

Refugees, medical treatment & legal issues

Background notes by Bill Madden¹
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There are four main areas of interest (albeit with a degree of overlap) for the medical practitioner concerned with refugees, medical treatment & legal issues.

- Privacy
- Informed consent
- Legal liability risks
- Communication and Cultural issues

1 Privacy

Privacy in New South Wales may be governed by Federal legislation *Privacy Act 1988* (Cth) or by State legislation *Privacy and Personal Information Protection Act 1998* (NSW), with the added overlay of State legislation specific to health records – *Health Records and Information Privacy Act 2002* (NSW). Schedule 1 to that Act creates Health Privacy Principles relating to:

- Purposes of collection of health information

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- Information must be relevant, not excessive, accurate and not intrusive
- Collection to be from individual concerned
- Individual to be made aware of certain matters
- Retention and security
- Information about health information held by organisations
- Access to health information
- Amendment of health information
- Accuracy
- Limits on use of health information
- Limits on disclosure of health information
- Identifiers
- Anonymity
- Trans-border data flows and data flow to Commonwealth agencies
- Linkage of health records

The Federal legislation creates general national privacy principles²; so does the New South Wales legislation, though slightly different³.

There have been a number of complaints to the Australian Privacy Commission regarding breach of privacy in relation to health records. A selection of the 2008 complaints appears in the table below.

Decision	Issue	Outcome
<i>S v Health Service Provider</i> [2008] PrivCmrA 19	Failure to keep personal information secure; National Privacy Principle 4.1 in Schedule 3 of the <i>Privacy Act 1988</i> (Cth)	The health service provider forwarded copies of the complainant's medical records and original x-ray films by general post (a postal service that could not track the transmission of items of mail) to another health service provider nominated by the complainant. Outcome: Sending original x

² http://www.austlii.edu.au/au/legis/cth/consol_act/pa1988108/sch3.html

³ http://portsea.austlii.edu.au/cgi-pit/maketoc.py?skel=/home/www/pit/xml/nsw/act/nswA1998-133_skel.xml&date=

		rays via ordinary post is in breach of the privacy regime.
<i>P v Private Health Service Provider</i> [2008] PrivCmrA 16	<p>Failure to destroy personal information which is no longer needed</p> <p>National Privacy Principles 2 and 4.2 in Schedule 3 of the <i>Privacy Act 1988</i> (Cth)</p>	<p>Prior to any consultation or treatment, the complainant decided not to use the health service provider's services and requested that the health service provider destroy any personal information that they had already collected.</p> <p>The health service provider refused to destroy the personal information and claimed this refusal was based on its obligations pursuant to the Medical Practice Regulations 2003 made under the Medical Practice Act 1992 (NSW).</p> <p>Outcome: Record required by legislation</p>
<i>K v Health Service Provider</i> [2008] PrivCmrA 11	<p>Improper disclosure of health information to a newspaper</p> <p>Section 6 and National Privacy Principle 2 in Schedule 3 of the <i>Privacy Act 1988</i> (Cth)</p>	<p>The health service provider was interviewed by a newspaper about their work in a remote community. As part of the interview, the health service provider discussed aspects of the complainant's health care. The health service provider did not specifically name the complainant, however, they did discuss the complainant's medical history. The complainant claimed that given the nature of the information discussed and the specific and remote location of the community, the complainant's identity was apparent to other residents of that community.</p> <p>Outcome: Financial compensation paid by agreement.</p>
<i>D v Health Service Provider</i> [2008] PrivCmrA 4	<p>Unauthorised access to and security of personal information</p> <p>National Privacy Principle 4.1 in Schedule 3 of the <i>Privacy Act 1988</i></p>	<p>The complainant provided their personal information to a health service provider, a private clinic, during a consultation prior to undergoing a surgical procedure. The complainant subsequently received a telephone call from the clinic</p>

	(Cth)	<p>asking the complainant to return for another pre-surgical consultation. The clinic advised the complainant that it again needed to prepare pre-surgical notes as those prepared earlier could not be located. The clinic advised the complainant that the notes were most likely in the complainant's possession, or the clinic's cleaning staff may have misplaced them.</p> <p>Outcome – Single sheet not personal information</p>
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For the purposes of this discussion, the issue of consideration is the scope for privacy issues to arise with refugee medical treatment. For discussion I would raise two possibilities. Firstly, the use of family or friends as translators, in circumstances where something may arise of a sensitive nature. Secondly as in case 11 above, the communication of what may seem to be generic information (be it to the media or in another context) but which because of the smaller nature of the community group, enables identification of the patient.

