0927

IIR CONFERENCES

THE 1992 NATIONAL MEDICO-LEGAL CONGRESS

"AN ERA OF CHANGE"

IIR CONFERENCES

THE 1992 NATIONAL MEDICO-LEGAL CONGRESS

"AN ERA OF CHANGE"

Justice Michael Kirby AC CMG

President of the Court of Appeal of New South Wales*

THE MALPRACTICE "EXPLOSION"

It is nearly a decade since I delivered the Arthur Mills Oration for the Royal Australasian College of Physicians in Adelaide. It was a great occasion. Everyone was dressed in their ceremonial robes. Newly inaugurated as Chancellor of Macquarie University, I came along in gold and black brocade.

However, my words were not golden to the collected audience. The topic assigned to me was "Negligence and the Physician".[1] I traced the so-called "malpractice explosion" in the United States. I explored the causes. I suggested the reasons why Australia had not, to that time, faced a challenge of the same magnitude. But I then reached the critical point in my address. I referred to the necessity to look on malpractice suits, in part at least, for the task of loss distribution which they perform. There are alternative models for such loss distribution, as I shall mention. But many, if not most, claims against medical

practitioners, hospitals and other healthcare workers for negligence are brought by patients who have suffered damage and loss in the course of healthcare treatment. In Australia, if the law cannot provide redress for them, they are cast on their own resources, the resources of their families or friends or the social security system. In many cases a mistake has occurred. The question then is whether that mistake, judged by standards of reasonable care, was negligent. Only if it is, will the patient recover damages.

Mistakes are bound to happen in any activity of human life. They certainly occur in the law. In fact, as an appellate judge, my own life is dedicated to correcting mistakes where these are shown to have occurred in the judgment under appeal. Mistakes also occur in the forensic efforts of barristers and in the work of solicitors and their clerks[2]. But mistakes in the course of healthcare services tend to affect people most intimately in their lives, their bodies and their psychological well-being.

Negligence actions are not trials of morality. Judges (and where they survive, juries) do not sit to evaluate moral blame. Inevitably, the concept of fault will sometimes pose moral questions: such as what ought to have been done or not done. But because mistakes are inevitable, and made the more so by the complexities of modern medical and technological developments, the practical issue usually becomes this: Who is to bear the costs of the mistakes? Are they to fall on the patient who has entered the healthcare system in the expectation of the highest standards? Or are they to fall on the community through a system of no-fault compensation or, for want of anything better, through the payment of an

invalid pension or other social security benefit? Or is the cost of the mistake to be spread amongst other patients, who like the unfortunate victim, have entered the healthcare system full of optimism and confidence?

Most medical practitioners and healthcare workers are, directly or indirectly, covered for their negligence by policies of insurance. Medical practitioners are usually provided with the very best of defence by a system of mutual insurance. So the burden does not fall (for the most part) on the practitioner himself or herself. It falls upon an insurance fund. It is true that the medical practitioner pays premiums to establish and maintain that fund. As the fund is depleted by claims which are paid, the premiums must increase to replenish it. But it is not usually the practitioner himself or herself, ultimately, who foots this bill. It is the consumer. Inevitably, the bill is passed on to the consumer in the form of medical fees. In this way, the patients themselves contribute, indirectly, to a fund which is there if they can establish liability when things go wrong. This is what judges and those who write the books on tort liability call loss distribution.

The principles of civil recovery are quite different from those which govern professional standards and professional discipline. Their object is usually to provide financial redress. But it is also, indirectly, to stimulate reform and change, the adoption of higher standards and the promotion of vigilance and excellence of care. This second purpose is only partly effective in a world of general, if not universal, insurance. If the motor car driver had actually to fork into his or her pocket to pay for the losses

occasioned by negligent driving, I imagine that there might be a marginal increase in care on the part of that driver. But the risk of loss to ordinary citizens is so great that the scheme of compulsory insurance of motor vehicles, in the case of personal injury occasioned by negligent driving, has been introduced by Parliament.[3] There is now a proposal to introduce similar compulsion to cover motor vehicle property damage insurance. That idea is much to be applauded.

