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OCKHAM'S RAZOR

THE MEDICAL MALPRACTICE MYTH?*

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The Hon Justice Michael Kirby AC CMG

How many times have you heard doctors complain about the medical malpractice explosion? The other day I read of a United States doctor who felt he had to retire because he was terrified of being sued and taken to the cleaners by the lawyers. I want to spend the next few minutes exploring this problem. My ultimate thesis is that medical malpractice is not the bogey it is sometimes presented to be by doctors. In fact, the facility to sue the doctor - or other healthcare worker - for negligence may be the only way by which a person who suffers as a consequence of mistake can recover damages, instead of being consigned to the genteel poverty of an invalid pension.

Mistakes inevitably happen in medical and surgical practice, as in any professional activity. The collection of the odds and ends left inside surgical patients shows what a variety of mistakes can

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* Adapted from a paper delivered to the 1992 National Medico-Legal Conference, Sydney, 6 April 1992 *sub nom* "An Era of Change". See that paper and references there cited and extracted for a fuller treatment of the theme.

sometimes happen. The miscellaneous array of instruments and other objects found inside patients rivals the objects which turn up in the Sydney Opera House after a performance. A recent report showed that these have included a pair of false teeth and two pork chops! Surgeons occasionally do little better.

From a period of minimal malpractice litigation in the 1940s and 1950s (the so-called "good old days"), claims against doctors began to rise in the 1960s. They increased significantly in North America, 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 medical 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 is concerned, it has been reported that the number of incidents notified to the main medical defence unions had actually doubled between 1984 and 1986. So it is on the rise.

Necessarily, insurance premiums have had to rise to meet these increases 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%. This was below the Canadian growth rate in insurance premiums. Over the decade 1978 to 1988, the United Kingdom subscription rates by doctors for negligence insurance increased by almost 40% a year in nominal

terms.

In summary, then, the experience in Canada, the United States, Britain and Australia has been 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 is reported at in excess of a steady 6% a year. Of course, some lawyers, facing hard times, look on this as a new growth area of legal practice. Many doctors are suspicious and fearful of this trend.

A number of causes 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 by a doctor to pursue them may give rise to a risk of being sued if things go wrong.

Another relevant factor in the professional environment is found to be the quality of healthcare professionals and their institutions for handling public complaints.

The third variable in the professional environment is the mode of practice and the degree of specialisation. Research in Canada has 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 has been substantially eroded in recent decades. The same is true in this country where, if necessary, the lawyers in Sydney will simply fly up a Melbourne doctor to testify against a co-professional.

The fourth feature of the professional environment is the complexity of medical procedures. Error of initial diagnosis

and inadvertence in the application of the new technology may increase the risk of litigation.

The social environment has also given an impetus to medical malpractice suits. There is the increase in the general propensity to litigate. Whilst contingency fees and other cost stimuli which exist in the United States do not exist, as such, in Australia, Canada or Britain, legal aid and specialised practitioners willing to postpone fees have encouraged plaintiffs to go to trial who otherwise might not have taken on the doctor and the Medical Defence Union. Higher standards of education and expectations 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 to compensate people who have suffered from the want of care on the part of another.

Some of the consequences of the "malpractice explosion" in North America certainly appear to be to the benefit of patients in the more careful attention to treatment and the consideration of the best attention that is available. This is what a review of the North American experience found.

A 1984 American Medical Association survey 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 of the survey commented:

"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 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.

The authors found no increase in defensive medicine, narrowly defined, ie, as steps having little or no therapeutic value to the patient.

In the United States, the Bush Administration, under the pressure of the American Medical Association, professional organisations and insurers, has sought to impose a $250,000 cap on non-economic damages for pain and suffering in such malpractice 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". 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 urgent need for litigating for healthcare mistakes which exists in the United States, simply because, for the healthcare consequences, there is often no other fund to which the injured patient can look.

Sometimes, it is the very concern to avoid potential civil liability which will teach doctors and others 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.

We should not get carried away with the enormity of malpractice litigation. A study in New York hospitals by researchers at Harvard University was published early in 1990. It 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 of a 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, a patient's 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 in a direct response to malpractice suits.

It is inevitable that lawyers and health providers will look at this issue from differing perspective, deriving from their different social functions. Doctors will look at medical malpractice as a distracting ogre, fuelled by avaricious lawyers using patients unwilling to accept the unavoidable risks of healthcare. Lawyers will look on such cases as a method of loss distribution for the victims of mistakes - so that, by fees and insurance premiums, we all share the risks when things go wrong.

The truth, as usual, probably lies somewhere in between.