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The Courts and Medical Practice –
Teaching Granny to Suck Eggs?

Address by

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Introduction

It is not uncommon for some doctors and others concerned with public health policy to protest loudly and vehemently that lawyers and judges without medical training or experience have set themselves up as the ultimate arbiters of appropriate standards of medical practice and that this has resulted in:

- a flood of claims for medical negligence;
- astronomical increases in medical indemnity insurance premiums;
- the departure of practitioners from some fields of practice; and
- the encouragement of defensive medicine practices.

As recently as 30 March 2010, after the Supreme Court of New South Wales upheld a claim relying on evidence for a number of practitioners to the effect the treatment the patient had received was below the standard of care that would be expected from a competent practitioner, it was reported that the President of the Australian Medical Association stated that decisions like that would encourage the practice of defensive medicine. Dr Pesce asserted that doctors were caught between a rock and a hard place. He asserted that if a bank of tests was ordered, practitioners could be investigated for over-servicing and reprimanded or fined. On the other hand, if tests were not ordered, practitioners were exposed to liability in negligence.

There is often a gap between perception and reality in public debate concerning contestable issues of public policy. Criminal justice is a perennial topic of public controversy. As I have pointed out more than once, most public debate on that topic proceeds on the assumption that

crime is increasing and the sentences by the courts are decreasing, whereas in fact neither of those things is true.

In this paper, I will address the question of whether there is a similar gap between perception and reality in the debate concerning the relationship between the courts and medical practitioners.

Have the Judges taken over Medical Practice?

It is appropriate to start by assessing whether the courts have in fact arrogantly usurped the role of the medical profession in setting appropriate standards of medical practice. That is because the perceived flood of claims and sky rocketing insurance premiums are often attributed to this takeover of control by the courts, following the decision of the High Court in *Rogers v Whitaker* (1992) 175 CLR 479. In that case, the High Court rejected the approach taken in England, generally known as the Bolam principle, after the case of *Bolam v Friern Hospital Management Committee* (1957) 1 WLR 583, in which it was enunciated. Essentially that principle means that a doctor will not be held to be negligent if he or she acts in accordance with a practice accepted at that time as proper by a responsible body of medical opinion.

It must, however, be acknowledged that *Bolam* was not a case which casts a favourable light upon either the medical profession or the courts. Mr Bolam was a manic depressive who was (voluntarily) given electro-convulsive therapy. One of the known dangers associated with the use of that therapy was the occurrence of seizures which would cause fractures of the patient's bones. It was also known that those dangers could be reduced by the administration of relaxant drugs and/or the application of physical restraints. Mr Bolam was not warned of the dangers associated

with the therapy at the time his consent was sought, nor was he offered relaxant drugs or physical restraints in order to reduce the risks to which he was exposed. During the course of his therapy he suffered very severe fractures of the pelvis. He lost his case on the basis of a direction to the jury to the effect that if they found that the failure to warn of risk, and the failure to offer to reduce the risks was in accordance with recognised medical practice, Mr Bolam's claim must be dismissed.

When a case like *Bolam* is considered, it should not come as a great surprise that courts are disinclined to abdicate entirely the responsibility of deciding whether a doctor has been negligent. It is also important to look carefully at precisely what was decided in *Rogers v Whitaker*, because of the tendency to significantly overstate the impact and effect of that decision. An aspect of *Rogers v Whitaker* that is often overlooked in commentary upon its effect is that it was not a case concerned with medical diagnosis or treatment. Rather, it was a case entirely concerned with the duty of a doctor to provide a patient with the information necessary to make an informed decision about whether or not to consent to a medical procedure.

As I observed in the decision last year in *Brightwater Health Care Inc v Rossiter* [2009] WASC 229, it is well established that the administration of medical treatment without consent is unlawful. That is because the law has traditionally recognised the autonomy of the individual and the right of the individual to determine his or her destiny even if, as in the case of Mr Rossiter, that destiny is an early death. Obviously, in order to be meaningful, a consent should be informed. In the relationship between doctor and patient, it is equally obvious that it is usually the doctor who has the information necessary to make an informed decision. It is

therefore hardly surprising that the High Court held that a doctor has a duty to provide that information to the patient prior to seeking the patient's consent. And where a medical procedure is attended with a risk which is not immaterial or insignificant, it is equally obvious that this is information which a patient should have in order to make an informed assessment of whether to undertake the procedure.

