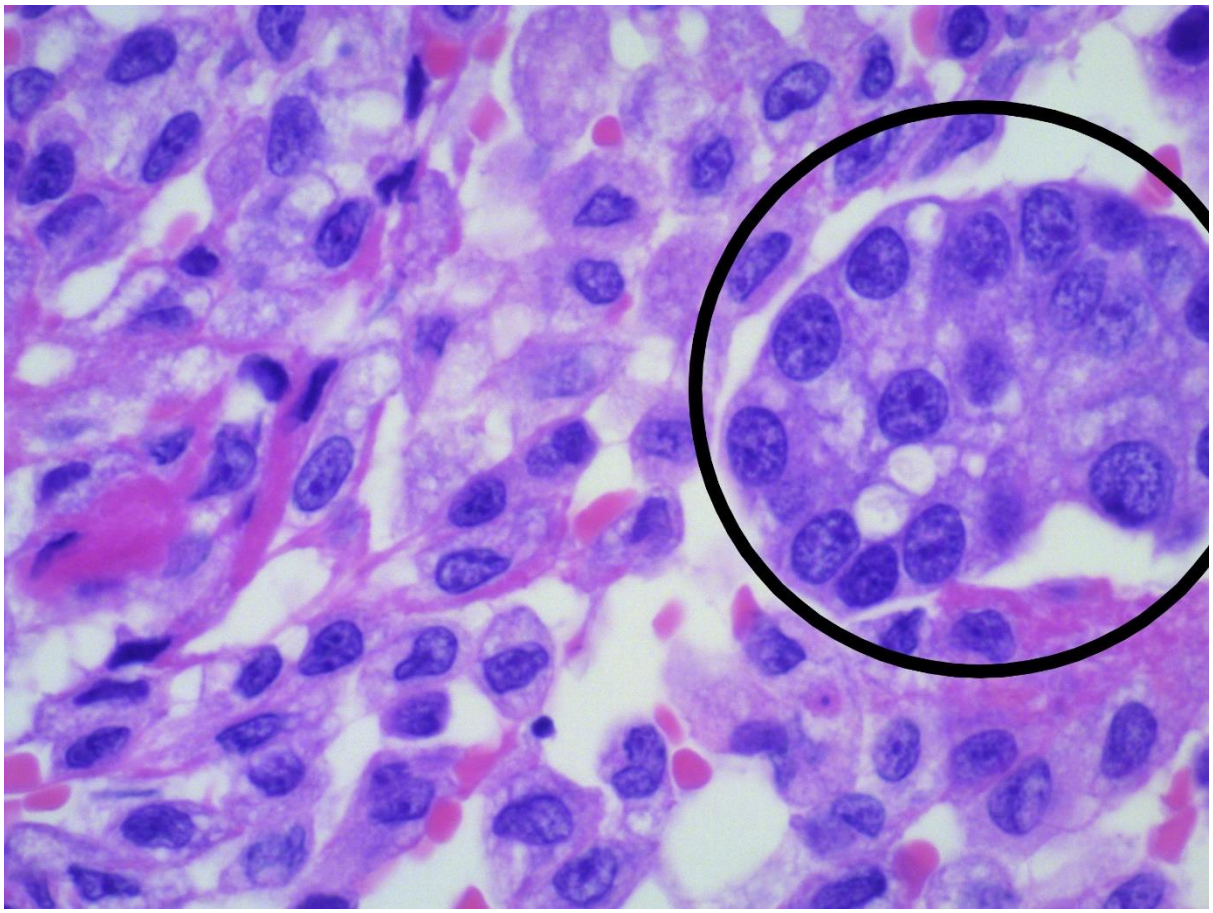

Figure 1
Haematoxylin and eosin stained section of a cell block prepared from pleural fluid which contained clumps of cancer cells (circled) in a background of numerous histiocytes.

The morphological similarity between the two types of cells can be readily appreciated and it requires a trained and alert eye to distinguish between them within a particular tissue milieu. In situations where diagnosis based on morphology alone is problematic, there are readily available chemical processes, so called *immunoperoxidase stains*, which will easily make that distinction. However, suspicion by an alert mind is required in order to initiate the undertaking of those further chemical methods of diagnosis.

In both above instances that suspicious questioning of an initial impression did not take place and the presence of benign histiocytes was interpreted and reported as malignant carcinoma cells.

