Medicolegal consequences of doctors accepting bequests and gifts under a patient's will

Doctors accepting testamentary gifts from patients' wills need to be mindful of complying with their overlapping legal, professional and ethical obligations to patients. The cases of *Schwanke v Alexakis; Camilleri v Alexakis* (*Schwanke*) and *Health Care Complaints Commission v Alexakis* (*HCCC*) demonstrate that although a testamentary gift to a doctor may be upheld, the doctor may nevertheless face disciplinary action.[1]

Dr Alexakis (Alexakis), a general practitioner, received a house and 90% of the remainder of an about $27 million estate under his patient's will, who died in 2017 aged 84 years. In *Schwanke*, it was alleged that Alexakis unduly influenced his patient (who had been discharged home after hospitalisation for serious ongoing conditions) so he could become the main beneficiary. In 2024, after lengthy legal proceedings, they were unsubstantiated. The will was upheld and Alexakis kept the testamentary gift.[1]

HCCC focused on allegations by the New South Wales Health Care Complaints Commission that Alexakis breached professional boundaries in his treatment and management of the patient, which ultimately resulted in testamentary gifts. The Tribunal accepted the Commission's submission that, at a minimum, Alexakis demonstrated a "wholesale ignorance" of ethical issues concerning the risk of undue influence.[1]

Will challenges

This is a complex area of law. Fundamentally, to be valid, a will must be in writing, signed by (or at the direction of) the will maker, and witnessed in the presence of two independent witnesses.[2] In addition, the will maker must have testamentary capacity[3,4] (presumed unless incapacity is established) and must know and approve of the will's contents free from undue influence, suspicious circumstances and/or fraud. Capacity and undue influence are interconnected, complex concepts. Undue influence generally includes the overbearing of a person's will. Therefore, to be unduly influenced, the person must have capacity at law.[3,4]

There is no presumption of testamentary undue influence. The person alleging it must prove it on the balance of probabilities, considering the seriousness of the allegation and need for compelling evidence. This requires close examination of the will-making circumstances. The nature of the doctor–patient relationship, and associated power imbalance, can raise questions around vulnerability and testamentary undue influence.[5] This can be contrasted with the law concerning transactions, including gifts, made during a person's lifetime where undue influence is presumed in the doctor–patient relationship such that the transaction may be set aside.[6] Further, although fiduciary principles have not been comprehensively applied to the doctor–patient relationship, courts have emphasised that doctors must not only carry out their duty to exercise reasonable care and skill in the provision of medical advice and treatment, but also ensure that no conflict arises between the patient's financial interests and their own.[7,8]

Schwanke case

In *Schwanke*, the court accepted evidence that the patient was an intelligent, albeit highly suspicious,[1] experienced businessman who continued to trade shares until his final hospitalisation in September 2017. A neuropsychologist gave evidence that he had testamentary capacity, which was accepted. Therefore, the argument focused on whether the 2017 wills were the result of undue influence by Alexakis. Further, it was alleged that a quid pro quo arrangement existed between Alexakis and the patient, whereby Alexakis would arrange for hospital discharge and regularly attend upon the patient at home in exchange for a testamentary gift. The evidence established that, following a report by doctors from the Royal Prince Alfred Hospital and a subsequent referral to NSW Police, the patient was advised by the solicitor who drafted the will to seek advice from an independent solicitor to address any challenges about allegations of undue influence by Alexakis. The patient did not take this advice.[1]

Despite concerns about the relationship and power imbalance between Alexakis and the patient, the Court held that undue influence was not established. There was no evidence of exploitation in circumstances where the patient was unlikely to be readily taken advantage of. The Court found that Alexakis' regular home visits, telephone calls and assisting the patient to find a solicitor to draft a new will, although "unconventional", was not the behaviour of a person taking advantage of someone's vulnerability. Rather, it evidenced a dedicated, diligent medical professional who brought "comfort and reassurance".[1] The Court also accepted that Alexakis did not know the terms of the 2017 wills, including that he was a beneficiary.