2 Informed consent

In Australia, the leading case on informed consent remains the 1992 High Court decision of *Rogers v Whitaker* [1992] HCA 58; (1992) 175 CLR 479, understandably described by some authors as the most

influential Australian medical law decision⁴. That decision is the commonly accepted defining point for the existence in Australia of the duty to warn, in defining the content of the duty, and for assistance in establishing when it may be breached. The crucial statement is that of Mason CJ, Brennan, Dawson, Toohey and McHugh JJ (at [5]):

The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. That duty is a 'single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment'; it extends to the examination, diagnosis and treatment of the patient and the provision of information in an appropriate case. It is of course necessary to give content to the duty in the given case [footnotes omitted].

Rogers v Whitaker assumes consent in general terms. Failure to obtain a patient's agreement in broad terms prior to undergoing a procedure is regarded as a total failure of consent and can give rise to an action in trespass. Trespass actions are appropriate even if the error on the part of the medical practitioner arose through mistake. In *Reibl v Hughes* (1980) 114 DLR (3d) 1, Laskin CJC said (at 10):

In my opinion actions in battery in respect of surgical or other medical treatment should be confined to cases where surgery or treatment has

⁴ See Madden & McIlwraith, *Australian Medical Liability*, Lexis Nexis Butterworths 2008 at chapter 7.

been performed or given to which there has been no consent at all, or where, emergency situations aside, surgery or treatment has been performed or given beyond that to which there was consent.

In *Chatterton v Gerson* [1981] 1 QB 432 Bristow J said (at 443):

Of course if by some accident, as in the case in the 1940s in the Salford Hundred Court where a boy was admitted to hospital for tonsillectomy and due to administrative error was circumcised instead, trespass would be the appropriate action against the doctor, though he was as much the victim of the error as the boy.

A recent Australian example is that of *Candutti v ACT Health and Community Care* [2003] ACTSC 95. The plaintiff was admitted to hospital for laparoscopic tubal ligation. She alleged that she was subjected to a laparotomy (a significantly more invasive procedure) without her consent, leaving her with an abdominal scar, continual abdominal cramps and pain. The plaintiff succeeded in her claim and was awarded damages.

In failure to warn cases, the plaintiff will have to show that they would have acted differently had the defendant not been negligent, and that the harm would therefore have been avoided. In trespass cases such evidentiary issues will not arise, as what the plaintiff would have done had they been given sufficient disclosure upon which valid consent could have been founded is not relevant. Again in *Chatterton v Gerson*, Bristow J said (at 442–3):

When the claim is based on negligence the plaintiff must prove not only the breach of duty to inform, but that had the duty not been broken she would not have chosen to have the operation. Where the claim is based on trespass to person, once it is shown that the consent is unreal, then what the plaintiff would have decided if she had been given the information which would have prevented violation of the reality of her consent is irrelevant.

Failure to offer an interpreter's services can expose doctors to risk⁵. In addition to informed consent hurdles, there is the potential for misdiagnosis based on incorrect history, inappropriate use of medications, or misunderstood post operative care instructions.

Discussion example

Consent for caesarian section and sterilisation.

In preparation for the introduction of national medical registration in Australia from July 2010, the *Australian Medical Council* on behalf of all state and territory medical boards is developing a national code of professional conduct for medical practitioners entitled '*Good Medical Practice*'. The Final Consultation Draft Code of Professional Conduct: *Good Medical Practice*⁶

⁵ C McDonald, *On the same page*, *Australian Doctor* 27 February 2009 at page 44.

⁶ <http://goodmedicalpractice.org.au/wp-content/downloads/Final%20Consultation%20Draft%20150409.pdf>

includes a helpful commentary regarding 'informed consent':

3.5 Informed consent

Informed consent is a person's voluntary decision about medical care that is made with knowledge and understanding of the benefits and risks involved. The information that doctors need to give to patients is detailed in guidelines issued by the National Health and Medical Research Council. Good medical practice involves:

3.5.1 Providing information to patients in a way they can understand before asking for their consent.

3.5.2 Obtaining informed consent or other valid authority before you undertake any examination, investigation or provide treatment (except in an emergency), or before involving patients in teaching or research.

3.5.3 Ensuring that your patients are informed about your fees and charges.

3.5.4 When referring a patient for investigation or treatment, advising the patient that there may be additional costs, which patients may wish to clarify before proceeding.

