Bill Madden, NSW

Tort reform and medical liability

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Introduction

For this special tort reform overview edition of plaintiff, I have been asked to provide a political and legislative update on recent developments in medical liability.

There are too many to address fully in the space available. So I will limit my detailed comments to the standard of care and informed consent; and briefly touch on emergency care, open disclosure, apologies and expert evidence.

I have deliberately excluded reference to some matters of lesser importance to the rights of the plaintiff, such as pre-litigation procedures. Limitation periods are of general application and not limited to medical liability, therefore I will leave that topic to other commentators.

Last Year

In October 2001, New South Wales was the only jurisdiction to have dealt in any substantial way with medical liability. Most of what we then saw in the Health Care Liability Act was not tort reform at all. It was simply the amendment of the law relating to the award of damages, no matter how meritorious the claim, so as to abolish or reduce the level of compensation awarded to the victim.

This is exemplified by cases such as the much publicised *Simpson v Diamond* decision (currently on appeal) which would have been quantified at 27% less under the then recent legislative changes.[1]

Tort Reform

We now have the luxury of at least four references to assist our understanding of this topic:

- *The Review of the Law of Negligence*, chaired by Justice Ipp – first report (now subsumed into the second report below);
- *The Review of the Law of Negligence*, chaired by Justice Ipp – second report;
- *The AHMAC*[2] *Legal Process Reform Group Report*, chaired by Professor Marcia Neave of the Victorian Law Reform Commission;
- *The NSW Civil Liability Amendment (Personal Responsibility) Bill Consultation Draft Position Paper* (with the accompanying consultation draft of the Bill, now replaced by the Bill as tabled in the NSW Lower House).

Standard of Care

The *Civil Liability Amendment (Personal Responsibility) Bill* 2002 (NSW) is the first statutory example. It will amend the test for the professional negligence standard of care. Sub-section 5O(2) is somewhat colloquially phrased as follows:

'However, peer professional opinion cannot be relied upon for the purposes of this section if the court considers that the opinion is irrational.'

I would draw your attention to the six key elements of section 40:

1. Practicing a *profession*
2. *Widely* accepted (can be more than one and need not be universally accepted)
3. In *Australia*
4. *Peer* professional opinion
5. Unless *irrational*
6. *Competent* professional practice.

The NSW position paper[3] suggested that this section will not embody a return to Bolam, as it requires a widely held belief, not just a body of responsible opinion. And there is the added gloss of the irrational test, based on the English Court of Appeal decision *Hucks v Cole*.[4]

Some light is shed on the 'irrational' test by the relevant recommendations in the Ipp Report as follows:[5]

'The proviso relating to "irrational treatment" needs further elaboration. Under the recommended rule, it is for the court to decide whether treatment is irrational. It would be rare indeed to identify instances of treatment that is both irrational and in accordance with an opinion widely held by a significant number of respected practitioners in the field. Such a rare instance is the finding of the court in *Hucks v Cole* [1993] 4 Med. L.R. 393...

Recommendation 3

The test for determining the standard of care in cases in which a medical practitioner is alleged to have been negligent in providing treatment to a patient should be:

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.

Recommendation 4

In cases involving an allegation of negligence on the part of a person holding himself or herself out as possessing a particular skill, the standard of reasonable care should be determined by reference to:

a) What could reasonably be expected of a person professing that skill.
b) The relevant circumstances at the date of the alleged negligence and not a later date.'

So what are the differences between the Ipp model and the NSW Bill? They appear to be the:

- Limitation to medical practitioners, as opposed to professionals;
- Use of the word 'respected', as a qualification to practitioners;
- Lack of the qualification 'competent', but which may be similar in effect to respected practitioners;
- Absence of the peer test.

I should mention that Ipp Recommendation 4 is intended as a restatement of the basic rule about the standard of care, so as to reduce misunderstanding and unnecessary fear and anxiety.[6] But the restatement may impose a gloss, 'professing that skill' to the extent that it requires consideration of what holding out might constitute.

Of course, there are issues arising from the Ipp Report's recommendations in Chapter 7 regarding foreseeability, standard of care, causation and remoteness of damage that are not limited to medical liability, but may have application in that context.