It is an aphorism in the day-to-day reporting of anatomical pathology that *mistakes are never made from lack of knowledge; mistakes are the result of not looking (attentively) or not thinking (analytically).*

In the first case the patient's definitive surgery took place in one of Sydney's major teaching hospitals, a tertiary referral centre. The institution, like all similar institutions, has an integrated pathology laboratory, staffed by many well trained and competent pathologists. An integral part of the normal daily work of the staff pathologists is to consult with each other on cases, which may be rare, unusual or difficult to interpret. Clinicians may visit the laboratory and informally request a second opinion on cases reported elsewhere and intra-departmental collegial consultations are an everyday frequent event.

In addition there are regular, weekly, or perhaps monthly formalised meetings where groups of surgeons from a particular subspecialty such as gastro-intestinal or breast surgery have their cases discussed, with the histological findings presented and discussed by Pathology Department staff.

The events of the second case study occurred in a country town of approximately 100,000 inhabitants, without the presence of a large teaching hospital. Diagnostic pathology services were provided through the local branch of a major private pathology laboratory based in that State's capital city. The central laboratory was comparable in staffing, facilities and technical resources to a tertiary teaching hospital's pathology department.

In the latter setting there were twice daily courier movements between branch and the central large private laboratory, facilitating and allowing the type of consultative process available in the teaching hospital laboratory.

The value and necessity for second opinions in the interpretation of tissue pathology is recognised in the Australian Government's Schedule of Medical Benefits through the allocation and government funding of a specific item for such a service[1].

In both these cases major surgery was undertaken based on an erroneous pathology report from a single source.

Another aphorism in the practice of pathology is the warning *that for pathological diagnoses to be accepted as correct, it should be in harmony with the associated clinical circumstances*. If there is a discrepancy between clinical findings and the reported pathology, then further discussion between clinician and pathologist is desirable and warranted.

It is not the common practice in Australia to routinely request the review of cancer diagnoses made from a biopsy sample, even though major surgical procedures or toxic drug therapies may be consequent based on those diagnoses. If the biopsies of the two cases under discussion were to have been reviewed by an independent pathologist, preferably from a different institution, it is almost certain that the erroneous diagnoses would have been corrected and the patient morbidities avoided.

It may therefore be considered prudent and standard practice for a clinician to routinely request the review of any pathology diagnosis on which consequent major therapeutic procedures are contemplated.

The great majority of cancer diagnoses by Australian pathologists will be confirmed through a second opinion, resulting in no change in planned therapeutic procedure. Adopting routine second opinion requests will result in an increased economic cost to the health system.

The answer to the first question posed in the title of this article is that while the reporting pathologist carries the primary blame for a false positive cancer diagnosis, secondary blame is also attributable to the treating clinician who fails to critically question and confirm the accuracy of that diagnosis.

The answer to the second question can be calculated by determining the total cost to the national health budget incurred from obtaining review opinions, divided by the number of discovered incorrect diagnoses and deducting the costs of thereby avoided treatments.

REFERENCES:

1. WHO Classification of Tumours. 2012 4th edition. International Agency for Research on Cancer. Lyon

2 Item: 72858
A second opinion, provided in a written report, where the opinion and report together require no more than 30 minutes to complete, on a patient specimen, requested by a treating practitioner, where further information is needed for accurate diagnosis and appropriate patient management.
Fee:$180.00 **Benefit:**75% = $135.00 85% = $153.00

Psychiatric Assessment of Medical Negligence Claims

Medical negligence claims are now prolific and likely to escalate in future. The majority of these claims are 'physical', meaning they arise from some medical, surgical, obstetric or gynaecological intervention, not psychiatric negligence, which is another category entirely.

It is now regular practice to include a claim for psychiatric injury in addition to other damages in medical negligence claims. This occurs in two ways: (1) psychiatric problems arising in the victim of the negligence; and (2) what lawyers refer to as 'nervous shock', psychiatric problems that occur in close relatives (even acquaintances) of the injured plaintiff. Experience in assessing several hundred claims has shown a pattern that will be of interest to those involved in medical negligence assessment.

Claimants: In most cases, this consists of the plaintiff's reaction to the negligent consequences. These could be the actual events; for example, an obstetric procedure that goes wrong, or coming close to exsanguination from mishap in Emergency Department.