The Final Consultation Draft Code of Professional Conduct: Good Medical Practice also contains

commentary on cultural awareness and the use of interpreters:

3.3.8 Making sure, wherever practical, that arrangements are made to meet patients' specific language, cultural and communication needs, and being aware of how these needs affect understanding.

3.3.9 Familiarising yourself with, and using whenever necessary, qualified language interpreters or cultural interpreters to help you to meet patients' communication needs. Information about government-funded interpreter services is available on the Australian Government Department of Immigration and Citizenship website⁷.

First published in 2005, the *Code of Professional Conduct: Good Medical Practice* has been re-published in 2008; it is the NSW Medical Board document referred to in section 99A *Medical Practice Act 1992* (NSW) hence relevant pending national registration. The provisions of a code of professional conduct are a relevant consideration in determining for the purposes of this Act what constitutes proper and ethical conduct by a registered medical practitioner (section 99A(4)). At its very outset the Code says:

1.1 Good clinical care

1.1.1 Good clinical care includes:

⁷ The Australian Government Department of Immigration and Citizenship's Translating and Interpreting Service (TIS) National can be contacted on 131 450, or via the website (http://www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/index.htm)

- a) *an adequate assessment of the patient's condition, based on the history and clinical signs and appropriate examination;*
- b) *communicating with patients respectfully and with the assistance of a skilled interpreter where necessary;*

See also the NHMRC document 'Communicating with patients'⁸ which helpfully outlines three issues of relevance:

3.4 CULTURAL AND SOCIAL DIVERSITY

Doctors see patients from a range of ethnic, cultural and socio-economic backgrounds. Social and cultural factors may determine such matters as why patients attend, and may influence the patient-doctor interaction and compliance. Doctors should strive to ensure good communication regardless of the social or cultural background of patients. Communication is facilitated when the doctor is aware of and sensitive to the background or cultural needs of the particular patient.

All of the advice in this document is relevant but additional measures to reduce the risk of misunderstanding include:

- *asking questions to appreciate the patient's understanding of health and disease; and*

⁸ http://www.nhmrc.gov.au/publications/synopses/_files/e58.pdf

- *explaining the doctor's understanding of health and disease.*

In certain situations, the following strategies may also be helpful:

- *seeking to establish an environment which welcomes and affirms the different background of the patient;*
- *in negotiation with the patient, considering the use of assistance of agents such as patient advocates, family members, pastoral care workers or spiritual leaders;*
- *using local institutional protocols for cross-cultural health care practice; and*
- *seeking advice from, and developing a working relationship with, community agencies that understand and advocate for patients.*

6.9 USE OF INTERPRETERS

When and wherever possible use should be made of qualified interpreters, including Auslan and telephone interpreters when consulting with patients not fluent in English or those with special communication needs. Accredited interpreters receive formal training and are bound by ethical standards of patient confidentiality and accurate interpreting.

Accredited Auslan interpreters should be used for consultations with deaf or deaf/blind patients, at the patient's request. English may be a second language for some deaf patients and relying on

written notes and/or lip reading can lead to misunderstanding.

For privacy reasons it is inappropriate to use family members or friends to interpret at medical consultations. However, not all cultural groups welcome the use of non-family members in such circumstances, and doctors need to be aware of, and sensitive to, such a possibility. When using an interpreter, it is important to address the patient directly rather than the interpreter.

6.10 USE OF PATIENT ADVOCATES

Patient advocates can play an important role in assisting communication and patient decision making. For example, they may be involved in assisting patients with chronic illness, mental illness, intellectual disability or those from different cultural backgrounds. Hospitals may employ Aboriginal liaison officers as patient advocates. The use of patient advocates must be negotiated with each patient as not all patients will want their involvement.

The Department of Immigration and Citizenship (DIAC) provides the *TIS National interpreting service* for people who do not speak English and for the English speakers who need to communicate with them. TIS National has more than 30 years of experience in the interpreting industry, and has access to over 1300 contracted interpreters across Australia, speaking more than 120

languages and dialects. TIS National is available 24 hours a day, seven days a week for any person or organisation in Australia requiring interpreting services.

TIS National recommends that interpreters should be used

- to ensure accurate communication between people who have different language needs
- because effective professional practice requires both parties to have a clear understanding of each other
- because in times of crisis or stress, a person's second language competency may decrease
- because all Australians have the right to access services freely available to English speaking Australians – irrespective of their ethnic background and first language preference.

If an interpreter is used for a consent process, it may be wise to have the interpreter co sign the consent form, confirming that a translation was made.

