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2000 PIAA INTERNATIONAL WORKSHOP
THE ROYAL COLLEGE OF PHYSICIANS
LONDON, ENGLAND, 11 SEPTEMBER 2000

"AN INTERNATIONAL PERSPECTIVE ON TORT SYSTEM
REFORMS"

TORT SYSTEM REFORMS - CAUSES, OPTIONS, OUTCOMES

The Hon Justice Michael Kirby AC CMG

MEDICAL MALPRACTICE - AN INTERNATIONAL PERSPECTIVE OF TORT SYSTEM REFORMS*

The Hon Justice Michael Kirby AC CMG**

GROWTH OF MEDICAL MALPRACTICE

In a New York Hotel my eyes fell upon the telephone book: always a good read in a foreign city. Imagine my surprise to find on the cover multiple tear-away slips informing me that a named attorney, with a toll free call line, would give me a free consultation in home or hospital for "all types of accidents & medical malpractice". My lawyer's eye discerned that medical malpractice was not classified as a type of "accident". It was in a category all of its own. The logo of a speeding car left me in no doubt that a lawyer could be with me in a moment, in a twinkling of an eye. If only I could think of some medical malpractice.. His sticky advertisement promised me: "We stick with you".

There is no doubt that in the United States, Britain, Australia and many other countries medical negligence cases are on the

* Text on which was based an address opening a conference at the Royal College of Physicians, London on 11 September 2000.

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increase¹. In Australia, this has produced conflicting proposals. The President of the Australian Medical Association, Dr Kerryn Phelps, told a seminar in Sydney in February 2000²:

"Tort law reform is a crucial issue for the ... Australian medical profession, and it would not be an overstatement to say that the situation has reached boiling point. Over the past eighteen months there has been a growing chorus of calls for the [Australian Medical Association] to work with government to do something to address the blow-out in medical indemnity premiums. This was brought to a head late last year with a call from the Victorian Medical Indemnity Protection Society demanding a full year's subscription from all members. ... We have reached a situation where clinicians in a number of fields are obliged to carry an unrealistic premium burden. This cannot be sustained on a long term basis. ... The effects are already being felt. Anecdotally, we are aware that many obstetricians are leaving obstetrics. One of the first group to "down tools" is the rural GP obstetricians. These rural services are not easy to replace, and communities in rural areas are already frustrated and angry about their declining health services. ... If we look at the trends in the United States, it is clear that the writing is on the wall for us here in Australia. ... [T]he American experience is a prediction of things to come in Australia and we would do well to take note".

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- 1 "Medical lawsuits soar" *Sun Herald* (Sydney), 27 August 2000, 22 recording that lawsuits against medical practitioners in New South Wales, the most populated Australian State, had quadrupled in a decade.
 - 2 K Phelps, "Tort Law Reform", unpublished address to a seminar, Sydney, 12 February 2000. cf S Girgis, C Thomson and J Ward, "'The Courts Expect the Impossible': Medico-Legal Issues as Perceived by New South Wales General Practitioners" (2000) 7 *Journal of Law and Medicine*, 273.

Two months later, the President of the Australian Plaintiff Lawyers' Association, Dr Peter Cashman, described talk of this kind as over-emotional³:

"There appears to be increasing hysteria within the medical profession of the so-called medical negligence crisis. Various groups are now actively lobbying to restrict victims' rights and to reduce damages. At a recent seminar on tort reform organised by the Australian Medical Association ... in conjunction with the United Medical Protection Limited, various doctors spoke of their increasing disquiet. ... Courts were said to be imposing liability on the medical profession in the absence of any element of fault or negligence. Judges were described as modern Robin Hoods. ... Defensive medicine was said to be on the increase. ... [However] a number of research studies, both in the United States and in Australia have confirmed that only a very small percentage of injured patients or relatives of patients who have died as a result of apparent negligence ever sue".

