MEDICO LEGAL SOCIETY
FRIDAY 26 MARCH 1999
7.30PM HERITAGE HOTEL

The Hon Paul de Jersey, Chief Justice of Queensland

I hope I do not presume - it being Friday night and after dinner - by addressing you in serious vein. I will, as necessary, pray in aid the permission your President has given me. I propose to develop three themes.

First I will respond to a trenchant criticism of the adversarial system as applied to medical negligence cases, very recently levelled by a most distinguished medical specialist.

Second, a short analysis of two fairly recent decisions of the High Court greeted with some consternation, I understand, in medical ranks.

Finally, and as a peroration, confirmation of the great worth of mutual support as we travel forward along our respective paths.

Published in the December 1998 Australian and New Zealand Journal of Obstetrics and Gynaecology (Vol 38 No. 4) is an article by Professor Carl Wood entitled "The Misplace of Litigation in Medical Practice". Apart from other major work, Professor Wood is known for his having been part of Australia s first "test tube baby" team in 1980. The editor of the journal expresses the view that the content of Professor Wood s article is "profound". What for my part I certainly accept is that it is profoundly disturbing if the author s views represent the general attitude of the medical profession to matters covered by the article. If it does, I will have to strive to dispel the concern.

Professor Wood severely criticises, if not condemns, the existing method of determining claims for damages for alleged medical negligence. Drawing heavily on current criticism of the so-called adversarial approach, he proposes that, for determination of these matters by courts, be substituted their consideration by a "committee of inquiry", comprising medical experts, a health counsellor, a consumer representative and lawyers - a body which might approach the issues in a more investigative way, with both an educative, disciplinary and compensatory role. Interestingly, in speaking of the current civil mechanisms, he adopts the language of the criminal court, speaking for example of prosecution and defence, and the punishment of doctors who, he suggests, see themselves, although defendants to civil suits, as "potential criminals". He goes so far as to refer to a presumption of guilt. He heavily implies (at least) a concern that doctors are being made to suffer the consequences of mere carelessness, rather than negligent acts.

Expressions of concern by medical practitioners about aspects of the law of medical negligence are not new. Inevitably, as patients become more aware of their rights, as more and more information about medical procedures and legal recourse becomes available technologically as through the Internet, as the respect traditionally accorded noble professions progressively erodes, the prospect of negligence suits will take on a deeper and more menacing hue. And escalating medical defence premiums will lend this a practical dimension. I am told, by United Medical Protection which covers two-thirds of Queensland s doctors, that the extent of medical negligence litigation has galloped over the last decade - only litigated claims in 1985, increasing to 69 in 1993, and almost doubling by 1994. Yet doctors are not the professionals most vulnerable to suits. *Australian Doctor* of 18 October 1996, put engineers in the lead, one in ten being sued annually, contrasting with one in forty doctors - and no politicians!

There is clearly growing concern about increasing exposure to claims in negligence. It may be this which focussed attention on the adequacy of the current mechanisms for the resolution of these claims. But the criticism I have most frequently heard is not of the wide-ranging variety expressed by Professor Wood. It is based more on lack of confidence in the capacity of the system sufficiently to educate the decision-maker, the judge, about complex processes.

As will emerge, I consider any such lack of confidence unjustified.

You will have gathered that I do not accept Professor Wood s views. I consider them misconceived. But it is healthy that we debate them. Let me tell you now why I reject the essence of Professor Wood s criticisms.

In the first place, he wrongly equates negligence with carelessness. As you know, negligence, for a person professing particular skills, involves departure from the standard of care ordinarily characterising the work of such a skilled person. Negligence is not mere error, mere carelessness. If it were, the position of professionals would be intolerable. Although Professor Wood does at one stage express the correct test, that expression is buried amid substantial reference to mere error, and he quotes a dictionary definition of negligence as "carelessness". Not so. And if that is the mindset, if that is the perception of the way the courts resolve these claims, then the concern so dramatically expressed is understandable. But that is not a fair assessment of the approach taken by the courts.

