

# DEFENCES IN MEDICAL NEGLIGENCE: TO WHAT EXTENT HAS TORT LAW REFORM IN AUSTRALIA LIMITED THE LIABILITY OF HEALTH PROFESSIONALS?

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## I. INTRODUCTION

On the 10<sup>th</sup> anniversary of the beginning of the insurance crisis and a period of significant torts law reforms, it is appropriate to take this opportunity to consider to what extent civil liability legislation (in various jurisdictions) has limited the liability of health professionals in Australia. Prior to the last decade, legislation on civil liability was usually used to extend liability, rather than to limit it.<sup>1</sup> Tort law reform has now resulted in legislation being passed by all Australian jurisdictions, implementing some recommendations contained in the Ipp Report<sup>2</sup> as well as other reforms that were not included in the recommendations.

The review of the law of negligence was in response to a perceived crisis in liability insurance; in particular, medical indemnity insurance.<sup>3</sup> This perceived crisis resulted from several factors, including the collapse of HIH, the destruction of the World Trade Centre, the provisional liquidation of Australia's largest medical defence organisation (United Medical Protection), and the subsequent substantial increases in medical indemnity insurance. The objective of the review was to restrict and limit liability in negligence actions.<sup>4</sup>

This article will consider and reflect upon the extent to which those reforms have affected the liability of health professionals in medical negligence actions. It is not within the scope of this article to consider the elements of the negligence action: duty of care, breach and damage. Rather, this article will consider the areas of defences and assessment of damages: contributory negligence, voluntary assumption of risk, good Samaritans, the peer acceptance defence, apologies and statutory limits on damages.

It will be argued in this article that the courts have generally interpreted the civil liability reforms as being consistent with the common law. However, the liability of health professionals has been limited by the civil liability legislation through the use of thresholds, caps and presumptions in the assessment of damages and apportioning liability between the parties rather than by the application of defences. Therefore, this paper will first consider defences and then statutory limits.

## II. DEFENCES

There are a number of possible defences to a negligence action, including contributory negligence and voluntary assumption of the risk. There are also specific defences in medical negligence like the peer acceptance defence. Other topics included in this section include the Good Samaritan defence and apologies.

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1 Loane Skene and Harold Luntz, 'Effects of Tort Law Reform on Medical Liability' (2005) 79 *Australian Law Journal* 345.

2 Law of Negligence Review Panel, *Review of the Law of Negligence, Final Report* (Commonwealth of Australia, 2002) ('the Ipp Report').

3 Skene and Luntz, above n 1, 346.

4 See terms of reference of the Ipp Report, above n 2, ix; Des Butler, Tina Cockburn and Jennifer Yule, 'Medical Negligence' in Ben White, Fiona McDonald and Lindy Willmott (eds), *Health Law in Australia* (Thomson Reuters, 2010) 212.

### A. Contributory Negligence

A common defence to an action in negligence is contributory negligence. Contributory negligence was once a complete defence to an action in negligence;<sup>5</sup> however, since the introduction of apportionment legislation, liability can now be apportioned and damages reduced.<sup>6</sup> The Ipp Report recognised that at common law the courts were applying a lower standard of care and made the recommendation that emphasis must be made to the fact that contributory negligence had to be measured against an objective standard (the standard being the same as in establishing negligence against the defendant). The civil liability legislation has introduced a number of sections to further this aim. Presumptions and mandatory reductions for contributory negligence have attempted to reduce the liability of defendants. It is now possible for damages to be reduced by 100 per cent for contributory negligence. Legislation now also expressly provides that the standard of care for contributory negligence is the same as for negligence.

There is an argument about whether the standard of care owed by the defendant and the plaintiff should be the same or a different standard. The common law has treated the standard differently because the failure by a defendant puts others at risk, whereas the failure by the plaintiff impacts on only them. However, the civil liability legislation states that they are the same. This idea has also found support from Callinan and Heydon JJ in *Vairy*, where it was stated that the plaintiff's contributory negligence involves a breach of one's duty to society not to become a burden on it by exposing oneself to risk where, at 483, their Honours said:<sup>7</sup>

The 'duty' to take reasonable care for his own safety that a plaintiff has is not simply a nakedly self-interested one, but one of enlightened self-interest which should not disregard the burden, by way of social security and other obligations that a civilised and democratic society will assume towards him if he is injured. In short, the duty that he owes is not just to look out for himself, but not to act in a way which may put him at risk, in the knowledge that society may come under obligations of various kinds to him if the risk is realised.<sup>8</sup>

This statement was supported by Ipp JA in *CBH v Edwards*, where his Honour noted the equivalence between the civil liability legislation and Callinan and Heydon JJ in *Vairy*.<sup>9</sup> Given this, the Court did not accept that the plaintiff's contributory negligence was less serious than the defendant's breach of duty of care.<sup>10</sup>

Prior to the recent civil liability reforms, apportionment legislation did not permit a court to find a plaintiff was 100 per cent contributorily negligent.<sup>11</sup> However, the situation is now different under new civil liability legislation,<sup>12</sup> where 100 per cent apportionment is possible. In *Adams by her next friend O'Grady v State of New South Wales*,<sup>13</sup> the Court held that it was 'entitled to come to a view that the contributory negligence should be assessed at 100 per cent of the cause of the injury'.<sup>14</sup> But this has not happened in medical negligence cases and, considering the expert knowledge involved, it is difficult to imagine such a case.