As usual, this debate between leaders of the medical and legal professions proceeded in the manner of two ancient vessels passing each other in the night. Each profession tends to look on the issue from the viewpoint stamped upon it by its respective mission. The *lawyer* looks across the desk at a patient who complains about a mistake in the provision of healthcare services. For that patient (and the lawyer advising the patient) the question, in practical terms, is whether money can be procured as compensation from the medical insurance system. Or whether the patient (or if the patient is dead,

3 P Cashman, "Tort Reform & Medical Negligence", *Plaintiff - Journal of Australian Plaintiff Lawyers' Association*, April 2000, 4.

the relatives) are obliged effectively to carry the burden for themselves or to look to social security, private insurance, the family or some other source to help them over the costs and disappointment of the mistake that is said to have occurred. For the patient or the family, the feelings may include a sense of shock, disappointment and outrage of what they see as a failing on the part of the medical professional involved. But for the lawyer it is rarely this. For the lawyer, the question is usually a pragmatic one. Against the energetic defence typically put up by medical professional insurance, can a cause of action be established that will provide compensation and afford an element of loss distribution in favour of the client? If it can, other patients, through their medical fees, helping to fund indemnity insurance, will contribute to the compensation recovered by the clients where things are said to have gone wrong. They will do so against the chance that, on some other occasion, they might be in the same boat. Distributive justice will be attained. The burden on the injured patient will be ameliorated.

Healthcare professionals: In my experience, medical practitioners rarely look on malpractice in this way. For them, the issue is not distributive justice but one of individual justice, including to the healthcare professional involved. The allegation of professional negligence is not only potentially costly. It is also personally insulting. It is emotionally hurtful. It tends to attract

media coverage. It gets known around the profession⁴. It is damaging to one's ego and practice. Defending it is distracting and time-consuming. Knowing of the devotion over long hours which the typical healthcare practitioner gives in the highly personal world of medical care to patients who are living and dying, and to their families, there is a sense of irritation with the patient who makes a big thing of what may be seen as a trivial, irrelevant or forgivable mistake. Remembering all the many good things done in a busy day, to devote so much effort to examining microscopically a suggested error of action or advice in a half-remembered incident months or possibly years earlier, seems completely disproportional.

The feeling of grievance in the health professions is inflamed by the tear-off promotions of New York attorneys. Equally by the more discreet but determined efforts of other plaintiffs' lawyers in other parts of North America, Europe, Australasia and elsewhere. The sight of lawyers getting rich on litigation that burdens the already hard-pressed healthcare services, and the dwindling funds available for such services, irritates most medical practitioners. Moreover, they question the cost effectiveness, neutrality and justice of the legal system by which chance and momentary

4 A recent report indicates that a law has been adopted in New York requiring information about medical malpractice judgments and disciplinary actions against medical practitioners to be posted on the Internet and available on a toll-free telephone line. The Governor of New York is considering whether to sign the statute into law. *New York Times*, 24 June 2000.

considerations can make the difference between a huge recovery and rejection of the claim.

Debates such as I have outlined have their parallels in every part of the world where the common law system of recovery for torts (civil wrongs) and breach of contract bring the two professions into litigious conflict⁵. As is usually the case, neither side has a monopoly of wisdom. Each side makes valid points. Each party is voicing reasonable perspectives. One lesson that is quickly learned as a judge is that complex problems rarely yield simple solutions. Justice, Janus-like, ordinarily has a dual face. Discovering truth is often a highly subjective exercise, the outcome to which depends upon one's starting point. One lesson I have learned in national and international discussions of workable strategies to confront the HIV/AIDS epidemic may have some relevance. Strategies that work must be based on sound empirical data, not on intuition, emotion, assumptions or self-serving catch-cries⁶. In the design of law generally, and tort law reform in particular, the noisiest lobby groups often win the ears of democratically accountable lawmakers. But for solutions that are well targeted and likely to be more enduring, it is essential that pre-suppositions be replaced by fact and emotional

⁵ The Medicine and Law Conference 2000 held in Melbourne 5-6 April 2000 was devoted to these issues.

⁶ This point was made by NSW Attorney-General J W Shaw in Cashman, above n 3, 4.

denunciations of one another substituted by calm dialogue addressed to identifying objectively any real problems that exist and weighing dispassionately the solutions that are available to address such problems.

REASONS FOR THE INCREASE

Law reform and empiricism: The starting point for an empirical approach would be to find exactly what has happened as a result of medical malpractice suits. This is the approach which the Australian Law Reform Commission took when I was chairman twenty years ago. Asked to reform the law of criminal investigation, we were not content to examine the statute books, judicial decisions, lobby submissions and academic articles. We travelled in the police cars. We watched the way confessions were procured in the cells. We sought to understand the problem from the point of view of investigating police, criminal victims and defence attorneys. The result was a highly influential report⁷. The same techniques were used in developing new laws on many topics including debt recovery⁸, defamation⁹ and so on. After my experience in institutional law reform, I lost my taste for hyperbole. After twenty

7 *Criminal Investigation* (ALRC 2), 1975.