Rather by way of contrast, last month s *"New Yorker*" published an article by one Atul Gawande entitled *"When Doctors Make Mistakes"*. (*The New Yorker*, 1 February 1999, page 40). That doctor author addressed similar issues to those addressed by Professor Wood, but less defensively. Dr Gawande begins his article constructively, with the subheading: "The real problem isn t how to stop bad doctors

from harming, even killing, their patients. It s how to prevent good doctors from doing so." You may agree. I also noticed a feature article in the *Australian* last Monday week which brought up the Australian Hospital Care study released in Federal Parliament in 1995 - the study which claimed 10,000 to 14,000 people were dying in hospital each year because of medical error. The AMA President, David Brand, is reported as having said that the AMA still disagrees with those numbers, but that "even if the truth is one-half or one-quarter of the figure ... there is still a problem that needs to be addressed". The author of the *Australian* article expressed a view similar to Dr Gawande in *The New Yorker*: "The key is not to get rid of bad doctors, but to reduce the number of mistakes made by the average doctor". Again, you will agree. But the question of compensation remains, and it is to that that the law of negligence is directed. I revert to Professor Wood s approach.

It is not enough to observe that some errors are inevitable. A major criticism of Professor Wood s approach is that demolishing liability in negligence would afford no practical solution to the range of problems resulting from medical error. From the profession s point of view, the object should of course be to reduce the error rate as much as possible. A board of medical experts could certainly help in that regard. But it would not be practicable to confer compensation distribution powers on such a board. The community simply would not tolerate a situation which involved referring all power in that area to a group of doctors.

What Professor Wood overlooks is that the focus of the law is upon loss distribution, not the identification and reduction of error. The law is concerned with how the cost of error is to be borne. One may note the two extreme alternatives. In the first place, the loss may lie where it falls - on the patient. Such a position would be unacceptable in our society. At the other extreme, a stipulation that all patients who suffered as a result of medical error should be compensated also would not be tolerated, simply because it would cost too much. There has to be compromise in this area, and a socially acceptable criterion to discriminate between who should be compensated and who will not be. At present, that test is provided by the law of negligence. The function of the law of negligence is not to assign guilt, as Professor Wood would apparently have it, but to distribute the cost of error in cases where that error amounts to negligence.

My second criticism of Professor Wood s approach is its denigration of the quality of the legal process. We discern his heavy focus on what he - and of course others - call its adversarial character, leading ultimately to his characterising the civil process as criminal: but not even an acceptable criminal process, there being, he suggests, even a presumption of guilt in the doctor sued in negligence.

The doctor is said to be forced into an environment where "yes" or "no" answers are preferable to explanations, and where the judge is "educated" by supposedly expert evidence from medical specialists chosen, however, for partisan sway. The author appears to suggest that the current system is obsessively black and white,

or as he puts it, "biased to make a decision appear 100 percent correct or incorrect" - a system inapt, in short, or unwilling, to appreciate that "truth is not often absolute in medicine". He claims: "The current adversarial system demands that a decision be made with certainty on the evidence available at that time." I disagree.

For a start, this charge entirely ignores the standard of proof, which is on the balance of probabilities, not certainty or exactitude. The assertion is interestingly belied even by the form of the judgments in this field, which more often than not display extremely careful evaluation of competing points of view, and not infrequently betray some anguish in the decision-maker about the position to which he or she has come. Will a panel of doctors, the health counsellor, the consumer representative and the lawyers proposed by Professor Wood, more likely reach a reliable result, and one which commands acceptance?

The quality of the decision given by a court in this field will, of course, depend on the quality of the evidence put before the Judge. Again confusing the terminology, the author asserts that "the prosecution and defence present only the information helpful to their cause", as part of a process "designed to distort evidence by choosing experts and information to establish the truth to (the parties) own advantage". Rhetoric aside, if this involves Judges being given the competing points of view, by expert medical witnesses of course expressing their competent and honest views, then why the concern? Experts reports are usually exchanged these days in advance of hearings: courts direct experts to confer to narrow areas of difference. Eventually, their views are tested in the court by advocates through questioning, and not in my experience generally stopping short at "yes" or "no" answers. I have listened to pathologists in murder trials provide an answer which covers literally pages of transcript. The Judge carefully considers the explanations and distils what appears to be the more reliable view: by the conclusion of the evidence often fairly apparent anyway. In cases of particular technical complexity, the Judge may have the capacity to sit with an assessor, by training expert in the field. I reject the suggestion that this finely crafted system, designed for fairness and affording all parties full opportunity to ventilate the relevant evidence and express their submissions, is inherently inappropriate to the resolution of this particular species of civil claim.