5 *Williams v Commissioner for Road Transport* (1933) 50 CLR 258.

6 *Civil Law (Wrongs) Act 2002* (ACT) s 102; *Law Reform (Miscellaneous Provisions) Act 1965* (NSW) s 9(1); *Law Reform (Miscellaneous Provisions) Act 1956* (NT) s 16(1); *Law Reform Act 1995* (Qld) s 10(1); *Law Reform (Contributory Negligence and Apportionment of Liability) Act 2001* (SA) s 7; *Wrongs Act 1954* (Tas) s 4(1); *Wrongs Act 1958* (Vic) s 26(1); *Law Reform (Contributory Negligence and Tortfeasors Contribution) Act 1947* (WA) s 4(1).

7 *Vairy v Whyong Shire Council* (2005) 223 CLR 422.

8 *Ibid* 483.

9 *Consolidated Broken Hill Ltd v Edwards* [2005] NSWCA 380, [68]–[69].

10 *Ibid* [71].

11 *Wynbergen v The Hoyts Corporation Pty Ltd* (1998) 149 ALR 25.

12 *Civil Law (Wrongs) Act 2002* (ACT) s 47; *Civil Liability Act 2002* (NSW) s 5S; *Civil Liability Act 2003* (Qld) s 24; *Wrongs Act 1954* (Tas) s 4(1); *Wrongs Act 1958* (Vic) s 63.

13 *Adams by her next friend O'Grady v State of New South Wales* [2008] NSWSC 1257.

14 *Ibid* [132]. See also *Zilio v Lane* [2009] NSWDC 226.

All jurisdictions, except for the Australian Capital Territory and the Northern Territory, have sections in their civil liability legislation dealing with contributory negligence,<sup>15</sup> which have been held to be reflective of the common law<sup>16</sup> — that is, the standard of care is the same as for negligence.<sup>17</sup> The standard is different when the plaintiff is a child.<sup>18</sup> Once contributory negligence is proven, the appropriate apportionment needs to be considered to determine what is ‘just and equitable’ in accordance with the legislation. This is subjective and based on findings of fact:

No doubt the making of the apportionment which the legislation requires involves a comparison of culpability of both parties ie, the degree to which each has departed from what is reasonable, but that is not the only element to be considered. Regards must be had to the relative importance of the acts of the parties in causing damage and it is the whole conduct of each negligent party in relation to the circumstances of the accident which must be subject to comparative examination.<sup>19</sup>

There are mandatory reductions for intoxication<sup>20</sup> but it would seem unlikely that intoxication would be relevant in medical negligence cases. The mandatory presumption can be rebutted by establishing that the intoxication did not contribute to the breach of duty.

Since the High Court decision in *Rogers v Whitaker*,<sup>21</sup> courts have been prepared to focus on the conduct of the patient.<sup>22</sup> However, cases involving successful claims of contributory negligence are rare.<sup>23</sup> There are some scenarios when contributory negligence can arise and be raised in medical negligence cases. One is when the patient does not return to see the doctor when requested or the patient does not adequately inform the doctor of the nature of their symptoms. In such a situation, damages may be reduced by 20 per cent, depending on the facts of the case.<sup>24</sup> There is a theme in the cases of an idea of ‘shared responsibility’<sup>25</sup> between the health professional and the patient and that there are rights and responsibilities as a ‘consumer of medical services’.<sup>26</sup> Other scenarios include the patient failing to keep appointments with the doctor (in one case, liability was reduced by 50 per cent),<sup>27</sup> and the patient failing to advise the staff at a fertility clinic that only one, not two, embryos should be transferred (where the liability

15 *Civil Liability Act 2002* (NSW) s 5R; *Civil Liability Act 2003* (Qld) s 23; *Civil Liability Act 1936* (SA) s 5K; *Civil Liability Act 2002* (Tas) s 23; *Wrongs Act 1958* (Vic) s 44; *Civil Liability Act 2002* (WA) s 5K.

16 *Consolidated Broken Hill Ltd v Edwards* [2005] NSWCA 380, [67]–[70].

17 *Civil Liability Act 2002* (NSW) s 5R; *Civil Liability Act 2003* (Qld) s 23; *Civil Liability Act 1936* (SA) s 44; *Civil Liability Act 2002* (Tas) s 23; *Wrongs Act 1958* (Vic) s 62; *Civil Liability Act 2002* (WA) s 5K.

18 *Doubleday v Kelly* [2005] NSWCA 151, [26].

19 *Wynbergen v The Hoyts Corporation Pty Ltd* (1998) 149 ALR 25, 29 (Hayne J).

20 *Civil Law (Wrongs) Act 2002* (ACT) s 95; *Civil Liability Act 2002* (NSW) ss 48–50; *Personal Injuries (Liabilities and Damages) Act 2003* (NT) ss 14–17; *Civil Liability Act 2003* (Qld) ss 46, 47; *Civil Liability Act 1936* (SA) ss 46, 48; *Civil Liability Act 2002* (Tas) ss 4A, 7; *Wrongs Act 1958* (Vic) s 14G; *Civil Liability Act 2002* (WA) s 5L.

21 (1992) 175 CLR 479.

22 Robert B Harper, ‘The Application of Contributory Negligence Principles to the Doctor/Patient Relationship’ (2001) 9 *Torts Law Journal* 1, 14.