8 *Insolvency: The regular payment of debts* (ALRC 6), 1976.

9 *Unfair publication: defamation and privacy* (ALRC 11), 1979.

five years as a judge, I have no more enthusiasm for quick fix solutions for legal problems presented by partisan interests.

Getting at the true facts: To evaluate the conflict of world view presented by the two opinions with which I began these comments, it will be essential to get down into the engineroom of medical and legal practice to find what is actually happening:

- To see if, in hospitals and doctors' surgeries, current law is actually causing "defensive medicine" and what precisely this means beyond telling patients exactly what they are in for;
- To elucidate the exact extent to which insurance premiums are actually driving out practitioners, and if so in what number. To be certain that the causative factor is not something else and that such premiums cannot be (and are not) passed on to patients generally;
- To discover if it is the threat of medical suits that creates the "crisis" of doctors in rural areas as claimed or whether that crisis is just an aspect of the general drift of populations from country towns to the city lights;
- To explore whether, given that on any view some malpractice actions are justifiable, it is the margin of unjustifiable legal actions which is having deleterious consequences or simply

general professional malaise for which legal proceedings are a popular scapegoat;

- To examine whether (as is sometimes claimed) medical defence organisations and insurers reflect the culture of the profession they indemnify and seek to vindicate the medical practitioner rather than to settle a case economically before costs have been run up and anger raised on both sides¹⁰; and
- To examine the practices of plaintiffs' attorneys to decide where the line may be drawn between drumming up wholly meritless cases or promoting objectionable forms of litigious blackmail (on the one hand) and legitimate help and support for comparatively powerless patients (on the other) so that, where justified, such patients can seek to vindicate their rights and recover damages for compensation and solatium.

Understanding the changing law: Finding the facts of this kind, elusive as that would be, addresses but one consideration that explains the growth of medical malpractice litigation. It is equally important to consider trends in the decisions of the highest courts. Such decisions fix the standards. Such standards are observed and applied by courts of trial and of appeal. But they reach further into

¹⁰ This is alleged by Mr Cashman. See above n 3.

the decisions made in offices when clients ask an attorney whether they have a case. They influence the lawyers' assessments of whether to bring or defend a case. They also affect insurance evaluation, and the decisions of medical defendants on whether they will settle the case or fight it to the end.

Every country has its own nuances of law in this area. Different countries have different modes of trial. In most parts of Australia, jury trial of civil claims has been abolished or is in decline; although occasionally a case returns to emphasise the large scope left to the jury where that mode of trial is still had¹¹.

Recent legal developments: Four related developments have occurred in Australian law which find parallels in other countries¹² and which expand the modern risks of medical malpractice suits:

- The so-called *Bolam* privilege¹³ has been rejected as part of the law. By the *Bolam* test, the standard to be applied in

11 *Naxakis v Western General Hospital* (1999) 73 ALJR 782; 162 ALR 540. R Mulheron and J Gordon, "Juries, Medical Negligence and Causation in the High Court of Australia" (2000) *Tort Law Review* 19.

12 F S Shuaib, "*Rogers v Whittaker*: The End of the *Bolam*'s Saga in Medical Negligence Cases in Malaysia?" (2000) 16 *Professional Negligence*, 25.

13 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 583 at 587 per McNair J.

malpractice cases was that of the "ordinary skilled man (sic) exercising and professing to have [the relevant] skill". It was not the test of "the highest expert skill" but only that of "an ordinary competent man". In Australia, and several other countries, the law has moved away from this surrender of a judgment about what was required to the medical "peers" of the practitioner concerned. It has substituted the assessment of the reasonable person who will take into account (but not necessarily be governed by) professional standards¹⁴.