The impact of schemes of compulsory, statutory insurance upon our very notions of what is negligence was referred to by me in a judgment of the Court of Appeal delivered last week.[4] In words which are not irrelevant to the context of medical negligence, I said:

> "There seems little point in denying that the advent of compulsory third party motor vehicle insurance has profoundly affected the approach of the courts to the content which has been given over the past fifty years to the tort of negligence and to the expectations of care on the part of drivers of motor vehicles and others. For example, were drivers or owners of motor vehicles not universally insured, there would be little doubt that a much more rigorous approach would have been taken by the courts to the standard of care by which the conduct of motorists in particular circumstances was judged. The law might say that the existence of insurance is irrelevant. So it is as a matter of strict logic. The insurer merely indemnifies the insured for the legal wrong established on the part of the insured. But can there be any serious doubt that the existence of compulsory statutory insurance for motor vehicle owners and drivers has affected the definition and statement of a standard of care which the courts have imposed upon drivers? I think not."

In an earlier decision I made the same point in relation to the shift, over the past fifty years, in the definition of negligence as it affects other tortfeasors, such as the occupiers of land or careless employers[5]. The increasingly

stringent standards laid down by the courts in Australia reflect community expectations. But they also reflect the reality that behind many of the persons who are in a position to cause harm to others, or make mistakes which occasion great losses to others, there frequently stand insurance companies whose business it is to spread and share the risks. This is the reality, and the beneficial reality, of the operation of the law of negligence in modern Australian society. It is important, when tackling the so-called medical malpractice explosion to keep this reality steadily in mind.

There are, of course, frauds, cheats and manipulators of the damages system. They need to be identified and weeded out. But, for the most part, claimants are people who have suffered harm of one kind or other. In earlier times, they might simply have accepted their losses out of a sense of resignation, an appreciation that mistakes are bound to happen, a respect for the healthcare workers whom they knew on a personal basis or a feeling of inability to take on a powerful profession, notoriously well organised to rebuff claims. All of this is changing in Australia. And the point I want to make is that the changes are not all bad.

The increase in medical malpractice cases is not self-evidently an evil to be stopped or diminished. The provision of a form of mutual insurance, indirectly procured through the healthcare provider for all patients, is a sensible means of spreading the risks of the inevitable mistakes that will occur. Most patients confronted with the problem expressed in this way would happily make that contribution to healthcare fees which is attributable to

insurance, rather than face the awful prospect that, if things go wrong for them, they are on their own.

I made all of these points in Adelaide. There was an almost stoney silence after my address. Yet there must be a streak of narcissism in the professions of health providers. From time to time I have been invited to return to make the same point at medico-legal meetings and like occasions.

I was even invited in 1985 to launch a book which marked the centenary of the Medical Defence Union. The book **"Mishap or Malpractice"** by Clifford Hawkins examined the "growth industry" in medical malpractice litigation in the United States. It gave voice to the fear that a similar development would occur in Britain and Australia. Once again, I ventured the opinion that there was a place for medical malpractice actions and that many healthcare providers fully understood this. I said:[6]

> "This book, with its vivid photograph of the collection of odds and ends left inside surgical patients shows (if proof were necessary) that mistakes do happen. The miscellaneous array of instruments and other objects ... is truly remarkable. It rivals the objects left in the Sydney Opera House which, a recent report suggested, included a pair of false teeth and two pork chops! ... If doctors could only look on malpractice as lawyers do, it would seem less unattractive. To the doctor, it is a public denunciation of his professional efforts. To the lawyer it is generally nothing more than a means of spreading the risk and ensuring that people who suffer get adequate compensation. ... If it is seen as a means of spreading the risk amongst all patients lest, by the grace of God, they might have been the victim of momentary carelessness, the malpractice ogre becomes a perfectly useful instrument of loss distribution."

The panic headline of this congress ("Avoid the Litigation Nightmare") and the promise to reveal "All you need to know

about medical negligence" exhibits a similar sense of urgency and even alarm. Whilst that is an understandable technique to attract paying participants, I conceive my function to be that of repeating my theme. It challenges the assumption that an increase in medical malpractice in Australia would be a wholly bad thing and that we must struggle, at all costs, to avoid the horrors of the American "nightmare". Whilst there is much that has occurred in the United States (and Canada) that we should learn from, a complacent belief that the "good old days" were better and that the North Americans have nothing to offer us in Australia simply does not bear close scrutiny.

