

MIIAA

Medical Indemnity Forum

Plaintiff viewpoint

Discussion notes

Bill Madden

Slater & Gordon, Lawyers

National Practice Group Leader, Medical Negligence

wmadden@slatergordon.com.au



Executive summary

Area	Comment
Consistent national scheme	Exactly the opposite outcome
Most significant impacts	Damages thresholds in Victoria & NSW 5% discount rate unsupportable Costs of raising a child claims – creation of immunity
Standard of care / Breach of duty	Divergence between recommendation and enactments Irrationality yet to find a home?
Public authority protections	Scope? Impact on co-defendant sharing arrangements?
Compulsory insurance impacts	Policy exclusions
The future?	Exclusion for entrepreneurial medicine Customary disclosure of medical error – early release issues No fault compensation for vaccine injury

Introduction & overview comments

1. I have been asked to provide a perspective for plaintiffs, or plaintiff lawyers, on where we are with the reforms¹ almost five years on, what impact they have had, any suggestions as to what needs to change, what the problems are and to make some predictions. I have the advantage, if that is the correct word, of coming from NSW, where the reforms (contained in the *Civil Liability Act NSW 2002*) are perhaps the most extensive in Australia impacting the substantive law, although Victoria arguably has the least palatable damages rules.

¹ Review of the Law of Negligence, October 2002

2. I can state shortly at the outset that, at least in NSW & Victoria, the damages thresholds (especially when coupled with costs recovery restrictions²) are of greater concern to most plaintiffs than the changes to the substantive law below. Remaining on the topic of damages, the 5% discount rate, in my view (and that of the Review panel³) remains unjustifiable by reference to market interest rates and the oft stated aim of assisting the most severely injured.

3. The limitations on the recovery of damages for the cost of raising a child without disability (in three jurisdictions⁴), in my opinion, create an unjustifiable immunity for that category of defendants.

4. The fact that those limitations on the recovery of damages for the cost of raising a child exist in three jurisdictions but not elsewhere provides one of many examples whereby Recommendation 1 of the Review of the Law of Negligence was ignored.

Breach of duty

5. Despite the generally accepted view that for medical negligence there has implemented in most jurisdictions a new and somehow different test for determining the standard of care⁵, I am not convinced, particularly with the divergence between the recommendation and the enactments.

6. The NSW courts have confidently stated that the statutory implementation of the test recommended in the Review Report⁶, has created a defence⁷, not a definition of the standard.

7. The NSW statute excuses a professional who acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as *competent* professional practice. What is the meaning of *competent*? It seems to imply more than the converse of common law negligence. The word does not appear at all in the *Review* recommendation 3, which suggested reference to an opinion widely held by *respected* practitioners in the field.

² Such as the NSW limitation on costs recovery for claims under \$100,000: Legal Profession Act NSW 2004 section 338.

³ Recommendation 53 supported a 3% discount rate

⁴ NSW, Qld & SA.

⁵ Review at paragraph 3.2 ff and recommendation 3

⁶ A medical practitioner is not negligent if the treatment provided was in accordance with an opinion widely held by a significant number of respected practitioners in the field, unless the court considers that the opinion was irrational. *Section 50 Civil Liability Act NSW 2002*.

⁷ *Halvorsen v Dobler* [2006] NSWSC 1307 at [182]

8. Of course, insertion of *respected* instead of *competent* may not have shed much more light on the topic – which is of no help to beleaguered tort lawyers in Victoria who now must contend with *respected* and *competent* and *significant number* in the one clause⁸.

Irrationality

9. The irrationality ‘safety net’ at least has some helpful background discussion in the *Review*. While the NSW version and other versions provide that peer professional opinion cannot be relied on if the court considers that the opinion is *irrational*⁹. In Victoria, the exclusion operates if the opinion is *unreasonable*¹⁰.

10. We’ve no useful guidance on either term as yet, with decisions like *Halvorsen* not needing to address the point¹¹.

11. There exists a potential for cross-over between treatment and the giving of information in circumstances which in broad terms might be described as “suitable candidate” or “refusal to treat” cases. A number of examples may be given – for example, is a particular patient a suitable candidate for laparoscopy or is laparotomy warranted. Perhaps of greater difficulty is the suitability of potential patients for purely elective procedures, such as cosmetic surgery.