- Connected with this line of authority is a growing insistence on the importance of securing true consent from the patient for any intrusive medical procedures. Such principles, influenced by judicial decisions in Canada and the United States¹⁵, demand that even remote risks, if they might have affected the patient's decision, must be brought to the patient's attention for decision. The failure to do so will sometimes contribute to

¹⁴ *Rogers v Whittaker* (1992) 175 CLR 479. This decision approved the opinion of King CJ in *F v R* (1983) 33 SASR 189 at 194. See Lord Irvine of Lairg, "The Patient, the Doctor, Their Lawyers and the Judge: Rights and Duties" (1999) 7 *Medical Law Review* 255 at 258-259. The new test established has been described as creating "impossible expectations". See Girgis, above n 2, 273. In the United Kingdom the *Bolam* principle has been qualified in *Bolitho v City of Hackney Health Authority* [1998] AC 322 (HL). See Lord Irvine, *ibid*, 239-261; M Brazier and J Miola, "Bye-Bye Bolam: A Medical Litigation Revolution?" (2000) 8 *Medical Law Review* 85.

¹⁵ See eg *Reibl v Hughes* (1980) 114 DLR (3d) 1.

the imposition of liability, although the measure of fault is small indeed¹⁶.

- A further area of liability has concerned the extension of legal duties beyond the immediate patient to others, such as an unborn child of a patient, perhaps conceived in an unwanted pregnancy¹⁷. A still more recent case saw the imposition of a duty of care on a medical practitioner to the de facto husband of the patient. She attributed her HIV positive status to sexual contact with her partner which, she said, would not have occurred unprotected had she been warned of his HIV status¹⁸.

16 *Chappel v Hart* (1998) 195 CLR 232. cf T Honoré, "Medical Non-Disclosure, Causation and Risk: *Chappel v Hart*" (1999) 7 *Torts LJ* 1; S W Waddams, "Causation, Physicians and Disclosure of Risk" [1999] *Tort Law Review* 5; M Stauch, "Taking the Consequences for Failure to Warn of Medical Risk" (2000) 63 *Modern Law Review* 261.

17 *CES v Superclincs (Australia) Pty Ltd* (1995) 38 NSWLR 47 (NSWCA). An appeal to the High Court of Australia was settled; cf *McFarlane v Tayside Health Board* [1999] 3 WLR 1301 and "The Unwanted Child" [2000] *Cambridge Law Journal* 238.

18 *BT v Oei* [1999] NSWSC 1082 (unreported, 5 November 1999, Bell J). The case is discussed in D Hirsch, "The Doctor's Duty of Care to a Patient's Sexual Partners", unpublished article. cf *Palmer v Tees Health Authority* (1999) *Lloyds Rep Med* 351 noted (1999) 7 *Medical Law Review* 331; A B Hocking and S Muirhead, "Warning, Warning, Warning - All Doctors!" (2000) 16 *Professional Negligence*, 31. Reference is made by Bell J to *Reisner v Regents of the University of California* 37 Cal Rptr 2d 518 (1995); *Goodwill v British Pregnancy Advisory Service* [1996] 2 All ER 161; *McFarlane v Tayside Health Board* [1999] 4 All ER 961. See also *Di Marco v Lynch Homes-Chester Country Inc* 583 A 2d 422 (1990).

- In another case, in somewhat special circumstances and having regard to a local statutory provision, a duty was imposed on a medical practitioner to respond to a call to an emergency which, had he done so, might have prevented profound injuries to a young patient living nearby who was in the throes of an epileptic seizure¹⁹.

These cases, and others outside the field of medical negligence²⁰, demonstrate the continuing rise of the imperial tort of negligence. It has expanded beyond all recognition from the days of *Donoghue v Stephenson*²¹. It is worth reflecting on the reasons for this expansion.

CAUSES OF CHANGE

The phenomenon of insurance: There could be no denying the influence which systems of statutory insurance in the fields of employer liability and motor car negligence have had on the expansion of the tort of negligence. The provision of schemes of compulsory insurance in those fields contributed significantly to the growth of a specialised section of the legal profession with particular

19 *Woods v Lowns* (1995) 36 NSWLR 344 (NSWCA).

20 cf *Perre v Apand Ltd* (1999) 74 ALJR 1190 and cases there cited.

21 [1932] AC 562 at 580 per Lord Atkin.

expertise and much enthusiasm for pushing forward negligence liability generally. It should be no cause for surprise that this push came to be felt in the field of medical negligence. There, practical considerations rather than statutory obligations, meant that a profession able to do so would ordinarily be insured, as would the institutions in which, and with which, that profession worked²².

The demand for accountability: Beyond this there is the consideration of public education and community attitudes. No only are medical practitioners under scrutiny and subject to criticism much more than they were in times gone by. The same attitude reaches into every section of society. It affects the judiciary, the churches, the political leadership and even the Royal Family. No one is now immune. Everyone is accountable. This tide is unlikely to turn. Consciousness of rights is much more clearly established. It is now served by a legal profession most of whose members share the attitude that wrong-doers should be rendered answerable in the courts which belong to all people and not just to the wealthy.