I would also encourage you to consider the possible application of the recommendations of the Ipp Report dealing with the standard of care[7], the onus of proof[8], contributory negligence[9] and assumption of risk[10].

We can quickly deal with the AHMAC paper. It simply concludes:

'Reform template for standard of care issues:

The AHMAC Legal Process Reform Group does not recommend any change to the present law under which it is for the court to determine on all the evidence before it, what the standard of care is and whether the standard was breached.

In cases where negligent treatment and diagnosis is alleged, the views of relevant experts will be influential or even decisive, depending upon the facts of the case, but are not legally conclusive.'[11] ▶

Duty to Warn of Risk – The Law

The NSW Bill deals by way of exclusion with the test for the professional negligence duty to warn in section 5P:

'5 P This Division does not apply to liability arising in connection with the giving of (or failure to give) a warning, advice or other information in respect of the risk of death of or injury to a person associated with the provision by a professional of a professional service.'

But there is more to the Bill's treatment of failure to warn cases than the simple exclusion provided by Section 5P. Not under the heading of Professional Negligence, but elsewhere in the Bill. Division 4 is headed 'Assumption of Risk' and deals with such cases in terms not limited to professional negligence, in Sections 5F – 5I.

Essentially, those sections develop the concept of an obvious risk, and deem that injured persons be presumed aware of such obvious risks. Obvious risks are said to be matters patent or of common knowledge, even if of low probability.

The test created is essentially an objective one, with obviousness being assessed by reference to the reasonable person.

Section 5G firmly places the onus of proof upon the plaintiff, to show lack of awareness of the type or kind of obvious risk. Not all risks are affected by this section, only the obvious ones.

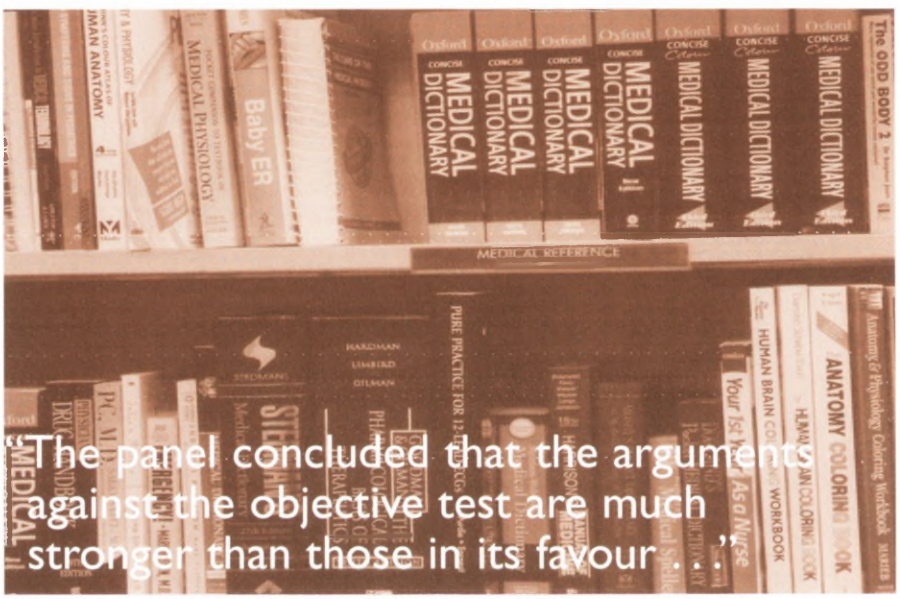
Section 5H states that there is no proactive duty to warn of an obvious risk. But see the exception of section 5H(2)(a) in terms of reactive duty.

Interestingly, sub-section (2)c excludes from section 5H (but not from sections 5F and 5G) circumstances where the:

'... defendant is a professional, and the risk is a risk of the death of or personal injury to the plaintiff from the provision of a professional service by the defendant.'

Finally we come to section 5I, which deals with inherent risk. A person cannot be liable in negligence (but perhaps under contract?) for harm suffered as a result of materialisation of an inherent risk. However, an inherent risk is said to be something that cannot be avoided by the exercise of reasonable care and skill. And the protection here does not extend to liability in connection with duty to warn of a risk.

