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MIND THE INFORMATION GAP: QUANTIFYING THE COURTS' ROLE IN RESPONDING TO PATIENT HARMS, 1989 TO 2013

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ABSTRACT

An empirical critique of Australia's medical indemnity 'crisis' challenges assumptions about the role of the courts through determination of civil liability for medical negligence, occupational discipline and criminal liability.

Courts were identified as a cause of a 'crisis' in the 2000s that triggered extensive legislative reform of medical negligence law, absent adequate empirical data substantiating either criticisms of the courts, or supporting the reforms. Changes to the occupational discipline framework for health practitioners were less controversial, but have resulted in increasingly legalistic responses.

Using a detailed longitudinal analysis across all jurisdictions this article examines the role of the courts in responding to patient harm across the relevant 25-year period encompassing these reforms, to determine whether the courts did 'cause' the medical indemnity crisis, what effect the reforms had and what other roles the courts play in responding to patient harms.

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INTRODUCTION

Prevention of errors and adverse effects to patients associated with health care (actual or potential harm) is a widely accepted public health priority.¹ In contrast there remains considerable tension between stakeholders about responses to patient harms. This tension is evident in discussion about the role of Australian courts in determining civil liability of health providers for harms suffered by patients,² the legal profession's role in healthcare occupational discipline,³ and public perceptions of the incidence of criminal liability for patient harms.⁴

Discourse about perceived systemic failures of the Australian medical indemnity system over three decades has been shaped by hyperbole about the causes and effects of a medical litigation 'crisis', notwithstanding an acknowledged lack of empirical evidence about the behaviour of the courts, insurers or health providers.⁵ Those claims supposedly substantiated perceptions of a negligence law crisis warranting fundamental immediate substantive law reform, despite subsequent but under-explored suggestions that such responses were unwarranted and the causes of the crisis (if it indeed existed) were mischaracterised.⁶ Evaluation of the impact of those reforms has similarly been inhibited by inadequate empirical data.

¹ Institute of Medicine, 'IOM report: patient safety – achieving a new standard for care' (2005) 12(10) *Academic Emergency Medicine* 1011; Troyen Brennan, Lucian Leape, Nan Laird, Liesi Hebert, A. Russell Localio, Ann Lawthers, Joseph Newhouse, Paul Weiler and Howard Hiatt, 'Incidence of Adverse Events and Negligence in Hospitalized Patients — Results of the Harvard Medical Practice Study' (1991) 324 *New England Journal of Medicine* 370; Ross McL Wilson, William B Runciman WB, Robert W Gibberd, Bernadette Harrison, Liza Newby and John Hamilton, 'The Quality in Australian Health Care Study' (1995) 163(9) *Medical Journal of Australia* 458.

² Thomas B Hugh and G Douglas Tracy, 'Hindsight bias in medicolegal expert reports' (2002) 76(6) *Medical Journal of Australia* 277; and Jeanette Ward, Colin Thomson and Seham Girgis, 'The courts expect the impossible': medico-legal issues as perceived by New South Wales general practitioners' (2000) 7(3) *Journal of Law and Medicine* 273.

³ Danuta Mendelson, 'Disciplinary Proceedings for Inappropriate Prescription of Opioid Medications by Medical Practitioners in Australia (2010-2014)' (2014) 22(2) *Journal of Law and Medicine* 255.

⁴ Janet Smith, *First report into the Shipman Inquiry: Death Disguised*, (2002); and Don Berwick, *A promise to learn, and commitment to Act: improving the safety of patients in England (National Advisory Group on the Safety of Patients in England)* (2013).

⁵ As later paragraphs of this article indicate, there has been surprisingly little scholarly commentary on the disjunct between rhetoric (particularly in the mass media) and the reality of the crisis, the extent to which problems among medical indemnity insurers were attributable to poor management or difficulties facing the insurance sector as a whole, and the efficacy of statutory responses. This article provides one empirical base for evaluation of claims of an unprecedented systemic failure attributable in part to defective jurisprudence.

⁶ Senate Economics References Committee, Parliament of Australia, *A Review of Public Liability and Professional Indemnity Insurance* (2002), [2.1]; Rob Davis, 'The Tort Reform Crisis' (2002) 25(3) *UNSW Law Journal* 865; Harold Luntz, 'Reform of the Law of negligence: Wrong Questions - Wrong Answers' (2002) 25 *University of New South Wales Law Journal* 836; Peter Cashman, 'Tort Reform and the Medical Indemnity 'Crisis'' (2002) 25 *University of New South Wales Law Journal* 888.

Australia's medico-legal landscape changed significantly between 1989 and 2013. It featured extensive legislative reform to both medical negligence law⁷ driven by the perceived crisis in negligence law, and expansive restructuring of occupational disciplinary frameworks governing health practitioners, influenced partly by high-profile criminal cases here and overseas, despite recognition of extensive gaps in the information available a decade ago to two major inquiries. The Australian Review of the Professional Indemnity Arrangements for Healthcare Professionals (*Tito*)⁸ broadly examined funding arrangements for patients injured through medical negligence or misadventure. The Review of the Law of Negligence (*Ipp*)⁹ focussed on options for reforming the common law of negligence – including medical negligence – in order to address the negligence law 'crisis'.