12. An unusual matter of that type was highlighted recently, not in a civil claim, but before the Health Practitioners Tribunal (Queensland), in a complaint brought by the Queensland Medical Board (QMB) against a plastic surgeon, Dr Peter Haertsch¹². Dr Haertsch was apparently approached by a 31 year old woman, following a breakdown of her relationship and the death of a close relative. She requested a bilateral reduction mammoplasty, or (according to the surgeon) a bilateral mastectomy with nipple removal. He refused the nipple removal but performed the mastectomy, without first referring the woman for psychiatric

⁸ *Wrongs Act VIC 1958 section 59(1)*. A professional is not negligent in providing a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by a significant number of respected practitioners in the field (peer professional opinion) as competent professional practice in the circumstances.

⁹ *Civil Liability Act NSW 2002 section 50(2)*

¹⁰ *Wrongs Act VIC 1958 section 59(2)*

¹¹ *Halvorsen* at [190]

¹² *Medical Board of Queensland v Peter Haertsch [2007] QHPT 001*

counselling or imposing a 'cooling off period' prior to the surgery¹³. Before the Tribunal, the surgeon pleaded guilty to unsatisfactory professional conduct.

13. In the context of such relatively extreme cosmetic surgery requests, including for example gender reassignment¹⁴, the failure to provide information or warnings may not be the central issue in a later dispute. Rather, there arises a prior gateway or threshold issue, that of acceptance of a person for surgery at all, forming part of the single comprehensive duty to exercise reasonable care and skill in the provision of professional advice and treatment¹⁵ - or more accurately, the potential refusal to provide treatment.

14. In those circumstances, which may be seen as a somewhat paternalistic¹⁶ protection of the patient from themselves¹⁷, the provisions such as section 5P **Civil Liability Act NSW 2002** are not drafted so as to readily apply. Rather, it becomes necessary to turn to provisions such as section 5O(1) **Civil Liability Act NSW 2002** where, either as a standard of care or as a defence¹⁸, evidence of competent professional practice widely accepted in Australia by peer professionals will reassume its importance.

15. With no underlying clinical need for surgery, and the somewhat entrepreneurial nature of cosmetic surgery, there is arguably a greater degree of inherent tension between the wish of a surgeon to sell his or her services, and the more rigorous patient selection required to protect the patient seeking such procedures from misconceived notions as to what may be to their benefit. Evidence of competent professional practice widely accepted in Australia by peer

¹³ The specific grounds for disciplinary action were that there should have been a further consultation, that sufficient time should have elapsed between consultation and procedure, or that the complainant should have received some form of counselling from a psychologist or psychiatrist.

¹⁴ See (with co-incident involvement of the same medical practitioner) *Bergman v Haertsch* [2000] NSWSC 528 at [16] where Abadee J recorded: "The surgery when ultimately performed (with full understanding of the risks) followed as I have said years of consideration, investigation and enquiry. The plaintiff's decision was not hasty but was in my view, the subject of long consideration and mature reflection." By way of contrast see [21] quoting from the consent document "In preparation for this surgery you have seen two psychiatrists who agree that it is reasonable for you to pursue this surgery."

¹⁵ *Rogers v Whitaker* [1992] HCA 58; (1992) 175 CLR 479 per Mason CJ, Brennan, Dawson, Toohey & McHugh JJ.

¹⁶ Nonetheless recognised as an ethical duty: "You must not abuse your patient's trust. You must not, for example...give patients, or recommend to them, an investigation or treatment which you know is not in their best interests". Clause 2.8, Code of Professional Conduct July 2005 made under Section 99A Medical Practice Act NSW 1992.

¹⁷ But distinguishable from the classic 'incompetent' patient. See generally Marion's case (1992) 175 CLR 257; [1992] HCA 15

¹⁸ *Halvorsen v Dobler* [2006] NSWSC 1307 at [182]

professionals may not paint the whole picture¹⁹ if it transpires that peer plastic or cosmetic surgeons do not customarily apply psychiatric screening and / or cooling off periods.

