THE ROYAL AUSTRALASIAN COLLEGE OF PHYSICIANS

ANNUAL SCIENTIFIC MEETING

ADELAIDE, 9 MAY 1984

THE ARTHUR E MILLS ORATION

NEGLIGENCE AND THE PHYSICIAN

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The Hon Justice MD Kirby CMG
Chairman of the Australian Law Reform Commission

ARTHUR E MILLS TODAY

Last week I was inaugurated as Chancellor of Macquarie University in Sydney. Deftly performing the ceremony was the doyen of Australia's University Chancellors, Sir Herman Black. He is the third of the Chancellors of my old University I have known. The first two were physicians, Presidents of this College. Sir Charles Bickerton Blackburn was 93 when he laid down his golden robes as Chancellor. Macquarie University has let it be known that it does not actually expect me to serve to my 93rd year. As a Fellow of the Senate of Sydney University I attended the last ceremony over which Sir Charles Bickerton Blackburn presided. I took part in the election of his successor, that sweet gentleman, Sir Charles McDonald, a Past President of this College. It is from his pen that I learned of the life and works of Arthur Edward Mills, to whose memory this contribution is dedicated.[1]

Mills was born into a different world in 1865 at Mudgee, New South Wales. Through the fine influence of the Headmaster of Sydney Boys' High School he entered the University of Sydney, after the tradition of those days, in Arts and Medicine. He was one of the early honorary physicians at the newly opened Royal Prince Alfred Hospital. An early practice in Picton near Sydney took him through the valley of poverty until 'an epidemic rained from heaven and work abounded'.[2] According to McDonald, he soon learned that knowledge of human nature was 'a most important equipment of any physician'. He rejoined the Faculty of Medicine at Sydney University, rose in its ranks and became the high priest of the new medicine founded in rationalism:

> The question 'Why?' rang from the lecturer's lips not once but a thousand times, and successive classes of students caught up the cry till every clinical teacher was forced to give reasons for his statements or run for cover.[3]

After war service Mills returned to the University. In the senior year book of 1924 he received the highest accolade of his students:

> for Professor Mills believes that it is the duty of the lecturer to be interesting, and not the duty of the audience to be interested.[4]

I feel bound to warn this audience that memorial lecturers do not always adhere to the same precept. Mills was a candid man:

> It was characteristic of the man that if he disapproved of the action or word even of a friend he would never hesitate to say so. This sometimes alienated the affection but never the respect of his colleagues.[5]

I will return to this quality for it is relevant to the subject I have been asked to address. Mills retired from his Chair at the age of 65 in 1930. At about this time he joined the Senate of the University, elected by Convocation. He rose to be Deputy Chancellor, a position he relinquished just before his death in 1940. His life, in the old professional values, should be an inspiration for all of us. According to Charles McDonald:

> His originality led him to anticipate developments in medicine which at the time seemed fantastic. His courage brought him bitter enemies and loyal friends. At no time did he seek popularity and often the hornets of opposition droned round his ears. He was a born champion of lost causes and was never so happy as when he went down fighting for a principle. But more often than not he won through by sheer faith in the cause that moved him.[6]

His life could be a copybook text for professional reformer or for a law reformer in modern Australia. Sir Zelman Cowen, delivering the 1968 Lecture, spoke of Mills and his assaults on tradition in clinical medicine. 'Tradition or the accepted beliefs of our forefathers in clinical medicine had attained an equal authority to the precedents of the lawyer'. The plain implication was that both were bad.[7]

As one who is constantly required by the reforming task to question and criticise precedents (even those long-established) I take inspiration from the life of Arthur Mills. I believe he would approve of what I am to say on

physicians' negligence. By the same token I do not doubt that he, like many of you, would be astonished at the way malpractice suits are growing and anxious about some aspects of the phenomenon.