CHANGING LITIGATION IN A CHANGING SOCIETY

General statements condemning particular court decisions in negligence cases or portraying the ogre of medical negligence as a real threat in the Australian context provide a less satisfactory basis for developing a rational approach to the problem presented to society by healthcare negligence than an empirical examination of the actual figures and a scrutiny of the operation of litigation as a tool for just loss distribution and as a stimulus for improved healthcare services.

A useful comparative examination of the so-called "medical malpractice crisis" was recently published in **Law and Contemporary Problems** , originating in North Carolina. The authors, Professor Dewees and his colleagues, set out to examine Canadian malpractice experience in the past decade and to compare its trends with those in the United States, the United Kingdom and Australia.[7] This comparative approach allowed the authors to suggest factors which have

differentially contributed to the growth of claims frequency and severity in the countries involved. As a result of their study the authors came to the conclusion that some popular conceptions about medical malpractice needed to be rejected. They looked at the problem in the context of changes in the professional environment, in the social environment and in the legal environment. Whilst there had been much study of the suggested problems in the legal environment, those in the healthcare professional community and in society had attracted insufficient attention.

The authors found that, from the period of minimal malpractice litigation in the 1940s and 1950s (the so-called "good old days"), claims began to rise in the 1960s. They increased significantly, indeed by a factor of 3, between 1971 and 1990. There was a compound annual growth rate in Canada of nearly 5% but even then, in absolute terms, the average frequency of claims filed against medical practitioners in the United States was about five times greater than in Canada. Interestingly, the United States rate began to fall sharply in 1988. The absolute level of average payments in Canada amounted to about two-thirds of those in the United States during the 1980s. The United Kingdom data on the frequency and severity of malpractice claims reflected increases comparable to those experienced in Canada. Indeed, on a population basis, the United Kingdom frequency rates appeared to be significantly higher than Canadian rates. So far as the Australian medical malpractice experience was concerned, it was reported that the number of incidents notified to the main medical defence unions had actually doubled between 1984 and 1986.[8]

Necessarily, insurance premiums rose to meet this increase in claims. In the United States there was an annual rate of increase of more than 20% in nominal terms between 1976 and 1987. Adjusted for inflation, the real growth rate was closer to 7% and this was below the Canadian growth rate in insurance premiums. Over the decade 1978 to 1988, the United Kingdom subscription rates increased by almost 40% a year in nominal terms. In summary, then, the experience in Canada, the United States, Britain and Australia was that of considerable growth in the frequency and severity of malpractice claims in the 1970s and 1980s. Both factors have grown in spurts. But the long-term average was reported at in excess of 6% a year.

The authors identify five trends which they suggest have affected the frequency and severity of malpractice claims in the healthcare professional environment. The first of these is increases or shifts in the utilisation of healthcare services. Obviously the more people who use services, and the more services that are available, the greater risks of error of commission and omission. Where laboratory tests and diagnostic imaging are available, failure to pursue them may give rise to a risk of being sued.

Another factor of relevance in the professional environment was found to be the quality of healthcare professionals and their institutions. Differences exist because of medical training, age, experience and even the location of the practice. Whilst high quality should lead to fewer adverse outcomes, specialisation and high quality provision may attract the most difficult cases. The research has found that foreign-trained physicians experience a

modestly greater likelihood of being sued in Canada than domestically trained and that their losses are somewhat greater. But they failed to find any association between frequency of claims and the age of the physician.

The third variable in the professional environment was the mode of practice and the degree of specialisation. The research in Canada found that the "conspiracy of silence" which often, in the past, led physicians to refuse to testify for malpractice plaintiffs concerning the appropriateness of the defendant's conduct had been substantially eroded in recent decades. This had greatly increased the ability of plaintiffs to pursue meritorious cases. Furthermore, nurses are now much more willing than in the past to testify as to events which take place in hospitals affecting other healthcare workers.