23 Loane Skene, *Law and Medical Practice* (LexisNexis, 2008) 238; Bill Madden and Janine McIllwraith, *Australian Medical Liability* (LexisNexis, 2008) 290.

24 *Locher v Turner* [1995] QCA 106; *Kalokerinos v Burnett* (Unreported, NSW Court of Appeal, Kirby P, Clarke and Powell JJA, 30 January 1996) accepted in *Tai v Hatzistravrou* [1999] NSWCA 306.

25 *Tai v Hatzistravrou* [1999] NSWCA 306, [56].

26 Harper, above n 22, 16.

27 *Young v Central Australian Aboriginal Congress Inc* [2008] NTSC 47.

was reduced by 35 per cent).<sup>28</sup> There are many examples where allegations of contributory negligence have not been successful in medical negligence cases.<sup>29</sup>

There were few examples in medical negligence cases where contributory negligence was successful before the civil liability reforms<sup>30</sup> and there are still few successful cases since the introduction of the reforms.<sup>31</sup> So it can be suggested that introducing the same standard for both the plaintiff and the defendant in the civil liability legislation has not resulted in an increase in the success of the defence of contributory negligence. However, more data would be needed to further that argument.

### B. *Voluntary Assumption of Risk*

*Volenti non fit injuria* ('no injury is done to one who voluntarily consents') is a complete defence to an action in negligence.<sup>32</sup> If a plaintiff, with full knowledge, voluntarily accepts the risk of injury, he or she will not recover any damages. The defendant needs to prove not only that the plaintiff accepted the risk of injury but also accepted that if injury should happen, the plaintiff would accept the legal risk.<sup>33</sup> Voluntary assumption of risk has traditionally been a difficult defence to prove especially since the introduction of the apportionment legislation. However, the Queensland Court of Appeal recently upheld a plea of the defence, stating that 'while the defence of *volenti* may be a highly endangered species, it is not yet extinct'.<sup>34</sup>

As a result of the civil liability legislation, the utility of the defence has been strengthened by introducing a presumption that the plaintiff is aware of obvious risks. The Ipp Report indicated that the intention was 'to encourage greater use by the courts of the defence of assumption of risk'.<sup>35</sup> As a result of the recommendations, most civil liability legislation, excluding the Australian Capital Territory and the Northern Territory, provides for a presumption that the plaintiff was actually aware of the risk if it was an obvious one.<sup>36</sup> The plaintiff has to prove, on the balance of probabilities, that he or she was not aware of an obvious risk. This reverses the onus of proof and makes *volenti* easier to use in the following way:

The effect of these provisions is that a plaintiff is rebuttably presumed to be aware of a risk where the risk would have been obvious to a reasonable person in the position of the plaintiff. A plaintiff cannot rebut the presumption by claiming that even though he or she was aware of the general risk of harm, he or she was not aware of all its possible manifestations, including the one that eventuated.<sup>37</sup>

In terms of the wording of the sections relating to obvious risk, there are some variations. Tasmania is the only jurisdiction where medical practitioners are under no duty to warn of obvious risk.<sup>38</sup> Other jurisdictions have provisions that make an exception to the protection afforded by the provisions relating to no duty to warn of obvious risks where the defendant is

28 *G & M v Sydney Robert Armellin* [2008] ACTSC 68.

29 See, eg, *Wighton v Arnot* [2005] NSWSC 637; *Boehm v Deleuil* [2005] WADC 55; *Munday v Australian Capital Territory Health and Community Care Service* [2004] ACTSC 134.

30 (2001) 9 TLJ 180.

31 Madden and McIllwraith, above n 23, 290.

32 *Rootes v Shelton* (1967) 116 CLR 383.

33 *Smith v Charles Baker & Sons* [1891] AC 325; *Canterbury Municipal Council v Taylor* [2002] NSWCA 24.

34 *Leyden v Caboolture Shire Council* [2007] QCA 134, [41] (Mackenzie J) (15-year-old plaintiff suffered personal injuries when riding a bicycle on a BMX track constructed by the defendant council).

35 The Ipp Report, above n 2, 129.

36 *Civil Liability Act 2002* (NSW) ss 5F, 5G; *Civil Liability Act 2003* (Qld) ss 13, 14; *Civil Liability Act 1936* (SA) ss 36, 37; *Civil Liability Act 2002* (Tas) ss 15, 16; *Wrongs Act 1958* (Vic) ss 53, 54; *Civil Liability Act 2002* (WA) ss 5F, 5N.

37 *Carey v Lake Macquarie City Council* [2007] NSWCA 4, [90] (McClellan CJ).

38 *Civil Liability Act 2002* (Tas) s 17.

a professional who has been asked for advice.<sup>39</sup> But the sections exclude professional services that carry the risk of injury or death.<sup>40</sup> Queensland and Tasmania have a specific provision relating to the duty of a doctor to warn of risk.<sup>41</sup> The section sets out the common law duty to warn which includes their proactive and reactive duty.<sup>42</sup> The proactive duty to warn means that the doctor has to give the patient sufficient information to make an informed decision about whether to accept treatment, taking into consideration all the material risks associated with the treatment. The reactive duty to inform means the doctor needs to give the patient all the information they need to make an informed decision about whether to agree to treatment based on the patient's requirements.