MALPRACTICE EXPLOSION

It is not inapt to refer to the growth of malpractice suits against physicians and surgeons in the United States as 'an explosion'. The rapid increase in such litigation by patients suing doctors is remarked upon in professional literature, the popular press and the conversations of white-faced practitioners returning from the United States. In 1978 Guinther tried to put a figure on the explosion:

> It has always been possible in the United States for patients to sue their doctors for causing them injury during the course of their medical treatment. Such suits, however, remained extremely rare into the 1950s, and it was not until the mid 1960s that the amount of litigation began to rise sharply; at that time, increments in the filing of malpractice claims, which had been hovering between 2% and 5% each year, suddenly rose to 15% per annum, a pace that has been more or less maintained ever since.[8]

Medical practitioners in the United States look back on the halcyon days of seeming physician immunity from legal suits. One of them, last year, recalled those days:

> Not long ago, medical malpractice litigation was virtually unheard of. The practice of medicine was far simpler, owing to limitations in pharmaceuticals and diagnostic equipment. Physicians held an almost deified position among the public. A poor medical outcome was attributed to 'an act of God'. Little thought was given to medical errors of omission and commission, and attempts at restitution for damages often met with failure by virtue of the inability to obtain medical testimony clearly outlining those errors. The medical community found itself enjoying a nearly immune status. The injured parties remained unknowledgeable and helpless. Iatrogenic injury was kept well in-house by the medical community.[9]

Why has this all changed in the United States? Does it have lessons for us in Australia where, at least in legal developments, things that have happend in America tend to happen in much the same way a decade or so on?

Various explanations are offered for the American phenomenon. Indeed, some of them are hinted at in the passage just quoted. The reasons for the explosion in medical malpractice suits include:

- Community attitudes. The development of a community which is at once better educated and more questioning.
- Professional status. The partial shattering of the professional pedestal and the unwillingness of the community to grant professionals (whether doctors, lawyers or even judges) the unquestioning faith and acceptance accorded to them in earlier generations.
- Sophisticated technology. The growing technology and sophistication of modern medical practice, with the consequent risk that more things can go wrong: technology can break down; it may be unavailable; it may be unknown to the practitioner in question; it may be out of date; there may be competing theories about it; it may be incompetently applied.
- Growth of legal profession. In the United States, the growth of the numbers of the legal profession is a phenomenon often called to attention. The numbers of lawyers, when compared, say, to Japan, is remarkable. Those lawyers must find something to do. The ingenuity of this intellectual cream of the community has been directed (in part, in the United States) towards new fields of endeavour, including medical malpractice.
- Cost rules. Cost rules can facilitate negligence suits, just as they can discourage them. In the United States, the availability of contingency fees positively encourages malpractice litigation. The lawyer takes a proportion of the verdict. This amounts both to an encouragement to litigation and to an encouragement to do it well and to succeed. The price of failure is a nil return. Although contingency fees are not professionally permitted in Australia (at least as a given proportion of a legal verdict) we should not be too self-righteous about our system. The United States system has been termed a 'free enterprise answer to legal aid'. It undoubtedly brings to justice many people who, in our system, would not have their case brought to the umpire. Some at least of those cases will be just cases. A recognition of this fact has led to the increase in government legal assistance in Australia. It has also led the courts to sanction speculative litigation where the lawyer forms the view that his client has a proper case to bring.[10]
- Out of town experts. Finally, there has been the discovery by lawyers of ways to circumvent the disinclination of local medical practitioners to give expert testimony against their colleagues. This is a disinclination that I believe Arthur Mills would have condemned. In human terms it is understandable. Colleagues who must work together find it painful to speak with candour, in the formal public setting of a court, of the errors and mistakes of a person with whom they may have frequent, if not

daily, professional contact. This 'brotherhood syndrome', if I can be excused such a sexist term, is perhaps best illustrated in the judiciary itself. Save for a recent notable example[11] it is unusual for one judge publicly to criticise another. There are conventions to be observed. When an appeal court overturns the decision of a primary judge it is rare indeed that the name of the primary judge appears in the decision. If by inexorable chance the name cannot be omitted, the salving balm of words is applied, so that he is described as 'the learned judge'. The more egregious the error being corrected, the more amply is the balm applied. The police tend to close ranks, as befits a para-military force. The medical profession is no difficult in this regard. Even if, privately, physicians might think that a colleague has erred, they will hesitate to become involved in giving evidence. They may considered the error to be unfortunate but understandable in the circumstances. They may consider that there, but for the grace and God and a lawyer, go they. They may consider that giving critical evidence in public will attract the approbrium of the Club, of the peer group. They may think that it will affect the flow of professional work, the references from colleagues, social intercourse in the hospital common room and uncomfortable moments at a dinner party. In any case, they may reflect upon the trouble that court cases involve, their own medical insurance, the many other things they can do with their time and conclude that it is just better not to become involved. Like the other samaritans, they may, in these circumstances, cross the street. Intellectually they will tell themselves that they could and should express their views. But life is more than intellect. There are the emotions to consider. It is in these circumstances that lawyers in the past have found it very difficult indeed to get medical experts to give evidence to ground the case that is necessary for a plaintiff to win against the medical practitioner accused of negligence.