Put another way, *Rogers v Whitaker* was essentially concerned with patient autonomy rather than standards of practice. This point was expressly made by five members of the court who observed (at 489):

> "There is a fundamental difference between, on the one hand, diagnosis and treatment and, on the other hand, the provision of advice or information to a patient. In diagnosis and treatment, the patient's contribution is limited to the narration of symptoms and relevant history; the medical practitioner provides diagnosis and treatment according to his or her level of skill. However, except in cases of emergency or necessity, all medical treatment is preceded by the patient's choice to undergo it. …
>
> Whether a medical practitioner carries out a particular form of treatment in accordance with the appropriate standard of care is a question in the resolution of which responsible professional opinion will have an influential, often a decisive role to play - whether the patient has been given all the relevant information to choose between undergoing and not undergoing the treatment is a question of a different order …"

As Gleeson CJ observed of *Rogers v Whitaker* in the subsequent decision in *Rosenberg v Percival* (2001) 205 CLR 434, at 439 [7]:

> "… the relevance of professional practice and opinion was not denied; what was denied was its conclusiveness. In many cases, professional practice and opinion will be the primary, and in some cases it may be the only, basis upon which a court may reasonably act."

It is true that in *Naxakis v Western General Hospital* (1999) 197 CLR 269, two members of the High Court (Justices Gaudron and McHugh) expressed the view that the earlier rejection of the *Bolam* principle in *Rogers v Whitaker* extended also to medical diagnosis and treatment. It is not at all clear that the other members of the court shared that view, but in any event, the subsequent observation by Gleeson CJ in *Rosenberg* makes clear that in the area of diagnosis and treatment, there will be little or no practical scope for the court to form its own view as to standards of practice or treatment, because Judges lack the training and experience to make determinations of that kind. However, failure to warn cases are quite different in nature. Judges are quite able to assess whether a risk, which is established by the medical evidence to exist, is of a kind that should have been notified to the patient in order that the patient could make an informed decision about whether to undergo treatment. That is not an assessment which requires medical training or experience.

The courts have also resisted attempts to extend the principle in *Rogers v Whitaker* beyond cases of failure to warn. In the recent case of *Hammond v Heath* (2010) WASCA 6, the patient contended that his surgeon owed him a duty to warn of complications that might arise in the course of surgery so that his views could be ascertained as to the course that should

be followed when those complications arose. The Court of Appeal of this State (of which I was a member) rejected that proposition, drawing a clear distinction between the duty to inform a patient of risks so that the patient can make an informed decision about whether to undertake the procedure, and the proposition inherent in the patient's submission that the surgeon was, in effect, subject to direction by the patient as to the steps to be taken if and when a complication arose in the course of surgery. (Application has been made for special leave to appeal to the High Court from this decision.)

Civil Liability Legislation

The significance of the approach taken at common law by the courts in this area is diminished by legislation which has been enacted in virtually all jurisdictions specifying the standards of care to be applied to medical practitioners. For example, in Western Australia, s 5PB of the *Civil Liability Act 2002* provides that the relevant standard of medical care is whether an act or omission was:

> "in accordance with a practice that, at the time of the act or omission, is widely accepted by the health professional's peers as competent professional practice."

The only exceptions to that standard are if the practice is so unreasonable that no reasonable health professional could have adopted it (reflecting a modification to the *Bolam* principle adopted by the courts in England), and in relation to informing the person of a risk of injury or death (adopting the line taken by the High Court in *Rogers v Whitaker*). So, while the legislation preserves the court's capacity to determine issues relating to patient autonomy in the context of claims of a failure to warn,

the importance of medical opinion as to appropriate standards of practice, already acknowledged by the High Court, is now enshrined in statute. In Western Australia, that part of the legislation came into force on 9 November 2004, and applies to all conduct occurring after that date. It follows that by 9 November this year, all cases brought under the preceding legal regime will have to have been commenced or they will be barred by the *Limitation Act*, except for those cases where time can be extended by reason of infancy, etc.