Evidence of error and malpractice: In the particular field of healthcare, there are many contemporary studies which demonstrate

22 In *Dimond v Lovell* [2000] 2 WLR 1121 (HL) at 1133 Lord Hoffman commented that "in truth virtually all compensation is paid directly out of public or insurance funds and through these channels the burden of compensation is spread across the whole community through an intricate series of economic links".

that error is relatively common. Redress is comparatively rare, occasionally necessary and sometimes fully justifiable.

There is growing evidence that mistakes having serious consequences do occur in medical practice. Because of the nature of healthcare, mistakes often have extremely serious results for the patient and the patient's family. The Head of the Clinical Risk Unit at University College London, Dr Charles Vincent, was reported in December 1999 as estimating, on the basis of an empirical survey, that up to 40,000 patients a year in Britain die as a result of medical error. This is about four times more than die from all other types of non-deliberate civil wrongs. The report also studied non-fatal errors in drug prescription and infections which are said to affect 280,000 people in the United Kingdom each year with an annual additional cost of remedial care of £730 million in England alone.

Dr Vincent's results were not dissimilar to those produced a few weeks earlier, published by the Kellogg Foundation concerning experience in the United States²³. That report concluded that 70% of the errors (and 155,000 deaths) in that country resulting from medical misfeasance, were avoidable²⁴. Even if one were to discount these cases significantly for patients and their families who

²³ L Rogers, "Blunders by Doctors Kill 40,000 A Year", (London) *Times* 19 December 1999.

²⁴ *Ibid.*

were philosophical about their fate, it cannot be denied that in many such cases legal proceedings for negligence and breach of contract would be completely justifiable. Such proceedings would sanction the losses of particular patients. They might also instil a greater measure of responsibility and reinforce professional efforts to ensure accountability.

In addition to these studies, there are countless reports supporting the need for particular care to avoid misdiagnosis. Some such studies are published by medical experts²⁵. Others are written by patients who took the precaution of securing a second medical opinion²⁶. Because of numerous headlines calling medical error to public notice²⁷, governments and their advisers are now much more aware than they were in earlier times of the fallibility of medical diagnosis and treatment and the justification of facilitating legal redress in at least serious cases. Even Eleanor Roosevelt, we now read, may have been a victim of misdiagnosis and mistreatment in her last days²⁸. If it could happen to her, it could happen to anyone.

25 eg J Kronz and Ors in *Cancer* (1 December 1999).

26 J Groopman, "Second Opinion", the *New Yorker*, 24 January 2000 40.

27 eg "Kidney blunder patient dies after week in coma", (London) *Times*, 2 March 2000, 5; "Wrong diagnosis - meningitis mistaken for flu" (Sydney) *Daily Telegraph* 29 February 2000, 11.

28 B H Lerner, "Final Diagnosis", *Washington Post Health Report*, 8 February 2000, 12.

A democratic society is not likely to tolerate a legal system which denies a remedy to such people, at least in serious cases. Such denial would be viewed as sanctioning an unjustifiable assignment of the economic burden of medical error, a failure to afford effective legal stimulus to the careless individual and to provide systemic remedies necessary to prevent such errors from recurring.

REMEDIAL ACTION

What can be done to respond effectively to the complaints about the current law of civil remedies in a way that attempts to meet the concerns of the reasonable critics whilst affording relief to those who suffer because of serious avoidable mistakes in the provision of proper healthcare?

- *Accident Compensation:* The most radical solution is to abolish tort recovery by statute and to replace it by a comprehensive system of exclusive monetary compensation for all "personal injuries by accident". This is the measure that was adopted by the Parliament of New Zealand following the Woodhouse Report²⁹. It built upon earlier schemes for workers' compensation benefits dependent upon compulsory insurance paid by employers. In some jurisdictions, such

²⁹ *Compensation for Personal Injury in New Zealand* (1967).

schemes have abolished tort claims for work injuries, making statutory compensation the exclusive remedy against an employer for all industrial accidents³⁰. In various countries this model, in turn, gave rise to the abolition or modification of tort claims for motor vehicle accidents. It substituted no fault benefits for the victims of such accidents based on statutory provisions allowing for weekly payments and lump sum entitlements³¹. In New Zealand, in 1974, Parliament went a step further. It swept aside tort remedies in all personal accident cases. It seems that a decision was originally taken that medical misadventure should be excluded from the Act³². However, some cases of medical error are now covered. To overcome the criticism that inclusion of such cases removed deterrence to healthcare providers, provision was later made for no claim bonuses and specific contributions from them to the fund in accordance with experience rating³³.