In many jurisdictions, there is no liability for the materialisation of an inherent risk (a risk of something occurring that cannot be avoided by the exercise of reasonable care and skill).<sup>43</sup> For example, there would be no liability for the inherent risks involved in a medical procedure. But this does not affect the duty to warn of the risks.<sup>44</sup>

The reversal of the onus of proof through the obvious risk sections has attempted to extend the scope of the defence of voluntary assumption of risk. The plaintiff has to prove that they were unaware of the risk. However, in relation to health professionals, this defence of *volenti* does not really apply because consent to medical treatment does not amount to an assumption of the risk. Even in the situation where a patient is told by a doctor that they are inexperienced, the appropriate argument would be about the relevant standard of care and not about the defence of *volenti*.

### C. The Peer Acceptance Defence

After *Rogers v Whitaker*<sup>45</sup> where the High Court held that it is ultimately for the court to decide the appropriate standard of care in medical negligence cases, health professionals were concerned about an increase in their liability in negligence. The peer acceptance defence has been introduced and enacted by legislation in response to a recommendation in the Ipp Report.<sup>46</sup> The Ipp Report recommended that the *Bolam* test<sup>47</sup> be re-introduced with modifications with regards to medical treatment. Under the *Bolam* test, a doctor would not be liable in negligence as long as the doctor acted in accordance with a practice accepted at the time as proper practice by a responsible body of medical opinion.<sup>48</sup> The recommendation says '[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'. It has been held that, by consideration of the language in the sections,

39 *Civil Liability Act 2002* (NSW) s 5H; *Civil Liability Act 2003* (Qld) s 15; *Civil Liability Act 2002* (WA) s 5O. More limited to health care in *Civil Liability Act 1936* (SA) s 38; *Wrongs Act 1958* (Vic) s 54.

40 *Civil Liability Act 2002* (NSW) s 5H(2)(c); *Civil Liability Act 2003* (Qld) s 15(2)(c); *Civil Liability Act 1936* (SA) s 38(2)(c); *Civil Liability Act 2002* (Tas) s 17(2)(c); *Civil Liability Act 2002* (WA) s 5O(2)(c).

41 *Civil Liability Act 2002* (Qld) s 21; *Civil Liability Act 2002* (Tas) s 21.

42 *Rogers v Whitaker* (1992) 175 CLR 479, 490; the Ipp Report, above n 2, [3.51]–[3.70].

43 *Civil Liability Act 2002* (NSW) s 5I; *Civil Liability Act 2003* (Qld) s 16; *Civil Liability Act 1936* (SA) s 39; *Civil Liability Act 2002* (WA) s 5P; *Wrongs Act 1958* (Vic) s 55.

44 *Civil Liability Act 2002* (NSW) s 5I(3); *Civil Liability Act 2003* (Qld) s 16(3); *Civil Liability Act 1936* (SA) s 39(3); *Civil Liability Act 2002* (WA) s 5P(2); *Wrongs Act 1958* (Vic) s 55(3).

45 (1992) 175 CLR 479.

46 The Ipp Report, above n 2, Recommendation 3.

47 That it cannot amount to negligence if what the defendant did complied with a practice regarded as proper at the time by a responsible body of opinion within the profession: *Bolam v Friern Barnet Hospital Management Committee* [1957] 1 WLR 582.

48 *Ibid* 586.

this is a defence and not an integer of breach<sup>49</sup> and so must be specifically pleaded by the defendant.<sup>50</sup>

There are differences in the language used in the peer acceptance defence in the different jurisdictions. One difference is in terms of who is covered by the defence. Some jurisdictions use the term ‘professionals’<sup>51</sup> (which has been held to include chiropractic treatment).<sup>52</sup> Western Australia provides a definition for health professional.<sup>53</sup> All jurisdictions use the terms ‘widely accepted’, ‘peer’ and ‘competent’.<sup>54</sup> Queensland and Victoria also include the terms ‘significant number’ and ‘respected’.<sup>55</sup> In terms of what is meant by widely accepted and competent, Madden and McIllwraith comment that this arguably gives rise to a test within a test.<sup>56</sup> The meaning of ‘widely accepted in Australia’ was considered in *Vella v Permanent Mortgages Pty Ltd*.<sup>57</sup> There can be conflicting expert evidence<sup>58</sup> and an expert can be someone who is materially interested in the proceedings.<sup>59</sup>

There are exceptions to the widely accepted defence, depending on the precise wording in the legislation in the particular jurisdiction, including where it is irrational,<sup>60</sup> unreasonable<sup>61</sup> or by *Wednesbury*<sup>62</sup> unreasonableness (so unreasonable that no reasonable health professional in the health professional’s position could have acted or omitted to do something in accordance with that practice).<sup>63</sup>

The defence must be pleaded, and possibly the section specifically referred to, if a defendant wishes to rely on it at trial.<sup>64</sup> There have been cases where the peer acceptance defence would have been successful but was not necessary because the plaintiff was not able to establish the elements of the negligence action. For example, in *Melchior v Sydney Adventist Hospital Ltd* the court found that while a duty of care was owed the content of the duty of care did not include administering the drug as pleaded by the plaintiff. Therefore, there was no breach or causation; however, if there had been an otherwise successful negligence action it would have failed because of the peer acceptance defence.<sup>65</sup>

It is important to note that the peer acceptance defence applies only to treatment and not advice.

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49 *Dobler v Halverson* [2007] NSWCA 335.

50 *Sydney South West Area Health Service v MD* [2009] NSWCA 343, [23], [29]–[31] (Hodgson JA), [51] (Allsop P).