So, when consideration is given to what the courts actually do, and the principles which they have adopted, and the statutory provisions which have been in force in this State since 2004, it is a gross overstatement to assert that courts and lawyers have usurped the power of the medical profession to set appropriate standards of medical practice.

If the decision in *Rogers v Whitaker* had effected such a radical change in the liability of exposure of Australian doctors as compared to their English counterparts practising under the benefit of the *Bolam* principle, one might expect to have seen higher rates of negligence claims and greater liability exposure in Australia than in England. However, such data as there is on the subject suggests the opposite. In the year 1999-2000, medical malpractice claims against the United Kingdom government totaled £4 billion, which was almost 10% of the overall National Health Service budget. More recently, as at 31 March 2009, the National Health Service Litigation Authority in the UK provided for potential medical negligence liabilities of £13.4 billion. NHS revenue in 2008/09 was £91 billion. So the estimate of claims liability was greater than 10% of the annual cost of the system.

While there is quite reasonable concern over the amount of legal costs incurred processing medical liability claims in Australia, in England those costs are horrendous. For example, in 2008/09, 5,635 clinical claims were finalised in the UK, at a cost of about £500 million. Legal costs were about £155 million in relation to those claims – that is, almost one-third of the total amount paid. I will deal later in this paper with the data relating to claims in Australia. While the data is not strictly comparable, it suggests that the claims experience of Australian doctors, and their cost, is somewhat less than their British counterparts.

The Flood of Claims

It is commonly asserted that both the courts and the hospitals are awash with a flood of medical negligence claims. As we will see from the data, it is certainly true that there was an increase in the number of claims in the latter part of the last century and the early years of this century.

However, it is appropriate to put those claims in their context, because surveys have shown that both in the United States and Australia, only a very small percentage of the patients injured, or the relatives of patients who have died, as a result of apparent negligence ever make a claim. Surveys suggest that perhaps understandably given the inherently risky nature of medical treatment, patients suffer adverse consequences as a result of erroneous decisions quite frequently. Some of the estimates are staggering. For example, in 1999, the head of the clinical risk unit at University College, London, Dr Charles Vincent, was reported as estimating that up to 40,000 patients a year in Britain died as a result of medical error. Around the same time, the Kellogg Foundation in the

United States concluded that 70% of the errors and 155,000 deaths in that country resulting from medical misfeasance were avoidable. An Australian study cited in "*Errors, Medicine and the Law*" by Merry & Smith suggests that about 16% of patients admitted to Australian hospitals suffered adverse events, over half of which were said to be "highly preventable". A more recent paper by Corbett recorded that about 10% of all hospital admissions to acute care hospitals give rise to preventable adverse events. Against those figures, the numbers of medical negligence claims actually pursued are surprisingly low.

Perhaps claimants are discouraged by their low rate of success. In Australia, only about 20% of those required to take their claims to trial succeed in court – see Cashman (2002) 25(3) *UNS Law Journal*. In the United States, Baker (*The Medical Malpractice Myth* (2005) – University of Chicago Press) has pointed out that malpractice plaintiffs in that country are relatively less successful than plaintiffs in other kinds of litigation.

In New South Wales, the number of medical negligence claims increased rapidly between 1996 and 2002, particularly in the latter years, probably in anticipation of the introduction of the *Civil Liability Act 2002*. However, since 2002 there has been a general decrease in the number of claims in that State.

In Western Australia, it is difficult to find definitive data on the subject. However, some indication of the extent of litigation can be gleaned from a review of decisions made by the District Court of this State which has

unlimited jurisdiction in respect of claims for personal injury. Analysis of decisions published by that court between 1996 and 2009 shows a little over 50 cases were tried involving claims for medical negligence. Of those, 15 cases were successful, although one was subsequently overturned on appeal, and another is currently subject to appeal. It follows that in this State over the last 15 years, claims have been successfully established in court at the rate of about one per year. The total amount of damages awarded in those cases is approximately $2.5-3 million. Three of the cases which were successful involved the same medical practitioner.