The fourth feature of the professional environment was recorded as the complexity of medical procedures. The rapid advance of technological innovation may have reduced health risks for society at large. But the possibility of error by momentary acts of inadvertence has sharply increased the risk of a negligence action. For example, before the invention of dialysis machines patients frequently died from kidney failure. Now, their risk of death is sharply reduced. But error of initial diagnosis and inadvertence in the application of the new technology may increase the risk of litigation. Furthermore, there is an increased variety of tests and treatments. According to the Canadian survey, most cases of malpractice arose not from general incompetence of the healthcare provider but from a momentary lapse by a wholly competent practitioner.[9]

The fifth consideration was professional discipline. The research has found precious little data on the interface between the tort system and disciplinary action. But discipline for negligence or incompetence is comparatively low in Canada, as here. It would certainly not be safe to rely on the discipline system alone to reinforce standards of care. Damages, even if not ultimately coming out of the doctor's own purse, has some effect in that direction. It must be conceded, however, that it is not a very cost effective or efficient system to achieve this goal, given the high concentration of the trial on the predicament of the plaintiff. It cannot stand alone.[10]

The authors of the Canadian survey turn to the features in the social environment which have given an impetus to medical malpractice suits. Most of these features which exist in Canada also exist in Australia. The first in the increase in the general propensity to litigate. Whilst contingency fees and other cost stimuli which exist in the United States do not exist in Australia, Canada or Britain, legal aid and specialised practitioners willing to postpone fees have encouraged plaintiffs to trial who otherwise might not have taken on the Medical Defence Union. Higher standards of education and expectation in the community reinforce these developments. Changing attitudes to the medical profession and towards pursuing healthcare workers where things go wrong are also cited as relevant factors. The familiarity of most people with a plaintiff who has recovered workers' compensation or motor vehicle damages has spread in the community a greater familiarity with courts and their rôle in loss distribution.

Finally, the authors examined the legal environment. This included a scrutiny of the liability rules. Specific attention was given to the necessity for informed consent. In Canada a stringent rule was laid down in **Reibl v Hughes**.[11] In Australia, an even more stringent test has been adopted in this respect. It is not whether a hypothetical "reasonable" patient or even a hybrid "reasonable patient in a position of the particular patient" would have accepted or rejected the treatment if fully and properly informed of the risks involved in it. The question to be asked in Australia is whether the particular patient in question, fully informed, would have accepted the risks.[12] Perhaps in the past there was just too much difference by the legal profession - including the judiciary - to the practices of the healthcare professional - especially medicare practitioners.[13]

Likewise the extension of vicarious liability in hospitals and other healthcare institutions has provided a means to permit injured plaintiffs to bring home liability to a defendant able to pay. The extension of vicarious liability was stretched in **Ellis v Wallsend District Hospital**[14] but the majority there drew the line and declined to extend it to a private hospital in the facts of that case. Special leave to appeal from my Court's decision was refused by the High Court of Australia.

Changes in legal costs were also seen as a factor in the Canadian debate. The growth of the number of legal practitioners specialising in malpractice suits could offer litigation at cheaper rates. Contingency fees and postponement of fees have also been considerations in North

America. In Australia, without contingent fees, many plaintiffs are still at a disadvantage in taking on litigation against a healthcare provider. The latter is usually well and expertly advised and indemnified by a mutual insurer which fights the cases with greater vigour than most.

One of the most interesting discoveries of the Canadian survey related to defensive medicine. It is often said that a negative consequence of a growth in malpractice litigation is that it forces healthcare providers into defensive medicine against the possibility that they may otherwise be sued for negligence. This assertion appears to have some truth to it. Doubtless, the consideration plays some part in healthcare decisions in Australia today.

However, the Canadian investigators reported a 1984 AMA survey which asked United States physicians to report changes in their practice patterns in response to the threat of civil liability. Forty-one percent reported ordering extra tests; 36% spending more time with patients; 57% keeping more detailed records; 45% referred more cases to specialists. The authors commented:[15]

> "While all these responses may be termed defensive medicine, they do not necessarily fail to benefit patients as is often implied; indeed they may often be beneficial to patients. Some activities may actually reduce the patient's exposure to be iatrogenic injury, such as procedures that clarify more precisely the patient's illness and appropriate courses of treatment, such as those associated with laboratory tests and diagnostic radiology. Defensive medicine, defined more narrowly however, might be taken to refer only to procedures induced by the threat of liability which have little or no therapeutic value. No studies to date of defensive medicine have attempted to segregate out such procedures. In our study, we examined increases in radiological services and laboratory tests, but do not attempt to quantify the purely defensive

> elements in these procedures. To test whether these procedures were important in explaining the trends in malpractice liability, we included the total cost of these procedures per physician, adjusted for increases in fee-benefit schedule in each of the regression equations. The coefficient of this cost variable ... fails to reduce the frequency of claims filed, the proportion of claims to succeed and the average magnitude of an award."