The great inducement of the New Zealand scheme was that it cut down the extremely expensive costs of delivering the compensation dollar by way of tort litigation. However,

30 J G Fleming, *The Law of Torts* (9th ed) 1998, 449, 559.

31 See eg *Motor Accidents Act* 1979 (NT) and Fleming n 30, 449.

32 Discussed J Vennell, "Medical Misfortune in a No-Fault Society", mimeo, 1989 noted Fleming above n 30, 451.

33 Fleming, *ibid*, 451.

accident compensation of this kind has many critics. Fiscal constraints have limited the growth of benefits in New Zealand in proportion cost of living changes. Borderline cases of entitlement have proved troublesome. Some critics have taken a more fundamental objection. "Privileged treatment for victims of accidents is difficult to justify in general grounds, and can be explained only as a pragmatic substitution for the former tort liability"³⁴. Why, for example, should there be public compensation for victims of accidents but not to those disabled by disease or illness? A scheme similar to the Woodhouse law was proposed for Australia in 1974³⁵. However, it was not enacted. Although it still has supporters within Australia, the prospects for such fundamental and national reform now seem "dim"³⁶. Since 1974, a further complication has intervened in Australia. At least in the case of persons who enjoy a common law right to compensation, it is now questionable whether the Federal Parliament could abolish such a right without affording those affected "just

34 *Loc cit.*

35 Australia, Report of the National Committee of Inquiry, *Compensation and Rehabilitation in Australia*, 1974, 4. cf H Luntz, *Compensation and Rehabilitation* (1975); G Palmer, *Compensation for Incapacity* (1979); J Keeler (1975) 4 *Adelaide Law Review* 121.

36 Fleming above n 30, 453. cf B Wilkinson, "New Zealand's Failed Experiment with State Monopoly Accident Insurance" 2 *Green Bag* 2D 45 (1998).

terms" as promised by the constitutional provision limiting acquisition of property under federal law³⁷.

- *No fault legislation:* Because similar political and constitutional problems would have to be faced in many democratic countries, it seems unlikely, at least in the short term, that comprehensive national compensation will replace the tort system. But specific no fault schemes will continue to be enacted by legislatures around the world. But, as in the past, it is probable that these will be confined to motor vehicles and industrial injury cases³⁸. Yet there is no reason in principle why a specific statutory scheme could not be adopted in respect of medical negligence³⁹. Nevertheless, to deprive an individual of established civil rights would have to run the gauntlet of constitutional provisions and human rights requirements. At least in Europe, the latter are having an ever-

37 Australian Constitution, s 51(xxxi). cf *Georgiadis v Australian Overseas Telecommunications Corporation* (1994) 179 CLR 297.

38 Fleming above n 30, 446-449. An exception was the scheme for compensation of persons who acquired HIV through medical transmission. See H Luntz, "Mrs Whitaker's Gothic Cathedral" (1996) 4 *Torts Law Journal* 195 at 201.

39 The Final Report of the Australian Review of Professional Indemnity Arrangements for Health Care Professionals, *Compensation and Professional Indemnity in Health Care*, 1995, did not support the development of a separate no-fault health care injury compensation scheme "at this time". See report, rec 90, xxvii. See also *ibid*, 182 (pars 7.78)ff.

increasing impact in this area of discourse⁴⁰. The moves in New Zealand, designed to ensure that healthcare providers contribute specially to the accident compensation fund, suggests that, in democracies, the lawmakers would be resistant to providing special immunities. Only the strongest possible arguments based on an intolerable blowout in litigation, a crushing burden of premiums that could not be deflected, established proof of undesirable consequences in medical practice, and unacceptable distortions to the healthcare system generally⁴¹ would seem likely to produce such a result. Yet democracy is a strange system of government. It can sometimes respond to loud voices and powerful lobbies. But in this area the relevant lobbies will generally tend to cancel each other out.