It is only now that this problem is being circumvented. The principal means of circumvention is the 'out of town' witness. In Australia this often means flying an expert from another State. In one important recent case a specialist was flown out from London to give evidence.[12]

AUSTRALIAN RETICENCE

In Australia we have a similar explosion in medical knowledge, a similar proliferation of ways in which things can go wrong and mistakes can occur, sometimes with devastating effect. We have a similar questioning of our professions. As has been pointed out, we have begun to turn to the out of town witness. Yet medical malpractice has not really taken off in this country to

anything like the extent that has occurred in the United States. The spectre of a similar phenomenon has long been predicted. There have been some early signs and yet the wave has not arrived. Why is this is? Will it remain so?

- Higher standards. One suggestion, often made, is that standards of health care in Australia are higher than in the United States and available to a greater cross section of the community. But even if this were so, as Mr Graham Fricke QC recently pointed out, there are 20 000 medical practitioners registered in Australia with millions of consultations and hospital admissions each year. Conceding the unlikely assertion that, physician for physican we do it better, it is still too much to assert that the high proportion of medical malpractice claims in the United States reflects so gross a difference between standards of care in that country and in this. Some other social or legal feature must explain the disparity.
- Cost differences. The cost rule difference, already mentioned, is the most obvious reason for lawyerly reluctance in Australia to take on cases which, in the United States, would find a ready lawyer. If a party, claiming damage as a result of the negligence of a physician, seeks to bring a legal action in this country, he or she will have numerous hurdles to overcome. A fund for costs will normally have to be provided. The cost of experts to support the claim will be substantial. Particularly will this be so if the expert must report (and come to the trial) from interstate or overseas. This very expense will tend to have a self-selecting effect. Only a case where serious injury has been done will warrant the provision of such fund. The cases, even when the expert testimony can be secured, are more unusual, complex, technical and difficult to present than the routine accident at work or mishap on the highway. The vigorous defensive posture of the medical defence insurance is well known. The inclination, even of a sympathetic specialist, to concede reasonable possibilities to a colleague's lawyer, can never be put out of mind. Even if a case can be made out sufficient to go to a jury (if one is summoned) the prospect is always there that the the jury — or judge sitting alone — will dismiss the claim. Only last week a report in the Sydney papers disclosed that a woman who claimed to have been negligently fitted with an inter uterine device five years ago lost her case against the doctor involved.[13] According to the report, the verdict was decided by consent. The defence was that the patient had failed to follow instructions and had not returned for further examination. It is well known in the legal profession that medical negligence cases are fought with much more vigour than the average run of claims against persons supported by insurance. In part, this may arise from the desire of medical practitioners to defend their reputations. In part, it may arise from the mutuality of insurance in

this class Australia. In part, it may arise from a deliberate posture adopted to discourage litigation of this kind. If the last mentioned phenomenon is a conscious one, it is undoubtedly rewarded with success. The position in Australia is reflected to some extent in the United States.[14]