In other words, the authors found no evidence that defensive medicine, narrowly defined, significantly affected liability in malpractice litigation. Some of the consequences of the "malpractice explosion" certainly appeared to be to the benefit of patients. Another benefit may be the lessons that have been learned in the need for greater care, patience and accuracy in communicating with patients. Many patients have asserted that their resort to a malpractice suit arose because it was only through the processes of litigation that they could secure a real explanation from the healthcare provider of what actually occurred and what went wrong.[16]

AVENUES OF REFORM

The purpose of this paper has been to redress the suggestion that we in Australia, including in the courts, should fight off the increase in healthcare malpractice litigation which has occurred in North America. In my view, a more discriminating response should be adopted. It should take as its guideposts the encouragement of the system of law and practice which promotes the most just and efficient procedure for loss distribution for patients who suffer as a consequence of healthcare mistakes and which stimulates constantly improving standards for the healthcare professional. These are objectives which are to the benefit

of that profession and also to the benefit of the patients and community.

In the United States, the Bush Administration, under the pressure of the AMA, professional organisations and insurers has sought to impose a $250,000 cap on non-economic damages for pain and suffering in such suits. It has endeavoured to do this by limiting the provision of Federal funds to physicians and hospitals in States of the United States of America which fail to enact the Federal reforms.[17] This has led to widespread criticism, stimulated by the evidence of a drop in successful malpractice claims against medical practitioners since 1985. Furthermore, since that time, jury awards have been growing at a much slower pace in the United States. It is often forgotten that the need for malpractice litigation in the United States may be greater than in countries such as Australia, England and even Canada. The existence of National Health Schemes in the latter countries obviates, to some extent, the urgency of litigating for healthcare mistakes in the United States, simply because for the healthcare consequences there is often no other fund to which the injured plaintiff can look.

The other reforms which have been adopted for healthcare accidents involve variations on the theme of no fault. The New Zealand **Accident Compensation Act** 1972 originally made no reference to "medical misadventure". That term was introduced into the Act by an amendment in 1974. It has been criticised as too restrictive.[18] The increase in benefits has not kept pace with inflation. On the other hand, neither the victim nor the healthcare provider has to

face an adversarial court process and the search for forensic expert medical witnesses is immediately called off. The cost factor in delivering redress is obviously reduced significantly. The idea of the scheme was to give the victims, rather than the lawyers, the benefit of the costs. Needless to say, the proposal for a similar scheme in Australia in 1975 met with resolute opposition from the Australian legal profession.

In Sweden, a no-fault compensation scheme known as the Patient Insurance Scheme was introduced in 1974. It is not statutory but voluntary, being organised by local authorities which have accepted liability for certain types of injuries sustained in connection with health and medical care. Insurance is arranged through private insurers at a cost of approximately $3 per person per annum. A civil right of action exists but is now much less frequently used.[19]

No fault schemes have also been introduced in a number of the States of the United States. In a sense, the proposed fund for compensating the patients of hospitals who received HIV through blood transfusion in the early 1980s in Australia can be seen as a form of no-fault scheme, although it can also be criticised, as discriminatory, on other grounds.

CONCLUSIONS

I have now reached my conclusion. The factors for the era of change in Australia are largely, I believe, those identified by the Canadian investigation. They apply as much in this country as they do in Canada. The trend towards greater malpractice litigation must be understood by reference to those factors. Often, litigation represents the only effective means that the patient who has suffered has to

redress the wrong and to secure the distribution of his or her loss through the larger healthcare system.

The greater complexity of medical technology today increases the complexity of the factual issues which must be determined, often on the basis of conflicting expert opinions strongly held and strongly expressed.