Evidence supporting suspicious circumstances included that the solicitor who drafted the 2017 wills was recommended to the patient by Alexakis and brought to the hospital by him to receive the patient's instructions during the June 2017 admission. Further, between May and June 2017, a period of just two-months, Alexakis attended the patient at the patient's home at least 91 times. Despite this, the Court found that this was not an example of a "most extreme" case of suspicious circumstances as the doctor was not present at or involved in the actual taking of instructions by the solicitor or drafting the will.[1]

Ethical and professional obligations

The *Good medical practice: a code of conduct for doctors in Australia*,[8] from the Medical Board of Australia,

Nicole E Kroesche
Tina L Cockburn
Kelly Purser
Karen A Sullivan

Australian Centre for Health Law Research, Queensland University of Technology, Brisbane, QLD.

kroesche@qut.edu.au

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describes expectations for Australian doctors. It sets out the principles characterising good medical practice, making explicit the standards of ethical and professional conduct expected of doctors, including managing conflicts of interest, upholding professional standards and avoiding financial relationships with patients.[8] The Code of Conduct is complemented by the Australian Medical Association's Code of Ethics, a guide to ethical practice with respect to patients, colleagues and society.[9] Notably, neither the Code of Conduct nor the Code of Ethics prohibit a doctor from accepting gifts under a patient's will, but instead provide that doctors should not encourage patients to make testamentary gifts to them. Further, while professional boundaries must be maintained, receipt of a benefit under a patient's will does not, in and of itself, constitute exploitation or establish an inappropriate doctor–patient relationship.[8,9] When a complaint is made about a medical practitioner, including complaints relating to doctors taking testamentary gifts, the complaints body must decide whether the doctor has acted in accordance with professional standards and, ultimately, whether they are a fit and proper person to hold professional registration.[10]

HCCC case

In *HCCC*, the Tribunal noted that "this is a difficult issue", with no "black and white written rules or guidelines".[1] In evaluating the conduct of Alexakis, the Tribunal grappled with delineating clinical from social visits given the high number, concluding that the frequency of visits by Alexakis to the patient in hospital and at home after discharge was "disproportionate to any professional or clinical purposes for such visits" and blurred "the boundaries of the doctor–patient relationship".[1] Nevertheless, even though Alexakis introduced the solicitor who prepared the patient's will and received a testamentary gift, the Tribunal found that while holding "suspicions" about his conduct, there was insufficient evidence that the patient was exploited or manipulated into changing his will. However, Alexakis was found guilty of unsatisfactory professional conduct and professional misconduct, in relation to inappropriate prescribing and inadequate record keeping. He was reprimanded, and extensive conditions were imposed on his registration under the *Health Practitioner Regulation National Law* (NSW) s149A (1)(b), which included requiring at least two other registered practitioners to work at the practice, a prohibition on conducting home or aged care visits, nomination of a professional mentor and completion of education modules.

Conclusion

Testamentary freedom and intention (a person's ability to leave their estate to whomever they want on their death) are foundational legal concepts. Challenges arise, however, in determining if and/or when a legal, professional and/or ethical boundary has been transgressed if a doctor receives a testamentary gift from their patient, given the power imbalance inherent in the doctor–patient relationship.

Risk management to address key findings in the *Schwanke* and *HCCC* cases

The health of the patient must be a doctor's first consideration.[11,12] However, just as a patient has the right to make their own health care decisions,[9] a doctor can decline to provide care in a way in which does not comply with professional standards. This includes attendances that are not medically justified and undertaking tasks that fall outside the doctor–patient relationship.

Conflicts of interest can arise when a medical practitioner puts their own professional, or personal (including financial) interests in conflict with the patient's.[13] Professional standards require conflicts to be identified as early as possible and timely action taken. Disclosure of the conflict or potential conflict should be made to the patient and a corresponding record made.

Where there are concerns that a doctor or other health professional may be exerting undue influence over a vulnerable patient in order to receive a testamentary gift or financial benefit, consideration should be given to reporting the matter to Ahpra. Before making a notification, doctors should work through ethical decision making, including seeking advice from key sources such as your medical defence organisation, employer and/or other professional association.

Managing a doctor's relationship with longstanding patients, and patients with complex medical issues, can be difficult. Consideration should be given to whether community supports can be incorporated in the patient's care plan, so psychosocial support is not reliant on one doctor–patient relationship.