Different laws and procedures. A further reason for the comparative lack of malpractice litigation in Australia lies in the relevant differences between the law and procedures in Australia and the United States. Though both countries share the common law tradition, the differences can be significant. For example, the availability of pretrial discovery in the United States is more ample than in most parts of Australia. This is the procedure by which, even before litigation has commenced, parties may have access to hospital or other medical records in order to discover whether a claim in law exists.[15] The importance of such records in medical negligence cases was amply demonstrated by the recent decision of the Court of Appeal of New South Wales in Albrighton v Royal Prince Alfred Hospital.[16] That was a case where a young woman, suffering from birth from a deformity of the spine, entered the hospital for treatment. She had a large hairy naevus on her lower back over the spine. This was some indication of possible 'tethering' or adherence of the spinal cord to the adjacent structures, with consequent risk of rupture if traction were applied. The hospital records, in the form of a 'consultation sheet' disclosed the request by one doctor for advice of another specialist on the significance of the hairy naevus in the event that traction was applied. The running sheet showed that the specialist consultation did not take place before traction. As a result of the traction the young women suffered severance of the spinal cord and became a paraplegic. Much of the time of the Appeal Court was spent on at the admissibility into evidence of the consultation sheet. In the result the Appeal Court, contrary to the learned trial judge, held that the whole of the record relating to the treatment at the hospital produced on subpoena was admissible and once admitted was evidence for all purposes under the New South Wales Evidence Act.[17]

Until recently at least, the common law of evidence, the practice of most courts in relation to pretrial discovery and the rules governing the proof of negligence have all, in Australia, tended to favour a defendant medical practitioner.

Slowly but surely, however, our legal system is moving in directions that will close the gap between laws and procedures available in the United States and those of this country:

- Discovery. Pretrial discovery has now been introduced in many of the courts of Australia.[18]
- Privilege. Many of the rules relating to legal professional privilege have been reconsidered, so that documents which once would not have been discoverable, on the grounds of legal professional privilege, are now more likely to be available to the opposite party for use in the preparation of his or her case.[19]
- Proof. The principle of Res Ipsa Loquitur has been developed for application in medical cases so that where common sense demands an explanation, the court will not generally allow medical practitioners to hide behind the plaintiff's inability to prove negligence. Thus, for example, if a swab is left in a patient's body it seems clear that the surgeon should be called upon to offer an explanation for what will otherwise be taken as professional negligence.[20] Having said this, however, it is clear that we have not reached a point that medical practitioners guarantee success even in routine procedures. The so-called principle of Res Ipsa Loquitur has distinct limitation in medical negligence cases, precisely because it depends upon inferences in the process of logic[21] drawn from the ordinary experience of mankind. That experience is often irrelevant in medical practice, simply because of its special knowledge and techniques.
- Vicarious liability. The most helpful development, from the point of view of plaintiffs, has been the growing tendency to bring liability home to hospitals in which medical practitioners are working. The case of Albrighton to which I have already referred is one such case. The court made it plain that the concept that a hospital fulfils its duty of care to persons treated in it simply by selecting and appointing competent medical staff is no longer an acceptable legal concept in Australia today. Furthermore, the court stressed that the concept that a hospital is not responsible for the negligent conduct of its medical staff in the course of their duties in the hospital unless it can be shown that the hospital has the power (whether or not it exercises it) of directing them as to the manner in which they will carry out their work has 'long since been eroded'. This so-called control test is 'not now acceptable in its full vigour'. Today, the uncontrollability of a person forming part of an organisation, as to the manner in which he performs his task, does not preclude recovery from that organisation. Specifically it does not preclude the finding of the legal relationship of master and servant such that master [in that case the Royal Prince Alfred Hospital] was vicariously liable for the negligence of the servants [in that case the orthopaedic and consulting neuro-surgeon]. Alternatively, the Court of Appeal made it clear that there was evidence supporting the view that the hospital was in breach of its own direct duty of care owed to the patient which it could not divest by delegation

either to doctors or para-medical staff. On this view, when the patient entered the institution, the hospital itself undertook to render her complete medical services through its staff, including surgeons, consultants and others all chosen not by her but by the institution.[22] These decisions expand the potential liablity for medical negligence in Australia. Yet the case probably gained more currency in the medical than in the legal profession. The wave of malpractice suits did not eventuate.

Now, however, a new feature is entering the debate. It is being said that lawyers must look to a future in which land title conveyancing may be lost to them, in whole or large parts.[23] That aspect of legal practice presently constitutes approximately 50% of the fee income earning activity of lawyers in Australia. If central computing activities and an insurance scheme take over the work of land title conveyancing, what are the lawyers thereby released to do? Some of them, at least, in the ingenuity of the legal profession, may be looking to what has occurred in the United States. The point I have been making is that if they then look at the development of court rules, evidence statutes and case law on medical negligence, they will find a fertile field still largely untilled in this country. But should we be encouraging such a development?