3 Legal liability risks

A medical practitioner's duty to a patient usually arises in contract and / or under the law of tort. Contract involves a payment of some type, not necessarily by the patient themselves – hence there is a contract even if Medicare covers the consultation cost: see *Breen v Williams* [1996] HCA 57; (1996) 186 CLR 71; *Edelsten v Health Insurance Commission* [1988] FCA 258.

However under the law of tort, the fact that a payment is not requested or made for a professional service does not relieve the medical practitioner of potential legal liability.

The Good Samaritan provisions of the *Civil Liability Act* 2002 NSW do not assist in the usual GP treatment context as those provisions are limited to emergency situations. Section 56 provides that a "good samaritan" is a person who, in good faith and without expectation of payment or other reward, comes to the assistance of a person who is apparently injured or at risk of being injured. Under section 57 a good samaritan does not incur any personal civil liability in respect of any act or omission done or made by the good samaritan in an emergency when assisting a person who is apparently injured or at risk of being injured.

The central provision remains section 50:

50 Standard of care for professionals

(1) A person practising a profession ("a professional") does not incur a liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice.

(2) However, peer professional opinion cannot be relied on for the purposes of this section if the court considers that the opinion is irrational.

(3) The fact that there are differing peer professional opinions widely accepted in Australia

concerning a matter does not prevent any one or more (or all) of those opinions being relied on for the purposes of this section.

(4) Peer professional opinion does not have to be universally accepted to be considered widely accepted.

It was not until 2007 that section 5O was first considered by an appellate court, the New South Wales Court of Appeal in *Dobler v Halverson* [2007] NSWCA 335⁹. In doing so the court held that the wording of the relevant section was such as to provide a defence. The claim was brought against a general practitioner after a young man suffered cardiac arrest and hypoxic brain damage.

It follows that However on scrutiny, the civil liability provisions operate in a three step fashion, requiring the courts to consider :

- Whether a health carer is negligent, by reference to the common law
- If so, to consider whether the health carer can rely upon a defence that the health carer acted in a manner that at the time the service was provided was widely accepted in Australia by peer professional opinion as competent professional practice
- If so, to consider whether the defence should be over-ridden as the widely accepted approach is irrational.

⁹ Giles JA (Ipp JA and Basten JA agreeing), delivered 26 November 2007. The appeal was from the NSW Supreme Court decision of McClellan CJ (Common Law) in *Halverson & Ors v Dobler*; [2006] NSWSC 1307.

The meaning of irrational has yet to be determined by a court, however based on the background materials such as the *Review of the Law of Negligence*¹⁰ it seems reasonably secure to assume that at least one application of the irrational exception will be the taking of a risk of causing grave danger, which could have been easily and inexpensively avoided. The other, derived from the National Women's Hospital example, may be in effect a policy consideration when the course of treatment, whilst defensible scientifically, is inconsistent with an individual's rights¹¹.

For discussion:

Let us assume that it is widely accepted in Australia by peer professional opinion as competent professional practice not to use an independent qualified interpreter for patient discussions. Will a court accept that, or will it say that such an approach is 'irrational'?

There has been the occasional case highlighting particular issues arising from patients newly arrived in Australia.

In *Harvey v PD* [2004] NSWCA 97 the plaintiff had attended a joint consultation with FH for the purpose, as understood by the doctor defendant, of having blood tests to ensure that neither carried HIV or any other sexually transmitted disease, prior to the couple getting

¹⁰ <http://revofneg.treasury.gov.au/content/review2.asp>

¹¹ Madden & McIlwraith, *Australian Medical Liability*, Lexis Nexis Butterworths 2008 at paragraph [1.16]

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married and engaging in unprotected sex. The plaintiff later received her results not from the doctor but from the clinic's receptionist, who told the plaintiff she was not entitled to receive FH's pathology report, which she had requested in view of the earlier joint consultation, but only her own. The plaintiff's HIV test was negative. However, FH deceived her into believing his results were also negative when in fact he was HIV positive. The plaintiff subsequently acquired HIV. She sued, alleging that the defendants had breached their duty to her in failing to take sufficient steps to cause her to be apprised that FH was HIV positive. She succeeded in her claim. Spigelman CJ, agreeing with Santow JA, stated (at [3]):

... the subject matter of the initial consultation and the fact that it was a joint consultation for the stipulated purposes meant that it was incumbent upon Dr Harvey, in the light of his knowledge of ethical requirements, patient confidentiality and s 17(2) of the Public Health Act 1991, to advise FH and PD of the need for each to consent to the supply of their results to the other. His failure to do so led to the damage suffered by PD on the basis that if FH had agreed, she would have been fully informed of his HIV status and if FH had not agreed, she would have terminated the relationship.