Managing conflicts of interest, particularly with increased technological connectivity, can be challenging. Patients should be referred to independent legal and medical advice when a potential and/or actual conflict arises. As part of continuing professional development, doctors should ensure that they include modules on maintaining professional boundaries.

When a patient has additional needs or is vulnerable, doctors may need to advocate for them to ensure appropriate care is accessed. Balanced against this is the expectation that they will work collaboratively and respectfully with other health care professionals. Patient advocate and social worker services can be used to both support patients as well as supporting the doctor to maintain professional boundaries.

Community, peers, employers and regulators expect doctors to provide medical services with integrity and professionalism. A lack of self-awareness and self-reflection may not only affect a doctor's ability to provide high level care but could also result in boundary violations and adversely affect professional reputations. If you are concerned about a potential conflict of interest, seek advice.

Where a risk of a conflict, or actual conflict of interest arises, it may be in the patient's and doctor's best interest to terminate the doctor–patient relationship. Doctors should discuss reasons for this decision clearly with the patient and facilitate appropriate handover. Consideration should also be given to emergency care obligations until care has been transferred.

Medical practitioners must maintain clear, accurate and up-to-date medical records for every attendance. Professional standards require that records include information given to patients, referral and other management activities, in addition to clinical history, investigations and diagnosis. Records must be sufficient to support prescribing and properly facilitate the transfer of care.[8]

Ahpra = Australian Health Practitioner Regulation Agency; *HCCC* = *Health Care Complaints Commission v Alexakis*; *Schwanke* = *Schwanke v Alexakis; Camilleri v Alexakis*. ◆

In *HCCC*, the Tribunal acknowledged that the Code of Conduct did not provide express guidance about receiving testamentary gifts. The *Schwanke* and *HCCC* cases demonstrate the difficulty delineating between professional and/or social, psychosocial and personal

attendances, particularly when a patient has become highly reliant on a doctor. Doctors can be supported, and patients protected, by implementing practice-based risk management strategies (Box).

However, professional standards and their status require clarification. In comparison, professional standards for nurses and midwives are more specific, detailing that receipt of anything other than a token gift from a patient under their care should be avoided, "to ensure that there is no perception of actual or personal gain".[14] Further, conflicts of interest and overinvolvement with patients outside the professional relationship may compromise care, damage the reputation of the nursing profession, and be considered unprofessional conduct.[14] The development of specific professional standards and/or guidelines for doctors and education could provide greater clarity, benefiting doctors and patients alike. This could also reduce the medicolegal risk of doctors becoming entangled in civil litigation about will validity and/or receipt of testamentary gifts and associated disciplinary consequences. Pending further guidance and education, doctors should be mindful of potential conflicts of interest and the risk of undue influence. In the first instance, doctors should seek advice from their medical defence organisation, employer, other professional bodies, independent legal and/or medical advisors if concerns arise (Box).

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1 *Schwanke v Alexakis*; Camilleri v Alexakis [2024] NSWCA 1181 ("*Schwanke* Case"); *Health Care Complaints Commission v Alexakis* [2023] NSWCATOD 992 ("*HCCC* Case"). *Health Care Complaints Commission v Alexakis* (No. 2) [2024] NSWCATOD 82 (21 June 2024).

2 *Wills Act 1968* (ACT), s9; *Succession Act 2006* (NSW), s6; *Wills Act 2000* (NT), s8; *Succession Act 1981* (Qld), s10; *Wills Act 1936* (SA), s8; *Wills Act 2008* (Tas), s8; *Wills Act 1997* (Vic), s7 and *Wills Act 1970* (WA), s8.

3 *Banks v Goodfellow* (1870) LR 5 QB 549.

4 Purser K, Sullivan K. Capacity assessment and estate planning — the therapeutic importance of the individual. *Int J Law Psychiatry* 2019; 64: 88-98.

5 *Jenyns v Public Curator* (Qld) (1953) 90 CLR 113; 118-119; Schwanke; 155.

6 *Bar-Mordecai v Hillston* (2004) NSWCA 65.

7 *Breen v Williams* (1996) 186 CLR 71, 25.

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