Justice Ipp's panel, however, has taken a more detailed approach, recommending a codification of the law concerning the nature and extent of a warning. The relevant recommendations are:



'Recommendation 5

The professional's duties to inform should be legislatively stated in certain respects, but only in relation to medical practitioners.

Recommendation 6

The medical practitioner's duties to inform should be expressed as duties to take reasonable care.

Recommendation 7

The legislative statement referred to in Recommendation 5 should embody the following principles:

(a) There are two types of duties to inform, a proactive duty and a reactive duty.

(b) The *proactive duty* to inform requires the medical practitioner to take reasonable care to give the patient such information as the reasonable person in the patient's position would, in the circumstances, want to be given before making a decision whether or not to undergo treatment.

(c) The information referred to in paragraph (b) should be determined by reference to the time at which the relevant decision was made by the patient and not a later time.

(d) A medical practitioner does not breach the proactive duty to inform by reason only of a failure to give the patient information about a risk or other matter that would, in the circumstances, *have been obvious to a reasonable person in the position of the patient, unless warning of the risk is required by statute.*

(e) *Obvious risks include risks that are patent or matters of common knowledge; and a risk may be obvious even though it is of low probability.*

(f) The reactive duty to inform requires the medical practitioner to take reasonable care to give the patient such information as the medical practitioner knows *or ought to know* the patient wants to be given before making the decision whether or not to undergo the treatment.' [my emphasis]

You will note the move towards an

objective test in 7(d), at least in the context of what should have been obvious to a reasonable patient. In the practical application of this test, much may depend on the courts' interpretation of obvious risks in the context of 7(e). See also the slightly broadened reactive duty in 7(f).

Finally, we need to look at the AHMAC report, which again does not recommend change to the law but rather some practical steps:

'It is unlikely that this practical problem can be remedied appropriately by any modification to the common law. Of much greater significance will be continuing medical education to help doctors communicate better with patients, and greater focus on communication in the primary training of doctors and other health care professionals. The NHMRC general guidelines for medical practitioners on providing information to patients may also assist doctors to put this duty into practice .... If an acceptable process could be developed with the support of both consumers and doctors, the fact that a doctor has followed this process could be a defence in a failure to warn case. Doctors and consumers should work together to develop such a process.'[12]

Duty to Warn of Risk – Objective or Subjective Test

This issue was one of three flagged in the initial Ipp Report.[13]

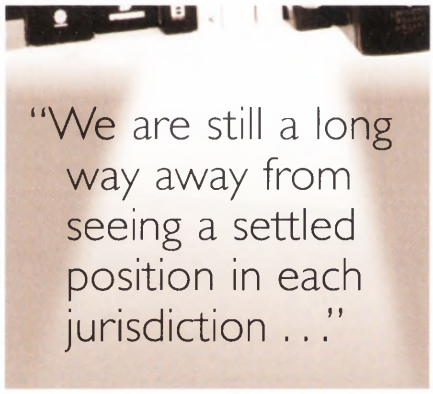
The question was framed as one of whether an objective or subjective test should be applied to determine whether the patient would have decided to undergo the treatment if the relevant duty to inform had been performed.

Australian law currently adopts the subjective approach, seeking to determine what the plaintiff would have done rather than considering what a reasonable person in the plaintiff's position would have done.

The panel concluded[14] that the arguments against the objective test are much stronger than those in its favour, and that Australian law is right to adopt the subjective test.

But the panel went on to make a rather unusual recommendation:

'On the other hand, the Panel is also of the view that the question of what the plaintiff would have done if the defendant had not been negligent should be decided on the basis of the circumstances of the case and without regard to the plaintiff's own testimony about what they would have done. The enormous difficulty of counteracting hindsight bias in this context undermines the value of such testimony. In practice, the judge's view of the plaintiff's credibility is likely to be determinative, regardless of relevant circumstantial evidence. As a result, such decisions tend to be very difficult to challenge successfully on appeal. *We therefore recommend that in determining causation, any statement by the plaintiff about what they would have done if the negligence had not occurred should be inadmissible.*' [my emphasis]



It seems strange to have a subjective test that nevertheless does not hear from the plaintiff, but rather (presumably) takes into account in an objective fashion evidence or submissions about what a reasonable plaintiff might do.