51 *Civil Liability Act 2002* (NSW) s 5O; *Civil Liability Act 2003* (Qld) s 22; *Civil Liability Act 1936* (SA) s 41; *Civil Liability Act 2002* (Tas) s 22; *Wrongs Act 1958* (Vic) s 59.

52 *Kocev v Toh* [2009] NSWDC 169.

53 *Civil Liability Act 2003* (WA) s 5PA.

54 *Civil Liability Act 2002* (NSW) s 5O; *Civil Liability Act 2003* (Qld) s 22; *Civil Liability Act 1936* (SA) s 41; *Civil Liability Act 2002* (Tas) s 22; *Wrongs Act 1958* (Vic) s 59; *Civil Liability Act 2003* (WA) s 5PB.

55 *Civil Liability Act 2003* (Qld) s 22; *Wrongs Act 1958* (Vic) s 59.

56 Madden and McIllwraith, above n 23, 130.

57 *Vella v Permanent Mortgages Pty Ltd* [2008] NSWSC 505.

58 *Dobler v Halverson* [2007] NSWCA 335, [103]–[104].

59 *Sydney South West Area Health Service v Stamoulis* [2009] NSWCA 153.

60 *Civil Liability Act 2002* (NSW) s 5O(2); *Civil Liability Act 2003* (Qld) s 22(2); *Civil Liability Act 1936* (SA) s 41(2); *Civil Liability Act 2002* (Tas), 22(2).

61 *Wrongs Act 1958* (Vic) s 59(2).

62 *Associated Provincial Picture Houses Ltd v Wednesbury Corporation* [1948] 1 KB 223, 230.

63 *Civil Liability Act 2003* (WA) s 5PB(4).

64 *Sydney South West Area Health Service v MD* [2009] NSWCA 343, [23], [29]–[31] (Hodgson JA), [51] (Allsop P).

65 *Melchior v Sydney Adventist Hospital Ltd* [2008] NSWSC 1282.

### D. Good Samaritans

Good Samaritans are people who give assistance to others in an emergency. There is a strongly held view among health professionals that they have a chance of being sued if they provide assistance in an emergency.<sup>66</sup> This concern, however, has not resulted in cases being heard by the courts.<sup>67</sup> Indeed, there is protection for good Samaritans even though the Ipp Report recommended against such protection.<sup>68</sup> The Ipp Report declined to recommend a specific section limiting the liability of good Samaritans.<sup>69</sup> However, the civil liability legislation in all jurisdictions has addressed the issue of liability of people who assist in an emergency.<sup>70</sup>

Generally, the protection in the legislation is for someone who offers assistance in a medical emergency with no expectation of being paid and the person acts in good faith. In some jurisdictions, there is also protection for medical practitioners.<sup>71</sup> Further, in some jurisdictions like Victoria and Tasmania, the protection extends to anyone who provides advice on how to treat an injured person.<sup>72</sup> For example, in New South Wales, a person who provides assistance, in good faith and without expectation of payment or reward, is protected in an emergency when someone has suffered injuries or appears to have suffered injuries.<sup>73</sup> Other jurisdictions, such as Queensland, have created protection for persons performing duties for entities to enhance public safety, if it is in an emergency and the assistance is provided in good faith, but have no specific provision for good Samaritans like in New South Wales.<sup>74</sup> There are also specific protections for health professionals giving assistance in an emergency. For example, medical practitioners and nurses are protected in Queensland<sup>75</sup> as well as ambulance officers in New South Wales and Queensland.<sup>76</sup>

There is no protection for health professionals who render assistance in an emergency from civil liability in certain circumstances. In South Australia and Western Australia, recklessness is not protected.<sup>77</sup> In Queensland, gross negligence is not protected and the services must be performed without expectation of fee or reward.<sup>78</sup> In all jurisdictions except Victoria, a good

66 Linda Cowley-Smith, 'The Duty to Rescue Unveiled' (1997) 4 *Journal of Law and Medicine* 352, 355.

67 Skene and Luntz, above n 1, 347.

68 Michael Eburn, 'Liability of Volunteers and Good Samaritans: Making it Safe to Volunteer or Restricting Claims for Damage?' (2010) 7(2) *Australian Civil Liability* 14.

69 The Ipp Report, above n 2, [7.24].

70 *Civil Law (Wrongs) Act 2002* (ACT) s 5; *Civil Liability Act 2002* (NSW) ss 56–7; *Personal Injuries (Liabilities and Damages) Act 2003* (NT) s 8; *Civil Liability Act 2003* (Qld) ss 26–7; *Civil Liability Act 1936* (SA) s 74; *Civil Liability Act 2002* (Tas) ss 35A–35C; *Civil Liability Act 2002* (WA) ss 5AB, 5AD; *Wrongs Act 1958* (Vic) s 31B.

71 *Civil Law (Wrongs) Act 2002* (ACT) s 5; *Civil Liability Act 2002* (NSW) ss 55–8; *Personal Injuries (Liabilities and Damages) Act 2003* (NT) s 8; *Law Reform Act 1995* (Qld) ss 15–6; *Civil Liability Act 1936* (SA) s 74; *Civil Liability Act 2002* (Tas) ss 35A–35C; *Civil Liability Act 2002* (WA) ss 5AB, 5AD; *Wrongs Act 1958* (Vic) s 31A–31D.