CRITICS

There are many critics of the medical malpractice phenomenon, including in the United States:

- The professional expert 'side show'. The critics are most vigorous in their denunciation of the so-called 'side show' of out of town medical experts. This is thought by some observers to be a demeaning development in which medical strangers are brought in to a friendly medical community to criticise, from the lofty heights of the witness box, the diligent and well intentioned work of hard pressed, busy medical practitioners. This attitude can be understood. Undoubtedly there has been abuse of the professional expert witness in the United States and indeed in this country. Legal commentators in the United States are warning about the need for care so that lawyers keep their independence and arms length distance from the professional medical expert. As Philadelphia attorney David S Shrager, who specialises in litigating medical negligence claims, told a medical symposium for trial lawyers last year:

> The expert must simply not be in a position to tell the attorney how to run the case. I make enough mistakes of my own. I can hardly bear to heap on those someone else's errors, particularly at great expense.[24]

But what is the answer to the critics of the 'road show of out of state witnesses ... called in as professional hit men to create cases where none exist'? An Australian lawyer, adverting to the 'conspiracy of silence' which exists in most professions, including in the medical profession, quotes an American defender of the expert in these terms:

> Physicians who are members of medical societies flock to the defence of their fellow members charged with malpractice and the plaintiff is relegated, for his expert testimony, to the occasional lone wolf or heroic soul who, for the sake of truth and justice, has the courage to run the risk of ostracism by his fellow practitioners and the cancellation of his public liability insurance policy.

In the Albrighton case the court in New South Wales took pains to castigate counsel for the way in which they had cross-examined the medical expert from London. Specifically, on a point of law, the court held that the fact that the plaintiff's expert witness had not practised in Sydney and did not claim any special knowledge of the state of medical practice in Sydney, did not render him incompetent to express a view as to the significance of the signs exhibited by the plaintiff, the dangers that would be indicated by a proper interpration of those signs or the courses that should and could have been taken to avoid risk of injury from any dangers so indicated. The court rejected the earlier view that what is charged as negligence must be shown to be in breach of the customary practice and procedures then prevailing in a particular medical community. The judges said that this was an issue that should have been left to the jury to decide and not taken away from the jury by the trial judge, as happened in that case.[27] An unstated premise in this reasoning must be taken to be the knowledge of the court of the difficulty which even plaintiffs with a just cause may sometimes have in securing medical evidence from doctors in the local medical community. If this is a difficulty in a large and vigorous city such as Sydney, it may be even more so in provincial cities or in country towns. One United States medical practitioner, recognising this difficulty, responded fairly:

> At least on the local level, one cannot be too critical of the practitioner who does not wish to become involved in testimony against colleagues that he or she sees on a regular basis, and who may even be a source of referral, or against hospitals in which he or she has staff privileges. It is primarily for this reason that plaintiffs' attorneys have sought medical evidence from a distance away ... When unable to obtain local medical expertise, the plaintiff's attorney must decide whether to make direct contact with a distant medical specialist, or to work through a service organisaion.[28]

- Staggering insurance. A second criticism of the American malpractice phenomenon is that the result is 'staggering' increases in medical insurance. Yet this assertion too seems dubious. A commentator, admittedly the President of the Trial Lawyers Association in the United States, asserts that the 'facts are to the contrary'.[29]

> The industry does not tell physicians that they produce about 1% of casualty insurance premiums and about 6% of casualty insurance reserves, a ratio that means that doctors generate five times as much investment income for the avaricious industry than should be their proportion contribution. In addition, it has been revealed that since the industry began filing medical malpractice information in 1975, it has earned more investment income on lost reserves alone than it has paid for medical malpractice claims. We have been urging doctors to free themselves from the clutches of the casualty insurance industry for years.[30]