A study of researchers at Harvard University in New York hospitals was published early in 1990 in the **New England Journal of Medicine**. The study found that only about 1 in 8 patients injured by medical negligence filed a malpractice claim. Only about 1 in 16 of these received compensation from a court or through settlement. The majority of law suits were brought by patients whose records carried no evidence or complaint of negligence. Whilst the health professions may draw from this an inference of false claims, the better inference will often be a lack of communication and trust in the relationship such as would allow or encourage complaint or expression of concern. One possibility of the decline of claims in the United States has been the effectiveness of risk prevention programmes developed by healthcare providers and stimulated by physician-owned insurance companies.[20]

It is inevitable that lawyers and health providers will look at this issue from differing perspective, deriving from their different social functions. The value of a conference such as this is that it should help participants to understand better the perspective of others. It should throw new light on the diamond which will reveal its different facets. The diamond is the common goal of the legal and healthcare professions: to serve the community according to

high standards. We must live together. And we should not yearn for a return of the good old days. They were often days of wrongs unredressed. Instead, we should respond in a modern and effective manner to the problems and challenges of today.

ENDNOTES

* Personal Views.

1. M D Kirby "Negligence and the Physician", Arthur E Mills Oration, the Royal Australasian College of Physicians, Adelaide, 9 May 1984.
2. A recent example is **Waimond Pty Limited v Byrne** (1989) 18 NSWLR 642 (CA).
3. **Motor Vehicles (Third Party Insurance) Act** 1942 (NSW).
4. **Mitchell v Government Insurance Office of New South Wales**, Court of Appeal (NSW), unreported, 1 April 1992.
5. **Johnson v Johnson**, Court of Appeal (NSW), unreported, 10 September 1991; (1991) NSWJB 74.
6. M D Kirby, launch of "**Mishap or Malpractice**" by Clifford Hawkins, Sydney, 18 November 1985.
7. D N Dewees, M J Trebilcock and P C Coyte, "The Medical Malpractice Crisis: A Comparative Empirical Perspective", 54 **Law and Contemp Prob** 217 (1991). An earlier version of the article was published in (1990) 17 **MUL Rev** 539 and 324 **New Eng J Med** 89 (1991).
8. P M Danzon, "The 'Crisis' in Medical Malpractice: A

Comparison of Trends in the United States, Canada, the United Kingdom and Australia" (1990) 18 **L Med & Health Care** 48.

9. Dewees et al, 234.

10. See J M Kuder, "How much may safety cost?" (1991) 1 **Iatrogenics** 33. Cf **Cekan v Haines** (1990) 21 NSWLR 296, 306 (CA). See also J Fleming "The Economic Factor in Negligence" (1992) 108 **LQR** 9.

11. [1980] 2 SCR 880; (1980) 114 DLR (3d) 1. See also G Robertson, "Informed Consent Ten Years Later: The Impact of **Reibl v Hughes** " (1991) 70 **Can Bar Rev** 425.

12. See J Murphy, "Grey Areas and Green Lights: Judicial Activism in the Rights of Doctors" (1991) 42 **N Ireland L Rev** 260. The author is very critical of **Bolam v Friern Hospital Management Committee** [1957] 1 WLR 582; [1957] 2 All ER 118 (QB). He says that it provided a high level of immunity to tort.

13. (1989) 17 NSWLR 553 (CA). See also **Albrighton v Royal Prince Alfred Hospital** [1980] 2 NSWLR 542 (CA); cf **Kondis v State Transport Authority** (1984) 154 CLR 672. Note K Nicholson, Review of D Giesen "International Medical Malpractice Law" in (1990) 12 **Adel L Rev** 500, 503. Not everyone agrees with the views expressed here. See eg D I Cassidy, "Malpractice - Medical Negligence in Australia" (1992) 66 **ALJ** 67, 86.

14. Id.

15. Dewees et al, above n 7, 230.

16. "Doctors' Poor Communication May Cause Malpractice

Suits" in **Washington Post Health Report**, 17 March 1992, 5.

17. S Glazer, "Whatever happened to the Malpractice Insurance Crisis?", **Washington Post Health Report**, 9 July 1991, 10ff.

18. E Murphy, "No Fault Compensation for Medical Negligence" (1989) 7 **Irish Law Times** 216.

19. Murphy, 217f.

20. Glazer n 17 above.