72 *Civil Law (Wrongs) Act 2002* (ACT) s 5; *Civil Liability Act 2002* (NSW) ss 55–8; *Personal Injuries (Liabilities and Damages) Act 2003* (NT) s 8; *Law Reform Act 1995* (Qld) ss 15–16; *Civil Liability Act 1936* (SA) s 74; *Civil Liability Act 2002* (Tas) ss 35A–35C; *Civil Liability Act 2002* (WA) ss 5AB, 5AD; *Wrongs Act 1958* (Vic) ss 31A–31D.

73 *Civil Liability Act 2002* (NSW) s 57.

74 *Civil Liability Act 2003* (Qld) s 26. See also *Civil Law (Wrongs) Act 2002* (ACT), ch 2, pt 2.1; *Civil Liability Act 2002* (NSW), pt 8; *Personal Injuries (Liabilities and Damages) Act 2003* (NT), pt 2, Div 1; *Civil Liability Act 1936* (SA), pt 9, Div 11; *Civil Liability Act 2002* (WA), pt 1D; *Wrongs Act 1958* (Vic), pt VIA.

75 *Law Reform Act 1995* (Qld) s 16.

76 *Health Services Act 1997* (NSW) s 67; *Ambulance Service Act 1991* (Qld) ss 38, 39.

77 *Civil Liability Act 1936* (SA) s 74; *Civil Liability Act 2002* (WA), pt 1D.

78 *Law Reform Act 1995* (Qld) s 16.

Samaritan is not protected if significantly impaired by alcohol or drugs.<sup>79</sup> In New South Wales, there is no protection if the person either intentionally or negligently caused the initial injuries.<sup>80</sup> In New South Wales and Tasmania, there is no protection if the person claims to have training they do not have.<sup>81</sup>

Another aspect to the issue of the civil liability of good Samaritans is the question whether a health professional will be sued if they do not assist someone in an emergency. The answer is that there is no duty to rescue in Australia.<sup>82</sup> Of course, a doctor is subject to a professional code of practice.<sup>83</sup> However, one case which causes conflict with this general proposition is *Lowns v Woods*,<sup>84</sup> where a doctor was held liable even though the plaintiff was not his patient. It could be argued that, since the case was decided by the Court in the era when the proximity test was used, and the courts now use the multi-factorial approach, the case could be distinguished on that basis.<sup>85</sup>

There have been no significant claims against health professionals for assisting in medical emergencies both before and after the changes in civil liability legislation.<sup>86</sup>

### E. Apologies

Legislation encourages apologies to be made, and thereby reduce the number of actions commenced, by providing that they are made with no admission of legal liability. The Ipp Report did not make recommendations about apologies. However, apologies are becoming increasingly important in medical negligence cases, especially in the area of the disclosure of adverse medical events. All jurisdictions in Australia have legislation which encourages apologies or the reducing or waiving of fees payable for the service by making such actions not an admission of liability.<sup>87</sup> There are differences in the legislation in terms of how an apology is defined and whether it is deemed not to be an admission of liability, or not admissible as an admission of liability.<sup>88</sup> The objective of the legislation is to reduce litigation. Many plaintiffs want 'recognition of their injury, an explanation and an apology'.<sup>89</sup> The theory is that fewer patients sue doctors if the doctors have apologised, and if apologies are not an admission of liability then more doctors will make apologies.<sup>90</sup>

Recent amendments in Queensland in September 2010 have extended apology protections to include implied admission of fault.<sup>91</sup> In addition to the existing sections dealing with 'expression of regret', Queensland now has sections covering an apology. Apology is defined as 'an expression of sympathy or regret, or of a general sense of benevolence or compassion, in connection with any matter, whether or not it admits or implies an admission of fault in relation

79 *Civil Law (Wrongs) Act 2002* (ACT) s 8; *Civil Liability Act 2002* (NSW) s 58(2); *Personal Injuries (Liabilities and Damages) Act 2003* (NT) s 8; *Civil Liability Act 1936* (SA) s 74(4); *Civil Liability Act 2002* (Tas) s 35C; *Civil Liability Act 2002* (WA) s 5AE.

80 *Civil Liability Act 2002* (NSW) s 58.

81 *Civil Liability Act 2002* (NSW) s 58(3); *Civil Liability Act 2002* (Tas), 35C.

82 *Sutherland Shire Council v Heyman* (1985) 157 CLR 424.

83 *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, 77.

84 (1996) Aust Torts Reports 81-376.

85 A separate issue is the appropriate standard of care in all the circumstances of the case: see *Imbree v McNeilly* (2008) 236 CLR 510.

86 Eburn, above n 66, 17.

87 *Civil Law (Wrongs) Act 2002* (ACT), pt 2.3; *Civil Liability Act 2002* (NSW), pt 10; *Personal Injuries (Liabilities and Damages) Act 2003* (NT), pt 2, Div 2; *Civil Liability Act 2003* (Qld), ch 4, pt 1; *Civil Liability Act 1936* (SA) s 75; *Civil Liability Act 2002* (Tas) ss 6A-7; *Wrongs Act 1958* (Vic) ss 14I, 14J; *Civil Liability Act 2002* (WA) ss 5AF-5AH.

88 P Vines, 'Apologies and Civil Liability in the UK: A View from Elsewhere' (2008) 12 *Edinburgh Law Review* 200, 202.

89 Skene and Luntz, above n 1, 362.

90 Vines, above n 85, 210.

91 *Civil Liability Act 2003* (Qld) ss 72A-72D.



to the matter.<sup>92</sup> An apology ‘does not constitute an express or implied admission of fault or liability by the person in relation to the matter.’<sup>93</sup> These amendments make Queensland similar to the other jurisdictions.