- *Capping damages:* The introduction by legislation of semi-arbitrary limits, or "caps", on the recovery of damages in particular cases has been a feature of lawmaking in many countries. In Australia and elsewhere statutory "caps" on the recovery of non-financial heads of damage have been introduced in legislation covering motor car injuries,

40 Lord Irvine, above n 14, 261.

41 H King and T L Wong, "The Changing Face of the Australian Healthcare System - New Frontiers for Legal Liability?" in Issues Paper 13 (Summer 2000), Australian Institute of Health Law and Ethics.

employment accidents and dust diseases claims⁴². Such caps can occasionally be quite severe. Effectively, they shift a proportion, or the whole, of former legal entitlements to compensation to the person claiming to be the victim of a legal wrong. In some jurisdictions of the United States (eg California) the capping of damages and the introduction of annuities and periodic payments for verdicts over a given threshold, together with restrictions on contingency fees, have had a significant effect on medical malpractice suits. Thus, the premium for liability insurance for obstetricians in California is now said to be \$US40,000 whereas in Florida, a State where no such reforms have been enacted, the premiums are said to be \$US152,000 a year⁴³. Such legislation, particularly if introduced to protect a special category of defendants, would in many jurisdictions have to run the gauntlet of constitutional requirements and human rights scrutiny.

- *Governmental subventions:* Sometimes remedies to particular problems concerning malpractice suits can be afforded without actual change in tort law. Thus, in New South Wales, Australia, in 1998 the specific concerns affecting obstetricians

42 eg Fleming above n 30, 448; T Harris, "Adding insult to injury", *Australian Financial Review*, 11 August 2000, 82 concludes that workers' compensation laws in Australia, with their differing controls on entitlements, are "in a mess".

43 Phillips above n 2, 1.

and gynaecologists in the Sydney area, said to be facing threats to the viability of their practices by reason of litigation risk and premium increase, resulted in governmental intervention. The State Treasury Managed Fund reportedly agreed to offer cover for services for public patients. These constituted more than 90% of the patients at risk⁴⁴. Legal liability law remained the same. But some of the risk was shifted to government rather than to prospective patients and their families.

- *Risk management:* Another remedy is the introduction of closer attention to risk management both by healthcare professionals and their insurers. A systemic problem of tort law recovery is that, in practice, court decisions and settlements often resolve individual cases without necessarily having much of an impact on matters of practice and on preventing recurrences of error. Drawing inferences from particular cases for risk management is an important obligation of modern professional people, their insurers and professional organisations. A report in *Annals of Internal Medicine* in December 1999⁴⁵ concerned a study of malpractice cases. The authors asked the question: why patients sue? The

44 *Ibid*, 2.

45 A W Wu, "Handling Hospital Errors: Is Disclosure the Best Defense?" (1999) 131 *Annals of Internal Medicine* 970.

reason discerned was that "patients often form unrealistic expectations because their physicians fail to discuss treatment alternatives"⁴⁶. The authors of the study recommended immediate disclosure of errors to patients and their families and thorough discussion with them about the results and the steps being taken to prevent recurrence of error. Whilst lawyers and insurers might have hesitations about this advice, the authors of the study at Johns Hopkins University School of Medicine suggested that such candour, and if appropriate an apology, diminishes the risk of litigation.

- *In-house Ombudsman:* Listening to the complaints of patients concerning the current system of tort remedies for medical malpractice makes it clearer that what is now in place is often very stressful, uncertain, highly expensive and a real ordeal for the average person without necessarily securing a commensurate improvement in medical standards. The average claimant will often already be upset by whatever has happened in the healthcare system, whether or not legal liability exists. To add to that burden the rigours of litigation can be a cruel and unusual punishment. Lawyers tend to take the system for granted. It is essential that they try to see it through the eyes of the inexperienced and unfamiliar. The

46 *Ibid*, 970.

same can be said about the predicament of healthcare professionals who commonly find our legal system inefficient, humiliating and expensive, both in time and emotional terms, even where they are represented by lawyers retained by medical insurance and even where they win.