Perhaps a more thoughtful answer to the criticism of 'staggering' insurance claims is the point that medical practitioners should themselves contribute, as a group, to distributing the risk in society for mistakes that almost inevitably will occur from their activities. In the event of mistakes, however unintentioned and reasonably explained, patients may suffer. Some may suffer very severely, as in the 'strenuously' defended case of Albrighton where the traction caused paraplegia. In those circumstances, social issues arise as to whether the patient should get no compensation, should have to look to the whole community for compensation or should be entitled to look to the collected resources of a well-off profession to compensate for the error. Last week the Age reported that evidence of taxation statistics indicates that medical practitioners in private practice in Australia have significantly improved their incomes relative to most other professions since 1966-67.[31] In these circumstances, it may not be unreasonable to expect medical practitioners to contribute at least a

small part of this increased income to funding the 'fall-out' ie the losses which will be suffered by those in society who look to the medical profession for care but have suffered loss as a consequence of a lack of care, however minimal. After all, we are talking here about fellow human beings who have suffered and who often, unless some form of medical negligence suit can be mounted, will be cast upon the general social security system, burdening the whole community for small benefits. The essential issue at stake is one of loss distribution. Whilst no-one would suggest that the medical profession should become a loss distributing agent for everybody who turns to the profession for advice, it is at least arguable that there are many in Australia who are suffering through incompetence, out-of date, unsophisticated or just plain careless medical treatment and who are not recovering compensation from the doctors or hospitals concerned because of cautious legal rules and traditions. I can never join in the self righteousness congratulation that exists in some professional quarters that malpractice suits have not developed in this country to the same extent as the United States. One can criticise the United States developments but still concede that American cost rules, legal procedures, rules of evidence and court ruling sometimes contribute to a better system of protection for people who suffer loss than our more gentlemanly system has done. The rule that professional people should not take contingency fees is doubtless an appropriate rule for a gentlemen's club. But it may also be a rule that denies access to justice to many people who, in the United States, would get access to justice and enforce distributive insurance so that their losses are borne by those most able to bear them, rather than cast upon themselves, their relatives or the general community's pocket in the form of social security.

Counter-productive effects. Of course, this is not to ignore the counter-productive effects of some of the malpractice litigation in the United States. It has been said that some practitioners will simply not perform surgery because of the higher risks of malpractice suits and very high premiums that they regard as unacceptable. There has also been the suggestion that medical practitioners will not aid accident victims, for fear that a failure to provide first-rate skills in the primitive conditions of the roadside may result in their being sued or joined with another defendant. This last-mentioned development has resulted in so-called good samaritan statutes in the United States. I was interested to read a recent report by a working party of the Health Commission of South Australia proposing that medical practitioners carrying out emergency procedures without consent in order to save someone's life should be given greater protection along United States lines.[32] It will be no surprise that I have previously expressed my doubts about the

need for and desirability of good samaritan legislation, not least because it may result, once again, in imposing the consequences of a lack of care, however forgiveable, upon the person least able to bear them (the accident victim) rather than requiring their distribution, through medical negligence insurance, amongst those who are much better able to fund the compensation.[33] However that may be, it seems likely to me that the alleged counter-productive effects of malpractice suits will not be a problem in Australia for many years to come, if ever. The real problem in Australia is whether, for the better compensation of victims of professional lack of skill, we can devise a system preferable to that which presently exists.

Improving the system. That brings me to my concluding point. The system of sanctions and remedies which we know as the law of torts is not devised solely to provide compensation for the victims of a wrong. True it is that represents a major purpose of the system and the one to which I have so far addressed myself. But there is a secondary purpose, namely to instil those high standards which, for fear of litigation, will prevent injuries occurring. In the case of medical malpractice, I do not believe it can be said that the fear of expense, either directly to the patient or indirectly through insurance funds, constitutes a major factor in instilling high standards amongst Australian physicians. The interposition of insurance has removed the sanction in great part. The contribution made by individual practitioners to insurance is relatively small to their incomes and likely to be divorced from a perception of a burden imposed for an individual wrong to an individual patient. Much more significant are the sanctions of peer pressure, lately peer review, publicity, professional gossip, the inconvenience of litigation, the uncongeniality of lawyers and so on.