Another reaction, often overlooked, occurs when severe collapse (multi-system failure, peritonitis, induced coma) leads to delirium. Delirium, in fact, can happen with almost any condition in a hospital especially where there is poly-system disorder, polypharmacy or in the vulnerable elderly. It is poorly recognised when it occurs and wrongly assumed that when it settles, there are no adverse sequelae for the patient. This is quite incorrect. The experiences of disorientation, illusions, hallucinations, and paranoia that are typical of delirium are difficult to integrate and patients are often embarrassed or scared to discuss them, adding to whatever other distress they are experiencing.

The most common reactions in the plaintiff victims are those that occur after the event when the reality of what has gone wrong sets in, and they must live with the often extreme or difficult consequences of the medical mishap. Added to this will be the resentment, anger, bewilderment, and sadness towards the entity responsible. Experience shows that there are differing reactions. It can be intense if there is an individual solely responsible, typically a doctor, but worse when there is system failure – such as the hospital – as the individual responsibility is covered up or hidden by the institution with a bureaucratic wall of obfuscation or denial. Often the plaintiff finds that attempts to confront the issue are blocked by the administration and they are left feeling that there has been a cover-up or that they are over-reacting.

Taking these issues into account, the commonest diagnosis made on such plaintiffs is *Adjustment Disorder with depression and anxiety* (AD). While this provides lawyers with a suitable injury to add to the claim, AD is a sloppy diagnosis and far too often pronounced without any thought about the underlying issues. Some indication of its ubiquity, despite the absence of scientific confirmation in the research, is that AD is believed to be the commonest psychiatric diagnosis in the world now. Its epistemological weakness is explained by the fact that it describes a sufficiently severe reaction to an external stressor. How to define this issue is a matter that might as well be left for the stars and there is simply no agreement on where normality stops, and pathology starts.

Should the former situation apply, then the diagnostic manual provides the category of *V-Code Disorders* – conditions that do not constitute a clinical disorder but attract medical attention; another way of putting it is a sub-clinical condition.
A more appropriate diagnosis in these situations where there is no doubt about the intensity of emotional distress, in accordance with the latest iteration of the Diagnostic & Statistical Manual 5, is *Depression or Anxiety due to Medical Condition* (eg., peritonitis due to perforated bowel).
For claimants who are left in chronic disabling pain as a result of the mishap the diagnosis is *Pain Disorder* subsumed under *Somatic Symptom Disorder (*DSM-5 300.82; F45.1). This is akin to what physicians would refer to as a chronic pain syndrome and often treated by rehabilitation or pain physicians. Somatic Symptom Disorders cover the terrain of abnormal illness behaviour, a concept well recognised by physicians working in this field.

Among the most difficult assessments are those claimants with long-standing psychiatric disorders such as schizophrenia, bipolar disorder, personality disorder or alcohol/drug abuse. Here it is a case of determining the extent to which the purported negligence has worsened an existing state. There is no fixed rule of thumb, and each case must assessed on its merits, always bearing in mind the phenomenon of *effort-after-meaning*; that is, attributing problems to a known external event associated with reward while ignoring the pre-existing unrelated problems – this is an entirely conscious process.

Some claimants may experience anxiety, especially panic attacks, which is not an unreasonable response to what they have experienced. However, some caution must be held as a careful history may reveal a long-standing pattern of pre-injury anxiety that is now solely focussed on the alleged negligence. Intermittent panic attacks do not, in themselves constitute a Panic Disorder.

The same approach is required with drug and alcohol dependence (officially listed in DSM-5 as *Substance Use Disorder* (alcohol, amphetamine, etc)) which may have been present before subject incident or an entirely unrelated issue.

A growing area of negligence claims arises from plastic surgery, mostly breast reconstruction. This has been exponentially increased by the activities of a rogue doctor who has since been deregistered. Living with mutilated breasts leads to a distorted body image with accompanying mirror avoidance, withdrawal from socialising, not wearing revealing clothing or having sexual activity with a partner. This can be classified as a form of Somatic Symptom Disorder but is often overlapped by a combination of anxiety or depression. Among such claimants – but not all – are some insecure and fragile women with longstanding personality problems. It is often an empirical decision to determine the extent that longstanding dysfunction has been worsened by the alleged negligence.