A reflection on these hard realities should propel us all to explore more low key, approachable, inexpensive, conciliatory, in-house remedies for complaints of medical or healthcare malpractice. This has been done in the Netherlands where every hospital and public healthcare system has established procedures that are easily accessible and patient-friendly⁴⁷. The result is that litigation in that country is only a fraction of that in other countries of Europe, not to mention the countries of the common law. In my view, professional insurance bodies and other professional organisations should be urgently examining these options. They could not replace all malpractice litigation. But one is driven to the conclusion that the establishment of relatively generous and sympathetic alternatives to tort actions would be less of a burden on

⁴⁷ J Hubben, "Costs of Clinical Negligence in Germany, France, Belgium and in the Netherlands in Particular", unpublished paper in Physician Insurers' Association of America, Conference Papers, London, September 2000 ("An International Perspective on Tort System Reforms"); cf J C Mohr, "American Medical Malpractice Litigation in Historical Perspective" 28 *JAMA* 1731 (2000).

individual healthcare professionals and patients and on the public and private purse. But is there the will, the imagination and self-interest to take such initiatives?

- *Case management:* In addition to the foregoing initiatives, it is essential for courts to streamline their processes in medical malpractice cases. Doing so will help promote mediation and court referred alternative dispute resolution where this is appropriate⁴⁸. In one jurisdiction of Australia, a special list and specialised judges deal with such cases efficiently. They can group proceedings involving common parties. They can facilitate the reception of reliable expert evidence and more easily differentiate reliable testimony from unreliable⁴⁹. One innovation of importance to hard pressed medical witnesses has been the growing use of telephone and video conference facilities in respect of certain testimony⁵⁰

48 A Abadee, "Streamlining the Court Process for Medico-Legal Cases - The Professional Negligence List (NSW) and Expert Evidence" in (2000) 8 *Australian Health Law Bulletin* 105. See also A Abadee, "The New Professional Negligence List: A Hands On Approach to Case Management" (1999) 11(4) *Judicial Officers' Bulletin* (NSW), 25.

49 *Stanton v Callaghan* [2000] 1 QB 75 (CA) per Otton LJ.

50 Supreme Court Rules (NSW), Pt 26 r 3(9) noted Abadee above n 48, 115.

THE FUTURE

The defects of the present way by which most countries of the common law deliver redress to the victims of medical misadventure are well established⁵¹. Equally plain are the defects of most of the alternative systems on offer. Suggestions that particular professional groups should enjoy legal immunity from suit for their errors adversely affecting other citizens would appear to fall on increasingly deaf ears. At least this seems so as far as the courts are concerned. To the contrary, the trend of recent authority in the United Kingdom⁵², Australia⁵³, the United States⁵⁴ and elsewhere has been to extend liability and to reduce immunities, even where these were formerly provided by the law. Advocates, and in parts of the United States, even judges are now being held professionally liable for errors revealing incompetence. So the trend of the common law seems to be running against immunity.

51 As to the way the extension of liability are sometimes kept under control in countries of the civil law tradition, see B Markensinis, "Judicial Style and Judicial Reasoning in England and Germany" [2000] *Cambridge Law Journal* 294 at 301, 309.

52 *Arthur J S Hall and Co v Simos* unreported, House of Lords, 20 July 2000.

53 cf *Boland v Yates* (1999) 74 ALJR 209 at 236-237, para [129].

54 "Judicial Liability Update: Are you Covered?" in California, *The Bench* (California Judges' Association), Vol 40 No 1 at 5 (2000).

If such immunity against suit for medical malpractice protection is to be provided, it will therefore probably have to come from the legislature. Courts can reconsider the scope of negligence liability. They can improve their procedures. They can offer determinative dispute resolution. But it seems unlikely that they will enlarge the immunities.

In most countries the introduction of national compensation schemes, to abolish tort liability altogether, now appears unlikely. But other statutory relief is available and has been tried. However, to make out a good claim for it, strong empirical justification is necessary. Angry words by doctors and lawyers will ordinarily not be enough. Generalities will usually leave the lawmakers, and the community, unmoved.

The dialogue on this issue between lawyers and healthcare providers, between plaintiffs and defendants, between Law Societies and Medical Colleges and between politicians and citizens will continue. But the foundation for successful future strategies lies in a lesson which reformers can learn from the techniques of medical research rather than from the law's technique of verbal rhetoric. It lies not in expostulation but in painstaking empirical studies and statistical data. Lessons can be learned from those countries that have introduced improved systems of conciliation and compensation which are cheaper, quicker and less traumatic. But unless healthcare professionals make out a compelling case for change, it

seems likely that, in most parts of the world, negligence will continue its imperial expansion. As with other imperial forces in the past, there will be more beneficiaries. And there will be further victims.