For these reasons, the malpractice suit is unlikely to contribute very significantly to improving medical practice. It is unlikely that the physicians of Australia will be encouraged to greater skill and competence for all their patients by the fear of a growing number of malpractice suits brought by a few. In these circumstances, thoughful people in the medical profession of Australia are turning to other means of improving and maintaining high standards, updating knowledge, distributing information about new techniques and new equipment. Perhaps the most important phenomenon is one addressed in a previous Oration in this series, namely the development of peer review.[34] I do not pretend for a minute that a growing number of malpractice suits would be any substitute for better medical care and preferable to internal disciplines of this kind. But peer review is small comfort to the paraplegic or other injured person suffering as a result of comparative

lack of skill by the practitioner who treated him. The fact that that practitioner may be disciplined, sanctioned, cautioned or even removed from the medical register will be no comfort to the injured. His daily life will be improved not a jot by these developments. It is for that reason that it is likely that pressure will continue for medical malpractice suits.

I am not ignorant of the debates that urge a more fundamental restructuring of the system of accident, injury and sickness compensation. The New Zealand system of national compensation, which divorces the right to compensation from the proof of fault and negligence, is now once again before the Australian community.[35] Nor do I ignore the arguments that there are cheaper ways of improving community health than those which we have been pursuing in Western society.[36] One risk of medical malpractice suits may be that they will force the cautious physician, for fear of litigation, into a mode of excessive and needless use of sophisticated tests and heroic technology that just might, in the exceptional case, turn up something relevant to this particular patient. From the point of view of the patient, sophistication and heroism cannot normally go too far. From the point of view of a society as a whole, anxious to use its medical dollar to best effect, there may be better ways to spend it. These are debates that remain for another time and I want to indicate that I am alive to them.

CONCLUSIONS

The point of my address is that medical malpractice is a booming industry in the United States. In Australia the legal profession is about to undergo a major restructuring as the impact of technology will force great changes upon large and hitherto profitable areas of professional activity, notably land title conveyancing. Many lawyers will be released by these changes to seek other socially useful legal work. The numbers of lawyers are growing anyway. Such an ingenious profession is likely to be looking, as doors close, for the other doors that will open.

The door marked medical malpractice has been cast ajar by a number of recent developments. First, there is the example of the boom in the United States with the flood of literature coming to lawyers in this country of cases involving misdiagnosis of cancer[37], error during anaesthesiology, when the patient is most vulnerable[38], error in the non-delegable duties of the hospitals[39] or in the emergency room[40], error in the obstructed labour situation and so on. But there are other local developments that are relevant. Court rules have been changed to facilitate pretrial discovery in Australia. Evidence law has been changed to facilitate access to documents and the

admission of documentary testimony such as hospital and other medical records, which may disclose a path of medical error. Furthermore, court decisions have expanded the circumstances of and responsibility for medical professional negligence, sounding in legal recovery. Clearly, therefore, there is a phenomenon to be watched. There remain impediments in the cost rules and ethical traditions of the Australian legal profession and the relative disinclination of Australians to sue, when compared with their American cousins. There also remain questions as to whether medical malpractice is desirable from the point of community health care, as distinct from compensating individuals and from the point of instilling high standards amongst medical practitioners, as distinct from redistributing loss in society from those who can pay to those who are suffering.

Arthur Mills, was no stranger to controversy. He would have looked upon this issue with equanimity and, I suspect, a little delight at the discomfiture of his fellow practitioners. He would have had little time for the self-righteous criticism of the American legal system as such. He would have less time for the expert physician who hid behind personal friendship to deny his impartial specialist expertise where a colleague had fallen into error. Mills is no longer with us; but he is celebrated still. Medical negligence is with us still. It will grow in importance in the law. Whether this should be celebrated depends entirely on one's point of view. The beauty of medical negligence is entirely in the eye of the beholder.

FOOTNOTES

1. CG McDonald, Obituary, Arthur Edward Mills, in Medical Journal of Australia, 22 June 1940, 878.

2. ibid, 879.

3. id.

4. Cited id.

5. id, 880.

6. id, 881.

7. Z Cowen, 'Balance in the Law', Arthur E Mills Memorial Oration, 1968, in Medical Journal of Australia, 21 December 1968, 1148.

8. J Guinther, The Malpractitioners, 1978, 3. Cited in GL Fricke, 'Medical Negligence', (1982) 56 Australian Law Journal, 61.