But in the NSW Bill we see as a result of that recommendation section 5D(3)(b):

'...any statement made by the person after suffering the harm about what he or she would have done is inadmissible except to the extent (if any) that the statement is against his or her interest.'

Emergency Care

This was the third issue flagged in paragraph 3.85 of the interim report.

'The standard of care applicable in circumstances where a medical practitioner or other health-care professional voluntarily renders aid to injured persons in an emergency.'

The panel took the view that change to the present law was unnecessary and undesirable.[15] However, such changes have nevertheless been introduced in some jurisdictions.[16] An extended version of such protection appears in the current NSW Bill in Part 8, sections 55-58.

Open Disclosure and Apologies

Part of the NSW Bill provides an example for the establishment of some protection for apologies. Section 69 provides that an apology made by or on behalf of a person does not constitute an express or implied admission of fault or liability, and is not relevant to determination of fault or liability. Further, evidence of the apology will not be admissible as evidence of the fault or liability.

The AHMAC report addressed this issue at length, and simply concluded:

'Reform template for legislation to support open disclosure:

The AHMAC Legal Process Reform Group supports the work of the Open Disclosure project and recommends the implementation of a balanced package of "open disclosure" legislation to support the broader work of that project. The package should include:

- provision that an apology made as part of an open disclosure process is inadmissible in an action for medical negligence.'[17]

Expert Evidence

Here the Ipp Report produced a qualified and mixed comment, however the conclusion was in favour of a three-year trial in appropriate jurisdictions of a system of court appointed experts. After a discussion of perceived problems and the current position relating to expert evidence, the panel concluded it had been unable to provide a detailed exposition of what such a system would entail. It, however, discussed some relevant elements at paragraphs 3.71-3.81. ▶

Conclusion

Looking towards the future, do we have any clear indication of how matters will progress, within NSW and elsewhere?

The AMA issued a media release responding to the Ipp Report on 2 October 2002 reproduced in part as follows:

'AMA Vice-President, Dr Trevor Mudge, said today that the AMA supports most of the recommendations of the Review of the Law of Negligence. Dr Mudge said the Review sets out a more realistic approach to the standard of care that can be reasonably expected of competent medical practitioners.

...

"But without the development of a national scheme for the long term care and rehabilitation of the severely disabled, the long-term care costs of the severely disabled still have the potential to cripple the medical indemnity industry. We need to remove the long-term care costs of the severely disabled from court awards.

...

"The AMA also has concerns that the recommendations relating to the revised limitation periods - the timelines in which people can sue - do not provide the certainty that insurers require.

"'Discoverability' leaves the way open for an uncertain amount of time to elapse before the limitation period commences, and leaves the way open for argument and litigation to occur over the date of 'discoverability'," Dr Mudge said.'

It is not yet possible to say what will come of the Ipp and AHMAC reports. Many of the states have begun their own reforms, and others have apparently declined to contribute to the Ipp Report cost.

We are still a long way away from seeing a settled position in each jurisdiction, let alone a consistent one. PL

Footnotes:

1 Dr M Keaney, *United Newsletter*, No 1 of 2002, p. 27.

2 Australian Health Ministers Advisory Council.

3 The NSW Attorney-General's Department's September 2002 Position Paper on the *Civil Liability (Personal Responsibility) Bill* 2002 (NSW), p. 37.

4 (1993) 4 Med LR 393.

5 Ipp Report para 3.19.

6 *Review of the Law of Negligence* para 3.32.

7 Recommendation 28; para 7.15 – 7.19.

8 Recommendation 29; para 7.25 – 7.51.

9 Recommendation 30; para 8.6 – 8.13 & 8.20 – 8.27.

10 Recommendation 32 ; para 8.28 – 8.32.

11 Chapter 6, 'Judging the standard of care: Who should determine the standard of care?'

12 op cit. para 6.49.

13 para 3.85.

14 para 7.40.

15 para 7.20 -7.24

16 e.g. s27 *Health Care Liability Act* 2001(NSW).

17 para 4.41.