Considering the extent to which the tort law reforms have limited the liability of health professionals, before the civil liability legislation was enacted in various jurisdictions, expressions of regret and apologies could be used as evidence of an admission of fault, whereas now they are not admissible. However, just because an apology is made does not necessarily mean there will be liability found. The apology forms part of the evidence used to establish the elements of an action.<sup>94</sup> Therefore, making apologies not an admission of liability does not necessarily have a significant impact once a matter goes to court. For health professionals, the utility of an apology is in the period before proceedings are instituted. However, it has been argued that apologies actually have the effect of alerting patients to the possibility of litigation.<sup>95</sup>

### III. STATUTORY LIMITS

When a negligence action has been successfully proved by a plaintiff, the court awards compensatory damages. The purpose of compensatory damages is to put the plaintiff back in the position they would have been but for the negligence of the defendant. The assessment of damages was governed by common law principles with the court exercising its discretion in determining the quantum of the damages. As a result of the tort law reform, there are now statutory limits placed on the recovery of damages including the use of thresholds and caps. The purpose of the statutory limits is to limit the amount and extent of liability and to thereby make it less attractive for plaintiffs to commence proceedings. There are also statutory prohibitions in terms of exemplary damages.

#### A. Thresholds

One of the largest components of damages awarded is for gratuitous care. The Ipp Report recommended that there should be a threshold on this head of damages.<sup>96</sup> Many jurisdictions have imposed a threshold for the awarding of damages under this head.<sup>97</sup> However, once the threshold has been reached, an award can be made even if the services afterwards are less than the threshold amount.<sup>98</sup> The Australian Capital Territory does not have a threshold for gratuitous care.<sup>99</sup> Tasmania has abolished the right to damages for gratuitous care.<sup>100</sup>

For claims for personal injuries under the head of non-economic loss, plaintiffs must now reach a threshold before an amount will be awarded under this head of damages. Included in non-economic loss is pain and suffering, loss of amenities of life, loss of enjoyment of life and, in some jurisdictions, disfigurement.<sup>101</sup> The Ipp Report recommended the threshold be set at

92 *Civil Liability Act 2003* (Qld) ss 72C.

93 *Civil Liability Act 2003* (Qld) ss 72D.

94 *Dovuro Pty Ltd v Wilkins* (2003) 215 CLR 317.

95 D M Studdert et al, ‘Disclosure of Medical Injury to Patients: An Improbable Risk Management Strategy’ (2007) 26 *Health Affairs* 215.

96 The Ipp Report, above n 2, Recommendation 51.

97 *Civil Law (Wrongs) Act 2002* (ACT) s 100; *Civil Liability Act 2002* (NSW) s 15; *Personal Injuries (Liabilities and Damages) Act 2003* (NT) s 23; *Civil Liability Act 2003* (Qld) s 59; *Civil Liability Act 1936* (SA) s 58; *Wrongs Act 1958* (Vic) s 281A; *Civil Liability Act 2003* (WA) s 12.

98 *Kriz v King* [2007] 1 Qd R 327; *Hill v Forrester* [2010] NSWCA 170.

99 *Civil Law (Wrongs) Act 2002* (ACT) s 100.

100 *Common Law (Miscellaneous Actions) Act 1986* (Tas) s 5.

101 *Civil Law (Wrongs) Act 2002* (ACT) s 99; *Civil Liability Act 2002* (NSW) s 3; *Personal Injuries (Liabilities and Damages) Act 2003* (NT) s 3; *Civil Liability Act 2003* (Qld) s 51; *Civil Liability Act 1936* (SA) s 3A; *Wrongs Act 1958* (Vic) ss 28C, 28LB; *Civil Liability Act 2003* (WA) s 9.

15 per cent<sup>102</sup> of a most extreme case and this has been adopted in New South Wales.<sup>103</sup> Other jurisdictions have adopted different approaches. For example, Victoria requires a ‘significant injury’ which, in most cases, means 5 per cent degree of impairment for personal injury and 10 per cent for mental harm.<sup>104</sup> Queensland does not have a threshold but has a sliding scale.<sup>105</sup> South Australia has a sliding scale and a threshold of significant impairment.<sup>106</sup> Tasmania and Western Australia have an indexed threshold.<sup>107</sup> Northern Territory has a 5 per cent impairment threshold.<sup>108</sup> The Australian Capital Territory has no threshold.

### B. Caps

The Ipp Report recommended a cap of \$250,000 on damages for non-economic loss.<sup>109</sup> Queensland adopted this cap but, in 2010, made amendments so the cap is now indexed if the injury arose from 1 July 2010.<sup>110</sup> In the other jurisdictions, except in the Australian Capital Territory, there is a cap for non-pecuniary general damages which is either indexed or higher than recommended.<sup>111</sup>

The Ipp Report also recommended that loss of earning capacity be capped to twice the average weekly earnings.<sup>112</sup> In all jurisdictions, there are caps for the loss of earning capacity which restrict the amount that may be awarded. Most jurisdictions have capped the loss of earning capacity to three times the average weekly earnings.<sup>113</sup> In South Australia, there is a prescribed limit.<sup>114</sup>

The Ipp Report also recommended that all awards for future loss be discounted by 3 per cent.<sup>115</sup> Most jurisdictions have adopted a rate of 5 per cent.<sup>116</sup> Tasmania and Western Australia have higher rates.<sup>117</sup> The Australian Capital Territory has continued with the common law.