In *Wang v Central Sydney Area Health Service* [2000] NSWSC 515 a mention was made of a language issue which may have had some bearing on the outcome for

the patient. Mr Wang had been assaulted and was taken by friends to Prince Alfred Hospital. There was a delay in attending to him and, not appreciating the seriousness of his condition, he left and went to a medical centre. The following morning his condition deteriorated and he was taken back to Prince Alfred Hospital by ambulance. It seems that his skull was fractured. He was suffering from extra dural haemorrhage, and surgical intervention at that stage was unable to prevent irreversible brain damage.

At [17] the court records that Li Yun, a friend of Mr Wang, said that at the hospital the plaintiff looked pale, and appeared to be tired and weak. David Ng, who arrived later, observed that he was still bleeding and appeared to be in pain, although he said that he was "alright". Mr Ng noticed that he spoke very slowly. (This may not have been obvious to Sister Carruthers, who did not speak Chinese, and there is no evidence that she was told that there was anything unusual about his speech.)

Perhaps cases like the preceding one contributed to recommendation 2 of the Garling Report (*Final Report of the Special Commission of Inquiry - Acute Care Services in New South Wales Public Hospitals*):

In order to improve the availability of interpreting services in public hospitals for non-English speaking patients, each Area Health Service must investigate the sufficiency of, and ensure the adequacy of, the hands free communication

equipment available in each hospital to maximise the opportunities for the use of the telephone interpreter service¹².

The Commissioners discussion on this issue is not so lengthy to preclude its reproduction in full:

Non-English speaking patients

In some parts of NSW, there is a large proportion of the population who do not speak English well, or at all. It was suggested by way of an example, that about 25 to 30% of residents in western Sydney are born in a non-English speaking country and approximately 10% of people rate themselves as speaking English poorly or not at all.

In some local government areas of western Sydney, which have had the highest refugee and humanitarian migrant intake of the state over the last 3 years, the proportion of residents who speak a language other than English at home is closer to 60%.

During my visit to Liverpool Hospital, I was told that about 40% of the 59,000 people presenting to the Emergency Department have no, or very little, English. (The on-site interpreting service was said to be very good.)

Language problems place an additional workload on hospital staff in obtaining information from the patient about their condition, and getting informed consent to medical treatment.

¹² See the discussion on non English speaking patients at [2.72] ff of the Garling Report.

(a) Dr Miriam Levy, a Gastroenterologist at Liverpool Hospital, said that it takes twice or 3 times as long to obtain a consent from a non-English speaking patient and this increases the workload for junior medical staff. As well, it takes time to identify the need for an interpreter and obtain one for patients in a ward which has the consequence that commencement of appropriate treatment may be delayed.

(b) A survey conducted by the Medical Staff Council at Liverpool Hospital confirmed that a culturally and linguistically diverse population was considered to increase workload per patient due to the increased time needed to overcome communication problems.

Professional healthcare interpreters are provided to assist in such cases. Interpreters attend in person, or can provide a telephone service.

Clarissa Mulas, Network Director of the Multicultural Health Network, said that in Sydney West Area Health Service, to provide interpreters more rapidly, a 24-hour call centre model is used which has an improved response rate: the call centre can assess whether an urgent response is required, in which case the call centre endeavours to source a telephone interpreter for the patient.⁹² In other cases, health trained interpreters are found.

However, Ms Mulas reported that only 60% of requests for interpreters at admission are met in the Sydney West Area Health Service, that is, for all patients who tick the box "interpreter required" on their admission form, interpreters are provided 60% of the time.

Further, patients were often provided with an interpreter on one occasion but not another. Family members are still regularly used as interpreters, which is against government policy.

I also heard a number of contrasting views about interpreter services: I was told that many days notice were required to set up a meeting with an interpreter. Interpreters were booked centrally through the area health service and had to travel from one site to another, causing inefficiency.

Ms Mulas said that improved access to hands free telephone services was needed in many hospitals to assist in the utilisation of telephone interpreter services. Ms Mulas observed that in a culturally and linguistically diverse society, these improvements should not be thought of as an "add-on" but be at the heart of the design.