9. GI Kravis, 'Medical Malpractice : Thoughts and Perspectives' in Trial, Vol 19 No 5, May 1983, 50.

10. Cf J Disney, J Basten, P Redmond and S Ross, Lawyers, 1977, 324ff. See Clyne v NSW Bar Association (1960) 104 Commonwealth Law Reports 186, 202 ['... and it seems to be established that a solicitor may with perfect propriety act for a client who has no means, and expend his own money in payment of counsel's fees and other outgoings, although he has no prospect of being paid either fees or outgoings except by virtue of a judgment or order against the other party to the proceedings. This, however, is subject to two conditions. One is that he has considered the case and believes that his client has a reasonable cause of action or defence as the case may be. And the other is that he must not in any case bargain with his client for an interest in the subject matter of litigation, or (what is in substance the same thing) for remuneration proportionate to the amount which may be recovered by his client in a proceeding'].

11. The reference is to the review by Justice Peter Connolly of the author's 1983 Boyer Lectures. See Proctor, March 1984, 1.

12. Albrighton v Royal Prince Alfred Hospital & Ors [1982] 2 New South Wales Law Reports, 542.

13. Stone-Herbert v Edwards and Women's Health and Resources Foundation, reported Sydney Morning Herald, 2 May 1984, 8.

14. Association of Trial Lawyers, 'A Position of Responsibility', 10-11, cited Fricke, 61.

15. Fricke, 62.

16. [1980] 2 New South Wales Law Reports 542.

17. ibid, 550.

18. See now Oswin v Radio 2UE Sydney Pty Limited (1968) 1 New South Wales Reports 461 and Part 3. Supreme Court Rules (NSW) (Preliminary Discovery).

19. Grant v Downs (1976) 135 Commonwealth Law Reports 674; Baker v Campbell (1983) 29 Australian Law Reports 385.

20. Mahon v Osborne [1939] 2 KB 14, 15 (Court of Appeal, England).

21. Chief Justice Barwick in Government Insurance Office of New South Wales v Fredrickberg (1968) 118 Commonwealth Law Reports 403.

22. Roe v Ministry of Health [1954] 2 KB 66, 89; Fricke, 67.

23. See eg G Lewis, The Future for the Conveyancer, in 1984 New Zealand Law Conference Papers, 1984, 21.

24. DS Shrager, 'A Medical-Legal Symposium for Trial Lawyers' in Trial, Vol 19 No 5, May 1983, 44, 46.

25. HA Specter, 'Medical Malpractice Responsibilities', Trial, Vol 19 No 5, May 1983, 6.

26. Kramer, Medical Malpractice, 1972, 66, cited Fricke, 63.

27. [1980] 2 New South Wales Law Reports 542, 553-556 ('I find the latter submission so bold as to border on the outrageous') (Reynolds JA).

28. Kravis, 50, 51.

29. Specter, 6.

30. ibid.

31. Age, 2 May 1984, 1.

32. South Australian Health Commission report, noted Canberra Times, 27 December 1983, 10.

33. MD Kirby, Law Reform, Science and the Good Samaritan, Address to the CSIRO Officers' Association Annual Dinner, 3 June 1983.

34. EC Rosenow, 'Maintenance of Standards in External Medicine', Arthur E Mills Memorial Oration 1976, in Aus NZJ Med (1976), 6, 57-65.

35. Australia, National Commission of Inquiry into Accident Compensation (Woodhouse Report) 1974. NSW Law Reform Commission, Accident Compensation, Working Paper, 1984.

36. See eg Health Care International, Survey, The Economist, 28 April 1984, 19. Cf ibid, 21 April 1984, 82.

37. RM Gerughty & AP Wilkinson, Negligence in the Diagnosis of Cancer, Trial, Vol 20 No 2, February 1984, 68. Cf 'Well, its Cancer, so What's the Issue?' in Trial, Vol 19 No 5, May 1983, 62.

38. E Grossman, 'Anaesthesiology — the Defenseless Patient' in Trial, vol 19 No 5, May 1983, 70.

39. Specter, 6.

40. HA Specter and K Benesch, 'The Hospital Emergency Room : Haven and Hazard' in Trial, Vol 19 No 5, May 1983, 78.