16. It is in this context that a role may emerge for argument as to breach of fiduciary duty²⁰ and failing that for provisions such as section 50(2) **Civil Liability Act NSW 2002**, whereby peer professional opinion cannot be relied on for the purposes of the section if the court considers that the opinion is irrational.

17. As a personal opinion, I wonder if entrepreneurial medicine ought not be excluded from the protections of the civil liability legislation entirely.

Public authority protections

18. There appears some as yet unclear potential in the public authority protections, whereby an act or omission of a public health authority does not constitute a breach of statutory duty unless so *unreasonable* that no authority having the functions of the authority in question could properly consider the act or omission to be a *reasonable* exercise of its functions²¹.

19. The two cases I have found addressing this provision have not found it necessary to dwell on the meaning of the protection, which did not form part of the *Review* recommendations.

20. In *Walker*²², for example the court rejected the plaintiff's claim on the basis that breach of duty was not proven, so that even less were the allegations capable of establishing that the failure to exercise the powers conferred by the Mental Health Act was so unreasonable that no area health service could have regarded it as a reasonable exercise of power²³. In *Dederer*²⁴ (not a medical case) the court

¹⁹ Though as I have argued elsewhere, the inclusion of the word 'competent' may assist:

"Competence and irrationality – Locating the Law", Australian Civil Liability, Volume 3 Number 5 & 6, October 2006.

²⁰ See the discussion of *Breen v Williams* (1996) 186 CLR 71 in the broader article "Fiduciary disclosure of medical mistakes: The duty to promptly notify patients of adverse health care events", Faunce & Bolsin (2005) 12 JLM 478.

²¹ See for example Civil Liability Act NSW 2002 section 43

²² *Walker v Sydney West Area Health Service* [2007] NSWSC 526

²³ See *Walker* at [168]

²⁴ *Phillip James Dederer v Roads and Traffic Authority and Anor* [2005] NSWSC 185

simply stated that it did not find the failure of the Council to exercise its enforcement powers to be unreasonable²⁵.

21. For private insurers, the usual sharing agreements for the cost of a claim may not be so even handed, in the cases where a public authority hospital has a greater level of protection than an individual medical practitioner.

Insurance policy terms

22. Notwithstanding the existence in NSW since 2001 of a regime for compulsory medical indemnity insurance to protect consumers in the event of injury through negligent treatment or advice, policies offered to medical practitioners contain a number of 'exclusions'. Such policy exclusions create a major gap in the consumer protection available under the compulsory medical indemnity regime despite the words of the then Health Minister Mr Knowles: *In this day and age there is absolutely no justification for a doctor not to carry professional indemnity cover. Going bare, as occurs in a very small minority of cases, will no longer be acceptable in this State. Consumers will be fully protected*²⁶

23. Despite those sound sentiments, consumers clearly are not fully protected. Such a gap is inconsistent, for example, with compulsory 'third party' schemes to protect victims of motor vehicle accidents. In those schemes, the fact that the driver may be affected by alcohol, drugs or act with gross negligence or even intention does not deprive the victim of access to compensation.

24. By reference to one particular insurers website, policy coverage exclusions can be readily identified, including:²⁷

- 24.1. Transmission of a contagious disease or virus from the practitioner to the patient, where the practitioner knew or ought to have known that the disease or virus was being carried.
- 24.2. Manufacture, distribution or sale of products
- 24.3. Sexual misconduct
- 24.4. Practice under the influence of an intoxicant or narcotic

²⁵ Dederer at [89]

²⁶ See the speech of Mr Craig Knowles, NSW Legislative Assembly, 19 June 2001.
<http://www.parliament.nsw.gov.au/prod/parlment/hansart.nsf/V3Key/LA20010619015>

²⁷ http://www.unitedmp.com.au/0/0.13/0.13.4/AMIL_PII.pdf

25. It is apparent that such exclusions cover a range of matters which extend from essentially negligent actions (such as transmission of a virus) with minimal intention, to intentional actions (such as practicing whilst affected by a narcotic).