Of course, the cases contested in court are only a portion of the total claims made. Many of the claims made are settled or compromised before proceedings are commenced, or prior to trial, and the figures to which I have just referred relate only to those cases that went to trial. Some indication of the volume of claims in this State is provided by an answer to a Parliamentary question given in 2006. The information given in the answer covered the period between 1 July 1997, when Riskcover, a State insurer, assumed responsibility for claims made against public hospitals or practitioners providing services to public patients in those hospitals. Over the period of about 9 years covered by the answer, 684 claims were made, of which 197 resulted in payments to claimants or families of claimants. The total amount paid was approximately $26 million. This, of course, is not an indication of the total amount of claims made in this State, as claims are obviously made against practitioners who are not insured by Riskcover, but claims made in respect of public hospital care would represent a significant proportion of total claims and provide some indication of total volumes. $26 million

over 9 years is, of course, something less than $3,000,000 per year, which helps to put the so-called "flood of claims" in some perspective.

Another source of reliable data is provided by the medical indemnity report produced by Insurance Statistics Australia Ltd (ISA) using data supplied by its members, who together cover about 80% of the privately indemnified medical practitioners in Australia.

That report shows a time sequence graph of claims per 1,000 practitioners notified to the insurers covered by the report. It shows that claims per practitioner stayed relatively constant for the years between 1995 and 2000, then rose significantly over the next 2 years, and have then fallen every year since then, to levels significantly below levels in the latter part of the last century, albeit with a slight rise in the last year covered by the report.

The report also contains a breakdown of claims frequency per area of practice, and again shows that over most areas of practice, there were significant increases in claims frequency in the latter part of last century, but more recently, significant decreases in frequency. For example, between the year ended June 2005, and the year ended June 2007, claims against anaesthetists decreased by 36%, against general surgeons by 32%, against obstetricians by 40%, and against orthopaedic surgeons by 50%.

The report also shows that the average claim cost per policy followed much the same trend as frequency of claims, increasing significantly

around the turn of the century, but then decreasing to levels about the same as those in the middle of the last decade.

So, while there was undoubtedly an increase in claims in the latter part of the last decade, claim frequencies are now below the levels which existed prior to that increase. Analysis therefore suggests that it would be a gross overstatement to suggest that the courts and the hospitals are each awash in a flood of claims of medical negligence.

Skyrocketing Premiums

The data produced by ISA shows that there was a dramatic increase in medical indemnity premiums in the latter part of the last decade which continued up to and including the year ended June 2002. However, since then, there have been slight decreases in premiums, although not to the same extent as the recorded decreases in claim frequency and costs.

The courts are often blamed for the increases, and as they followed shortly after the decision in *Rogers v Whitaker*, it is suggested that there is a causal relationship between the line taken by the courts in that case, and premium increases.

That proposition is dubious, not least because of the limited impact of the decision in *Rogers v Whitaker*, as I have already explained. A number of commentators have attributed the significant increase in premiums to changes in the way in which medical indemnity insurance has been

written, and in particular, the fact that in past years inadequate provision was made for future claims.

Medical liability insurance is what is called "long tail" insurance. That is because the total liabilities arising from the year in which premiums are collected will not be known for many years. Most jurisdictions have a limitation period of 6 years for the bringing of claims, and most jurisdictions also have provisions which enable infants to bring claims within a period of attaining their majority, so that insurers can be potentially exposed to claims finalised 10 or even 20 or more years after the year in which cover is provided. Many commentators have suggested that those responsible for providing medical liability cover were not adequately alive to the risks to which they were exposed and made inadequate allowance for future claims. Because many of the providers of insurance were co-operatives, and did not assume a legal liability to indemnify (but had a discretion to refuse cover), they were not subject to regulation by the Australian Prudential Regulation Authority, which enabled them to continue in business with inadequate provision for future claims.

This all came to a head in 2001/2002 when each of HIH and UMP failed. Both were prominent in the provision of liability cover in the Australian insurance market. Their failure brought to light the unsatisfactory nature of existing practices in relation to providing for future claims liabilities. When the true extent of those future liabilities was properly appreciated and recognised, and the need to allow for them also appreciated and recognised, understandably, premiums had to rise in order to reflect the true risk being taken by the insurer.