A lot of criticism of the adversarial system is captious. While it may not be designed directly to ascertain ultimate truth, this system, at least in Queensland, looks to uncovering the truth through a careful mechanism which invites full exploration of issues through a series of steps, including the possibility of a mediated settlement, an unrestricted presentation of relevant evidence, illuminated frequently through substantial interlocutory processes, full ventilation of submissions, and due consideration by the tribunal. Add in the prospect of appeal, and one may be excused for thinking that more often than not the result does reflect actual truth. And the integrity of the process is further enhanced by the obligation of the advocate to assist and not mislead the court. That is why I baulk

at readily embracing these days what has become the pejorative description adversarial . To suggest that proceedings in the civil court are akin to some tournament or joust in the lists is not simply emotive, it is positively misleading. Of course we look to further streamlining. Recent initiatives about mediation, the refinement of experts views out of court, other steps designed to lessen any element of surprise, ambush, uncertainty: a good system is being made even better through modern managerial approaches by courts. Critics must not be aware of these things.

I also suggest that Professor Wood s paper betrays a paternalism which has no place in modern medicine. His approach focuses on the doctor almost to the exclusion of the patient. For example, he describes the "process of medical diagnosis and treatment" as a system which "takes into account the mathematical bias of probability in determining the significance of the variables". Such a process would appear to ignore, as but one example, the patient s autonomous right to accept or reject treatment, a matter to which I will come shortly. The skewing towards the doctor may further be illustrated by the Professor s treatment of the effect of mood.

Doctors may err, he says, because their mood may affect their judgment. And, he implicitly adds, that should not be held against the doctor, as may occur through a suit for negligence. So also, he says, a patient s mood may affect the patient s acceptance and retention of information given by the doctor, leading sometimes to false denial of having been provided with the relevant information. Yet, he suggests, that should be held against the patient, and he offers it as a further ground for sympathetic treatment of the doctor.

Eighteenth century liberal thinking confirmed that people have rights, rights so significant that many now feel they should be given constitutional weight as in a "bill of rights". One such right is the right to determine the fate of one s own body. The point was put pithily by the noted American Judge, Cardozo J in *Society of New York Hospital* (1914) 105 NE 92, 93: "every human being of adult years and sound mind has a right to determine what shall be done with his (or her) own body; and a surgeon who performs an operation without his (or her) patient s consent commits an assault.". In focussing on a mathematical character of medical decision-making, in focussing on the play of mood only in alleviation of the doctor s position, the author does I fear display, although no doubt unconsciously, a paternalism which has no place in modern medicine.

Before I leave Professor Wood s paper, may I say that if one acknowledges the social need for the law of negligence - as a loss distribution mechanism, and the best one we have as yet devised, then of course one must also address the need to identify and reduce medical error. The *New Yorker* article refers to the American experience of "morbidity and mortality" conferences held in American hospitals, in which doctors are regularly encouraged to speak candidly of the errors they have

made, with a consequently more open approach to the identification and rectification of error. The article reads:

> "There is one place, however, where doctors can talk candidly about their mistakes, if not with patients, then at least with one another. It is called the Morbidity and Mortality Conference, or, more simply, M & M. and it takes place, usually once a week, at nearly every academic hospital in the country. This institution survives because laws protecting its proceedings from legal discovery have stayed on the books in most states, despite frequent challenges. Surgeons, in particular, take the M & MN seriously. Here they can gather behind closed doors to review the mistakes, complications, and deaths that occurred on their watch, determine responsibility, and figure out what to do differently next time."

With proper controls on the conduct and recording of such meetings, and control over the admissibility in civil proceedings of what is said, the objectives of error reduction and the facilitating of compensation claims could both be met. I do not know if these occur in Australia, but on this scenario, controls could be considered such as apply under the Air Navigation Act (section 19HF) as to the admissibility in civil proceedings of evidence of cockpit voice recordings in aircraft, the so-called "black box".

It may be also that the objectives would be advanced by a generally greater willingness in the medical profession to recognise the need to compensate victims of negligence in accordance with the law, improved co-operation in providing evidence, frank admissions of negligence where it genuinely exists, and a somewhat less combative attitude on the part of medical defence societies; and further, I respectfully suggest, some greater contribution by the learned colleges and defence societies to error research.

I repeat the *The New Yorker* aphorism: "The real problem isn t how to stop bad doctors from harming, even killing, their patients. It is how to prevent good doctors from doing so."