26. Medical indemnity insurers may argue, quite rightly, that individuals in certain circumstances such as intentional acts ought not have access to the benefit of insurance cover. Such an argument must concede the fact that in practice unless the individual has substantial assets, the victim will go uncompensated. The relative interests of insurers and individual medical practitioners can be balanced in what ought be a small number of these cases, by allowing the insurer a right of recovery from the individual medical practitioner of reasonable compensation paid to a victim.

27. To the extent that such reasonable compensation paid to a victim proves irrecoverable from an individual medical practitioner, the insurer is better placed to bear that loss than an individual victim.

Obligations to disclose error

28. *“Within a decade, full and frank disclose of (medical error) to patients is likely to be the norm, rather than the exception”*²⁸

29. The NSW Medical Board (NSWMB) obtained approval from the then Health Minister, Mr Morris lemma, for a code of professional conduct entitled *“Good Medical Practice: The Duties of a Doctor Registered in New South Wales”* under section 99A of the Medical Practice Act NSW 1992. Standard 2.5. reads: *“..act immediately to put matters right, if it is possible, if a patient under your care has suffered serious harm, through misadventure or for any other reason. You should explain fully to the patient what has happened and the likely short and long-term effects. When appropriate, you should offer an apology. If the patient lacks the maturity to understand what has happened, you should explain the situation honestly to those with parental responsibility for the child. If the patient is cognitively impaired you should provide explanation to the patient's parent, guardian, carer or person responsible”*.

30. Most state and territory medical boards in Australia have adopted, or are in the process of adopting, provisions in essentially the same terms as the NSWMB Code.

²⁸ Disclosing Harmful Medical Errors to Patients; Thomas H. Gallagher, M.D., David Studdert, LL.B., Sc.D., M.P.H., and Wendy Levinson, M.D. N Engl J Med 2007;356:2713-9.

31. Whilst the recently imposed ethical obligation goes some way towards supporting patients' rights in such circumstances, it lacks national consistency, clarity²⁹ and further lacks a framework for application on a day to day basis.

32. A similar obligation has, elsewhere in the world, been crystallized as a statutory obligation such as in New Jersey, with its *Patient Safety Act*³⁰. The New Jersey legislation requires that every health care facility inform every patient affected by a 'serious preventable adverse event or adverse event specifically related to an allergic reaction, no later than the end of the episode of care, or, if discovery occurs after the end of the episode of care, in a timely fashion'.

33. The Act further specifies that: 'The time, date, participants and content of the notification shall be documented in the patient's medical record' and that the content of the notification 'shall be determined in accordance with the rules and regulations of the commissioner'. The notice can be provided to a family member if disclosure 'would seriously and adversely affect the patient's health'. If an adult patient is not informed of a serious preventable adverse event or adverse event specifically related to an allergic reaction, the facility shall assure that the medical record includes a statement that provides the reason for not informing the patient.

34. Given the recent ethical pronouncements and work of the various clinical excellence / patient safety bodies, the I can only agree with the opening quote by Gallagher, Studdert & others that full and frank disclosure of (medical error) to patients is likely to be the norm. Perhaps the next challenge will be to deal with the ethical and legal obligations to injured patients, should early disclosure lead to early compensation agreements, with releases being signed in the absence of legal advice.

No fault compensation

35. Long term care schemes of wide application have been mooted in various guises by various parties for some time. It appears that the concept has not found favour with the Federal government. The various State & Territory governments would apparently prefer to await a medium term assessment of need once the operation of the civil liability regimes have been in operation for a sufficient period. However, there may be scope for the introduction of a limited scheme in the narrow area of vaccine injuries. Vaccine injuries can occur in three relevant ways:

²⁹ For example, in the context of therapeutic privilege.

³⁰ NJSA 26:2H-12.25(3)(d); NJSA 26:2H-12.23 and following; available online at <www.lindabury.com/resources/Patient%20Safety%20Act.pdf>.