It is also of some significance that both State and Commonwealth governments have taken steps to ameliorate the impact of those premium rises by, in the case of the States, assuming liability for public hospitals and practitioners providing services to public patients (as occurs in Western Australia), and in the case of the Commonwealth, by making a financial contribution to premium cover and indemnifying medical insurers for high cost claims.

So, while it is certainly true that medical liability insurance premiums have increased dramatically over the last 15 years or so, and some of those increases are likely to be associated with the increase in claims frequency which occurred in the latter part of the last decade, it is very difficult to see any correlation between any principle of law enunciated by the courts, or the outcome of claims before the courts and those premium increases. It seems that the most significant impact on premiums has come from the need to rerate risk by the insurers who were under-valuing the liabilities to which they were exposed. Data recently published by ISA suggests that premium income is now substantially in excess of those liabilities, which, if correct, would suggest decreases in premiums in the future.

Discouraging fields of practice

One assertion regularly made is that the dramatic increase in premiums for obstetric cover has discouraged a number of practitioners from that field, particularly rural practitioners.

Those propositions were analysed in a paper published by Clarke in 2002 (*Journal of Law and Medicine* – Volume 9). Although she acknowledged that the data on the topic was limited, such data as did exist did not suggest any decline in the number of specialists entering training in the field of obstetrics. She also observed that the shortage of practitioners in rural areas in both Australia and the United State is not confined to obstetricians. She endeavoured to analyse the common assertion that rates of Caesarian section have increased because of the threat of litigation and concluded that the data was inadequate to enable any conclusion to be drawn on that subject, one way or the other.

Defensive Medicine

I commenced this paper by referring to a recent statement by the President of the AMA to the effect that a recent decision of the Supreme Court of New South Wales would encourage the practice of defensive medicine. It is appropriate to end by considering the validity of that proposition.

Defensive medicine is generally taken to have two components – sometimes called positive defensive medicine and negative defensive medicine. Positive defensive medicine is the tendency to over-service, and in particular, order tests that are not necessary, in order to avert the risk of a claim arising from a failure to test. Negative defensive medicine refers to the failure to service, or to treat, because of the litigation risks associated with that treatment or the patient.

An interesting paper on this topic by Salem and Forster was published last year in the *Journal of Law and Medicine* (2009 at 235). The paper relied upon survey results for the conclusion that defensive medicine practices, which undoubtedly exist, were driven not so much by personal experience of litigation by a practitioner, but by a non-specific fear of litigation. A survey of medical practitioners in New South Wales showed that a majority of respondents to the survey believed that law suits against medical practitioners in that State had increased over the last 5 years, when in fact they had significantly decreased, according to the authors, as a consequence of the *Civil Liability Act*. 71% of the respondents had never heard of the *Civil Liability Act*. The authors therefore concluded that defensive medicine practices in New South Wales at least were being driven by fear of litigation, rather than the fact of litigation. If that conclusion is correct, it would strongly suggest that it would be good public policy to educate medical practitioners as to the true extent of the risks which they face, in order to discourage them from adopting inefficient and expensive practices, or from avoiding high risk patients or illnesses, to protect themselves from a risk which they perceive to be greater than it really is.

Conclusion

The task which I set for myself in this paper was to analyse the accuracy of not uncommon assertions that the courts have usurped the role of the medical profession in setting appropriate standards of medical practice, thereby producing a flood of medical liability claims which have caused insurance premiums to rise astronomically, practitioners to leave certain fields of practice, and others to practise defensively. My analysis would

suggest that this is another one of those areas of public policy debate in which there is a significant gap between perception and reality.

I do not suggest that the courts should not be subjected to scrutiny and criticism in the way in which they approach and decide medical negligence cases. I do, however, suggest that the portrayal of the courts as "teaching their granny to suck eggs" in relation to the proper standards of medical treatment and care is not just inaccurate, it is also, and far more importantly, in no-one's interests — not medical practitioners, not the patients who rely upon their care, and not the broader community's.