### C. Exemplary Damages

Exemplary damages can be awarded at common law to punish and deter certain behaviour by defendants. This category of damages is usually awarded in circumstances where the defendant displayed some conscious wrongdoing, demonstrating that the rights of the plaintiff have been disregarded by the defendant. An example in a medical negligence case where exemplary

102 The Ipp Report, above n 2, Recommendation 47.

103 *Civil Liability Act 2002* (NSW) s 16(1).

104 *Wrongs Act 1958* (Vic) ss 28LB–28LI.

105 *Civil Liability Act 2003* (Qld) s 62, sch 6A.

106 *Civil Liability Act 1936* (SA) s 52.

107 *Civil Liability Act 2002* (Tas) s 27; *Civil Liability Act 2003* (WA) ss 9–10.

108 *Personal Injuries (Liabilities and Damages) Act 2003* (NT) s 27(2).

109 The Ipp Report, above n 2, Recommendation 48.

110 *Civil Liability Act 2003* (Qld) s 62, sch 6A.

111 *Civil Liability Act 2002* (NSW) s 16(2); *Personal Injuries (Liabilities and Damages) Act 2003* (NT) s 27; *Civil Liability Act 2003* (Qld) s 62; *Civil Liability Act 1935* (SA) s 52; *Civil Liability Act 2002* (Tas) ss 27–28; *Wrongs Act 1958* (Vic) s 28G; *Civil Liability Act 2003* (WA) s 10. Section 99 of the *Civil Law (Wrongs) Act 2002* (ACT) allows reference to prior cases.

112 The Ipp Report, above n 2, Recommendation 49.

113 *Civil Law (Wrongs) Act 2002* (ACT) s 38; *Civil Liability Act 2002* (NSW) s 12; *Personal Injuries (Liabilities and Damages) Act 2003* (NT) s 20; *Civil Liability Act 2003* (Qld) s 54; *Civil Liability Act 2002* (Tas) s 26; *Wrongs Act 1958* (Vic) s 28F; *Civil Liability Act 2003* (WA) s 11.

114 *Civil Liability Act 1935* (SA) s 54.

115 The Ipp Report, above n 2, Recommendation 53.

116 *Civil Liability Act 2002* (NSW) s 14; *Personal Injuries (Liabilities and Damages) Act 2003* (NT) s 22; *Civil Liability Act 2003* (Qld) s 57; *Civil Liability Act 1935* (SA) s 57; *Wrongs Act 1958* (Vic) s 28I.

117 *Common Law (Miscellaneous Actions) Act 1986* (Tas) s 4; *Law Reform (Miscellaneous Provisions) Act 1941* (WA) s 5.

damages has been awarded is the Canadian case of *Shoebridge v Thomas*,<sup>118</sup> where a surgeon left an abdominal roll in the patient's upper abdomen and took steps to conceal the mistake from the patient for two months. Exemplary damages of \$20,000 were awarded in that case.

In response to a recommendation in the Ipp Report,<sup>119</sup> New South Wales, the Northern Territory and Queensland have abolished the awarding of exemplary damages with some exceptions.<sup>120</sup> This has, therefore, limited the liability of health professionals in those jurisdictions.

#### IV. CONCLUSION

A pattern can be seen to emerge from the various defences and statutory limits: legislation has been passed with the purpose of limiting liability, but the interpretation adopted by the courts has resulted in the same effect for actions in negligence as under the common law. This result is understandable, considering the objectives of the Ipp Report were to re-state the law of negligence and to limit liability. It could be argued that, by 2001, the High Court was already moving towards 'a greater orientation towards the defendant'.<sup>121</sup> With the decision of *Sullivan v Moody*,<sup>122</sup> the High Court was already beginning to interpret the law of negligence in a more restrictive manner by rejecting the proximity test and instead moving to a multi-factorial approach which considered the relevant factors in the circumstances of the case which included control and vulnerability, coherency of the law and policy arguments. Therefore, it could be argued that the defences have not really changed. However, what has changed since 2001 are the statutory limits on the amount of compensation.

While it is right to say that the civil liability reforms have impacted on the liability of health professionals, it is not because of the successful use of defences, but rather the use of statutory limits like thresholds and caps which limit the assessment of damages. This has had the impact of reducing the quantum of damages awarded by the courts.

There have been some changes to medical negligence but, generally, courts have interpreted the tort law reforms in compliance with common law where there is any ambiguity. In relation to defences, while on the surface the legislation appears to place limits on the liability of health professionals, in practice it appears to have not made much difference to the outcome of whether there is a negligence action. The greatest impact has been on the quantum of damages. Therefore, the result is that health professionals are held liable for negligence but the damages are reduced because of statutory limits like thresholds and caps.

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118 (1999) BCJ 1747 (SC).

119 The Ipp Report, above n 2, Recommendation 60.

120 *Civil Liability Act 2002* (NSW) s 21; *Personal Injuries (Liabilities and Damages) Act 2003* (NT) s 19; *Civil Liability Act 2003* (Qld) s 52.

121 Justice David Ipp, 'Themes in the Law of Torts' (2007) 81 *Australian Law Journal* 609, 611.

122 (2001) 207 CLR 562.