- 35.1. Contamination, adulteration, improper configuration, other errors in the manufacturing process, inadequate testing or incorrect labeling.
- 35.2. Even if the vaccine itself is not defective, it may be administered improperly; an incorrect dosage used or contraindicated because of allergy, illness, immune suppression or age.
- 35.3. Non-defective vaccines properly administered can nevertheless produce idiosyncratic or allergic reactions in individual cases³¹.

36. In Australia at least, recent data suggests only a very small number of adverse events following immunization (AEFI). Professor David Isaacs, speaking at a recent Australian Health Policy Institute seminar³², summarised the 2000 – 2004 findings of the Adverse Drug Reactions Unit³³ (ADRU) as showing definite or probable vaccination causes for four patients recovering with sequelae and one patient death. Five AEFI following immunization over four years represents a small proportion even of the total reports to ADRU, some 5128, and much smaller proportion of total immunizations.

37. A significant number of developed countries have introduced vaccine injury compensation schemes, the first being West Germany in 1961. In Europe followed Switzerland, France and Denmark. The United States created a scheme in 1986 and England in 1987. Japan, Taiwan, Singapore, New Zealand and South Korea operate schemes in the Asia-Pacific region.³⁴

38. However to simply note the existence of schemes for vaccine injury compensation is not to say that all such schemes are equivalent. Some apply to compulsory vaccines only, and the compensation structure differs widely. England for example provides a single lump sum payment whilst Japan makes provision for medical allowances, care provision and a disability pension.

39. There is in my view a sound policy argument for establishment of a vaccine injury compensation scheme in Australia. Most other forms of medical treatment provide benefit to an individual, the resultant health or otherwise of whom is of no direct benefit to society as a whole other than perhaps in some indirect economic sense. Vaccination however provides a benefit to an individual, and provided that sufficient individuals are immunized, to society as a whole by further reducing the

³¹ Compensation programs for vaccine related injury abroad – A comparative analysis. W K Mariner, 31 St Louis University Law Journal 599 (1986-1987)

³² Seminar of the Australian Health Policy Institute convened by Professor Stephen Leeder, School of Public Health, University of Sydney held November 2005.

³³ <http://www.tga.gov.au/adr/>

³⁴ For a more comprehensive listing, see D Issacs, “Should Australia introduce a vaccine injury compensation scheme?” J. Paediatr. Child Health (2004) 40, at 247-300.

risk of infection. The policy argument is strengthened should vaccination be compulsory. In Australia vaccination is not compulsory but various incentives and reminders aim to promote it³⁵.

40. The political potential is perhaps analogous with amendments to the NSW motor accident legislation, where compensation will be available to victims of what has been described in a shorthand way as “inevitable accident” cases – such as where the driver of a motor vehicle suffers an unexpected cardiac arrest or epileptic seizure. Such cases are also rare but can be catastrophic for an individual.

41. Under a vaccine injury scheme, there will remain the challenge of discerning which are ‘valid’ AEFI, as opposed to disabilities arising from other causes or for no ascertainable reason. However the various international schemes outlined above have found ways to facilitate that threshold of lesser complexity and cost than the adversarial Court system.

42. Such a scheme need not deprive victims of medical negligence of their current legal rights³⁶; indeed the preservation of that alternative avenue of compensation by having an ‘opt in’ scheme would assuage concerns about what probably would be lesser levels of compensation available under a scheme compared to the modified common law.

43. Finally, such a scheme may provide some easier framework for victims should a vaccine manufacturer be granted legal immunity or indemnity in certain unusual circumstances, such as has been raised in the context of rapid and perhaps less rigorously tested avian influenza vaccine production.

Bill Madden

³⁵ Apparently with some success: Of a large sample of 1779 Melbourne children in childcare in 1997, only 13 (0.7%) had not received any vaccines. Bond L, Nolan T, Lester R. Immunisation uptake, services required and government incentives for users of formal day care. *Aust N Z J Public Health* 1999; 23: 368-376.

³⁶ Professor Isaacs in , “Should Australia introduce a vaccine injury compensation scheme?” *J. Paediatr. Child Health* (2004) 40, at 247-300 notes that of the 13 schemes he identified, 3 countries made it contingent that claimants not seek damages through the Courts and 5 imposed limits, the remaining 5 apparently imposing no restriction.