I turn now briefly to the two recent decisions of the High Court: if, as I am told, they have inspired terror, they must have been misunderstood. The cases are *Rogers v. Whitaker* (1992) 175 CLR 479 and *Chappel v. Hart* (1998) 72 ALJR 1344.

Rogers v. Whitaker concerned the obligation of a medical practitioner to advise on material risks. The duty to exercise reasonable care extends not only to examination, diagnosis and treatment, but also to the provision of appropriate information. The issue here was whether a surgeon should, in advance of an eye operation, have warned of the risk of sympathetic ophthalmia, a risk shown to eventuate in one in 14,000 such operations. Mrs Whitaker was almost totally blind

in the right eye. She wanted to have some scar tissue removed from that eye. She presented to Dr Rogers as keenly interested in the outcome, concerned about the risk of any accidental interference with her good left eye. She incessantly questioned him. He conducted the operation with the requisite skill. But she did develop sympathetic ophthalmia in the left eye, and it led to blindness. Despite her anxiety, the doctor had given her no warning of the risk. Dr Rogers led evidence from a body of reputable medical practitioners that they would not have given the warning. (There was other, contrary evidence.)

Invoking the protection of *Bolam* (1957) 1 WLR 582, 586, Dr Rogers contended that he was ipso facto therefore not negligent. The High Court held, however, that he was, because he knew that had he warned Mrs Whitaker about this risk, she would have regarded it as significant. The Court formulated the duty as follows (page 490):

> "The law should recognise that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient s position, if warned of the risk, would be likely to attach significance to it or
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> if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This duty is subject to the therapeutic privilege." (my underlining)

(that refers of course to the doctor s being excused from the need to make the disclosure if the doctor reasonably believes the disclosure would prove damaging to the patient.)

The essence of *Rogers v. Whitaker*: Mrs Whitaker with apparent anxiety sought to be informed of all relevant risks and was not. She was not informed of a risk so significant, if it materialised, as to lead to almost total blindness. As the High Court put it, the question having been asked, it should have drawn "a truthful answer". I find it difficult to regard the result as remarkable. In terms of legal theory, the case is significant in confirming that doctors cannot rest their defences solely in the support of a body of medical opinion. In the area of advice and information in particular, the approach of the particular patient must be addressed, even if thought to be unreasonable. And so the matter falls within that almost clichéic category of "communication".

The facts of *Chappel v. Hart* were not dissimilar. Mrs Hart was a teacher. She was inconvenienced by a pharyngeal pouch, and surgery was inevitable. When Dr Chappel proposed removing the pouch, she raised with him the risk of damage to her voice. As she said: "I don t want to wind up like Neville Wran." Dr Chappel

assured her there was no risk. The operation proceeded, and the oesophagus was perforated - leading to infection and laryngeal damage, permanent impairment of her voice, and an early retirement. The doctor had failed to warn her of that risk. Had he done so she would, on the evidence, have postponed the operation and secured the most experienced surgeon in the field. And also on the evidence, that would have lessened the risk.

The High Court accepted that the impairment of her voice was the consequence of the doctor s negligence in failing to disclose the risk. The Court approached the issue of causation in a commonsensical way, largely by adopting what we call the "but for" test: but for Dr Chappel s failure to give the advice, Mrs Hart would not then have undergone the operation which led to her injury, and would have postponed it and secured another surgeon with a lessening of the risk. The present significance of this case is that it again exemplifies the burden which follows when medical practitioners do not comprehensively respond to inquiries seriously made and plainly relevant to the operation to be undertaken.

The practical importance of these cases is that they stress the need for comprehensive communication between medical practitioner and patient. United Medical Protection tells me that over the last five years, 55% of litigated claims have settled out of court, 40% have been discontinued, and 5% led to judgments. I hazard the view that with better doctor-patient communication, that 5% will reduce even further.

And that leads me finally to what Mr Murdoch would call "another thing", and just one other thing. Courts must communicate more effectively with their public. So also one cannot understate the importance of good communication between doctor and patient. I think that is a large part of the key to forestalling problems and meeting those which develop. In similar vein, I have tonight thought it useful to respond to Professor Wood s criticism, not to suggest that my contrary view is necessarily right, but to explain - as briefly as time has allowed - why I firmly believe it is, and to offer assurance that the Judges who determine these claims, if not already aware of the relevant nuances of medical practice, are anxious to be told of them.