To the extent that one may draw parallels between the approach of the courts when the patient is of aboriginal descent and perhaps has limited understanding of Australian medical science, it may be useful to note *Young v CAACI & Ors* [2008] NTSC 47. The court held that CAACI had a responsibility to put administrative procedures in place to deal with patients who fail to

attend appointments relating to potentially serious conditions, in this case being suspected ischaemic heart disease. As there was no system implemented at the time, breach of duty was found on the part of CAACIC. However the court also found contribution to any loss or damage by the patient failing to keep appointments at the clinic, failing to follow up with the doctors and failing to inform doctors of these tests at his subsequent attendances at for various unrelated ailments. The defendant's liability was reduced by 50%.

4 Communication and Cultural issues

A coroner can order a post mortem examination of the deceased, either as part of a preliminary investigation to determine if an inquest is required, or as part of the inquest itself: *Coroners Act 1980* (NSW).

In recognition of sensitivities and cultural beliefs that may cause serious distress to relatives and family of the deceased, all jurisdictions except South Australia provide for coroners to allow for an objection to the holding of a post mortem by next of kin: *Coroners Act 1980* (NSW), s 48A.

In *Abernethy v Deitz* (1996) 39 NSWLR a man died after a road traffic accident. The coroner ordered a post mortem which was objected to by his widow, as the family were strong adherents to the Jewish faith and believed that a post mortem was a desecration of the

deceased. The coroner refused to accede to the objection. This decision was appealed.

The Court held that the causes of death, including septicaemia, pneumonia, renal failure and multiple trauma were not questioned, and there was no indication of any other cause. Medical evidence was accepted that a post mortem would reveal nothing in relation to the cause of death that was not already known. The cause of death was clearly known, and there was no evidence that the interests of society would be served if there were a post mortem. In these circumstances, the wishes of the deceased's legal personal representative and family should be the determining factor in deciding whether to carry out a post mortem.

In *Simon Unchango (Jnr), Ex Parte Simon Unchango (Snr)* (19 August 1997, Supreme Court of Western Australia in Chambers, CIV 1891 of 1997) (from *Australian Health and Medical Law Reporter* ¶34-220.41), a 12-day-old Aboriginal baby died suddenly. The most likely cause of death was considered to be Sudden Infant Death Syndrome (SIDS), however the coroner held that without a post mortem other causes could not be ruled out and that it was in the interests of the health of the Aboriginal community to determine more accurately the cause of death. Concern was expressed that the age of the child was low for SIDS and that SIDS is related to respiratory disease which may have a public health significance.

It was also suggested that, as the baby had been in shared accommodation, there was the possibility that intoxication in co-sleepers could have led to "overlay" of the baby, a matter that should be inquired into by police. Finally, concern at the high Aboriginal mortality rate and a consequent desirability to make proper medical inquiries into deaths was cited as a reason for the post mortem. The child's father testified to the traditional belief of his people that if subjected to a post mortem, the child's spirit would roam and not be able to enter dreamtime, affecting both the child's spirit and the community.

The Court overruled the coroner's order for a post mortem for the following reasons:

- the evidence indicated that death occurred as a result of natural causes, and intervening factors such as "overlay" were excluded by police;
- the court's intervention would not prevent the coroner from definitively establishing the cause of death;
- the finding that there was a cause of death other than SIDS would not advance the situation; and
- it is necessary to consider the strong cultural beliefs of relatives and the community, and the traumatic effect of a post mortem.

Difficult communication issues can arise in other circumstances, as for example described in a claim brought by parents for mental harm following the death of their child. *Hunter Area Health Service v Marchlewski & Anor* [2000] NSWCA 294 concerned a child born

clinically dead who was resuscitated and placed on ventilator life support system. After removal from the system the child continued breathing. Without consultation with the parents, the hospital decided that the child should not be resuscitated.

The hospital later admitted that its original breach caused brain damage leading in turn to death and admitted breach of duty of care leading to the parents' nervous shock.

The court noted at [8] the practical difficulties which can arise:

Senior hospital staff endeavoured to explain their diagnosis and prognosis to Maria's parents, the respondents. The task was unusually difficult for a number of reasons: each parent had a limited understanding of English because it was not the first language of Lamphud (Thai) or Roman (Polish); there were cultural and religious differences that needed to be accommodated, not only as between the hospital staff and the parents but also as between the parents themselves; and throughout this period the staff at the hospital were at pains to keep to themselves whatever understanding they then had of what was to be admitted much later as negligence on the part of the hospital. Most significantly, there were the difficulties stemming from the fact that the parents were understandably distraught and angry about the unexpected outcome of a

*perfectly normal pregnancy and their perception
that the medical people had been at fault.*

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