Nervous Shock: Some assessors will have encountered such claimants in a different jurisdiction, namely survivors of motor accident fatalities. When the negligence victim has survived, their relative may have an Adjustment Disorder or depression as a result, but care should be taken to exclude the likelihood that they are simply having a normal reaction to such stress which would not meet the criteria for a psychiatric disorder – this occurs quite often.
When the negligence victim has died, it comes down to determining the extent of grieving in their survivors. Bereavement, unfortunately, has become another casualty in the business of medicalising normal distress. The official view of many is that any distress or grief persisting for more than a year after the death constitutes a condition listed as *Complex Persistent Bereavement Disorder (CPBD).*

This is quite egregious, if not iniquitous. Bereavement, especially following the death of a loved one that is sudden, unexpected, or linked with external mishap, can go on for some years, if not longer and is best categorised as *Normal Bereavement*, leaving it to the court to decide what to make of this, opinions varying widely as to whether in itself it constitutes a psychiatric injury.

CPBD, on the other hand, requires a lengthy period of grieving, certainly several years, to be the appropriate diagnosis and must be accompanied not only by sustained grief-related activities, pervasive mood changes and evident inability to resume a lifestyle that would be expected following the bereavement. It also raises the issue whether they have progressed beyond grief to a depressive disorder. It can be a difficult distinction, but the key issue is not as much mood, but the persistence of the bereaved lifestyle.

The problem in litigation is that such claimants are sent for assessment too soon, eg., within a year of the loss, when still in the stage where normal bereavement is expected. In such cases the best path is to insist that they require more time, say two years, before the final diagnosis can be made. This is not news the plaintiff and their lawyer like to receive.

A diagnosis that should be avoided in almost all situations is one that represents the pinnacle of current psychiatric discord: *Post-traumatic Stress Disorder.* PTSD, as it is widely known, for many psychologists is the diagnosis *du jour* for any distressing situation, including illness, childbirth, and surgery, that people can experience. The diagnosis, according to the most reasonable current criteria (and there are many versions) requires a stressful event *outside the normal range of human experience*. As Paul McHugh, an authority on the condition points out, it is simply ridiculous to claim that someone having an argument at work is in the same state as a person who has been in battle or survived a concentration camp.

Going through a difficult labour or operation is, of course, upsetting but would not meet the Criterion A for a stressful event to qualify as PTSD. If this is sufficiently severe, Adjustment Disorder would be most appropriate finding instead.

Conclusion: Assessment of psychiatric consequences of medical negligence is an important and growing area of litigation. Assessors should have good understanding of phenomenology, solid clinical experience and be prepared not to accept claimants at face value without a detailed history and examination, considering past and unrelated issues to the claim.

The World of Medicine depicted by Francesco Goya.

Francesco Goya (1746-1828), undoubtedly one of the most famous Spanish painters, produced at least 50 images related to Medicine, including paintings, graphs, and tapestry. (1).

Goya became Court painter to 4 successive Spanish kings, but never forgot his humble origin. He is depicting the life of the poor, the jailed, the sick, the deformed and the results of war and hunger, including the image of invalids inflicted by neuro-vasculo-osteo Lathyrism.

There are two particularly humanitarian gestures attached to his name.

One, in support of King Charles III dated 1778, Goya dedicated to the king a special painting as a tribute for the Royal order on responsibility of builders for the care of an injured worker, a topic well known to us today.

The second humanitarian gesture was the praise and dedication to his friend and private physician in his painting "*Goya cured by Dr Arrieta*". The physician from a family of refugees from the Inquisition, was protected by the painter. The painting depicted his own illness, close to death, when the doctor offers comfort with personal touch and a drink. The image today in Minneapolis, is an homage to his doctor.

Goya was inflicted in his mid-40's with recurring episodes of headaches, nausea, dizziness, instability, severe tinnitus and progressive deafness. The rebounds were infrequent, leading to depression and hallucinations. However, just as the other genius Beethoven, the loss of hearing eventually led to intensive productivity.

Goya's condition was speculated as involving various diagnoses and was finally agreed to be recurrent minor cerebral events. The painting shows the left hand grabbing the cloth, but an immobile right hand, with left eye closed. Stroke?

George M.Weisz

#.The Belgian medical historian J.Tiammont published the list of Goya's medical images and inspired me.(B-ENT, 2008;4:55-76).