Neither inquiry received comprehensive data, covering for example counts of litigation, outcomes of actions, and damages awarded. That may be partly because judicial reporting remains incomplete (transitioning from hardcopy to electronic), and because practices around reporting are also subject to change. Significantly, lower level courts and tribunals still do not consistently report every pertinent decision they make.

Reliance on proxy data, from for example insurers, is also problematic. Different data collections define critical thresholds differently. Only a small fraction of matters that are reported to insurers ever appear before a court or tribunal. Consequently, evaluation of the need for, and the outcomes of, legislative reform has proven daunting.

Empirical-based Evaluation

For this study we used hardcopy and electronic repositories of court judgments to build a baseline assessment of reported court activity 1989 to 2013, encompassing the period prior to, and after, the legislative reforms.

⁷ Peter Cane identifies the elements of a negligence claim as 'there must be a duty to take reasonable care owed at the time of the act of negligence by the defendant to the plaintiff; negligent conduct on the part of the defendant; and damage suffered by the plaintiff as a result of that negligence, which is not too "remote"'. In common with other negligence claims, each of these elements must be satisfied in a claim for medical negligence. Kit Barker, Peter Cane, Mark Lunney and Francis Trindade, *The Law of Torts in Australia* (Oxford University Press, 5th ed, 2012) 418. Other authors divide the elements differently; however the same fundamental concepts (harm, duty of care, breach of duty of care determined with reference to a standard of care, causation, including remoteness and foreseeability of harm) are constant throughout. Cane is a leading Australian torts law academic and was a member of the major Ipp Review discussed below.

⁸ Review of Professional Indemnity Arrangements for Health Care Professionals (Commonwealth Department of Human Services and Health), *Compensation and professional indemnity in health care: Final Report* (1995) (*Tito*). The Review was undertaken by Fiona Tito for the Commonwealth government from 1991 to 1995.

⁹ Panel of Eminent Persons, *Review of the law of negligence: Final Report* (2002) (*Ipp*). The review, chaired by Justice David Ipp, and conducted by a panel consisting of a mayor, a torts law academic, and a surgeon, as discussed below, resulted in recommendations for statute reform about medical and other negligence. The recommendations were embraced by all Australian jurisdictions.

This baseline provides a better picture of what role, if any, courts had in causing the negligence law ‘crisis’ of the early 2000s. It provides a basis for evaluation of the impact of the Ipp reforms regarding medical negligence law. Analysis of occupational disciplinary reforms imposed by the National Health Practitioner Laws is complicated by concurrent changes in occupational board and tribunal structures, and inconsistent reporting practices. Nonetheless our data demonstrate that increased involvement of courts and tribunals in occupational discipline matters should not necessarily be conflated with a deterioration in the competence and skills of practitioners, but may instead reflect changes in the way healthcare practice is regulated.

This article accordingly provides a quantitative study of the role of Australian courts in resolving matters associated with patient harm and safety during that period. The study fills key information gaps identified in *Tito* and *Ipp*. It contextualises that data in evaluating widespread reform of the law of negligence across Australia and implementation of the National Health Practitioner Law.

It examines the civil pathway, particularly negligence, as the legal mechanism popularly perceived as being the most ‘problematic’ for practitioners in the context of patient harm. It also examines the occupational discipline and criminal prosecution pathways as responses to patient harm. The former is available as a pre-emptive mechanism, that is before harm has actually occurred to a patient. The latter is restricted to the most serious forms of harm and is associated with a far higher degree of legal and moral culpability on the part of the practitioner. Occupational regulation, particularly discipline, has been transformed in recent years, with a national system of credentialing and registration designed to enhance early identification of at-risk practitioners.¹⁰ Observations from several jurisdictions, including Australia, indicate that some practitioners account for a disproportionately high number of occupational disciplinary matters.¹¹ By extension, noting concurrent availability of occupational discipline and civil liability pathways arising from many incidents, past occupational discipline behaviour is likely to be indicative of future risk of civil liability, as well as occupational complaint. Timely robust occupational disciplinary mechanisms may also have a role in minimising or preventing harms of such severity they attract criminal sanction. As part of our study, therefore, we consider overlap between the three legal mechanisms, including opportunities for data-sharing as a means of predicting, and possibly preventing, future harms.

¹⁰ Marie M Bismark, Jennifer M Morris and C Clarke, ‘Mandatory reporting of impaired medical practitioners: protecting patients, supporting practitioners’ (2014) 44(12a) *Internal Medicine Journal* 1165; and Marie Bismark, Matthew J Spittal, Tessa M Plueckhahn and David M Studdert, ‘Mandatory reports of concerns about the health, performance and conduct of health practitioners’ (2014) 201(7) *Medical Journal of Australia* 1.

¹¹ Marie Bismark, Matthew J Spittal, Lyle C Gurrin, Michael Ward, David M Studdert, ‘Identification of doctors at risk of recurrent complaints: a national study of healthcare complaints in Australia’ (2013) 22(7) *British Medical Journal of Quality and Safety* 532; Ron Paterson, ‘Not so random: patient complaints and ‘frequent flier’ doctors’ (2013) 22(7) *British Medical Journal of Quality and Safety* 525; and Matthew J Spittal, Marie M Bismark and David M Studdert, ‘The PRONE score: an algorithm for predicting doctors’ risks of formal patient complaints using routinely collected administrative data’ (2015) 24(6) *British Medical Journal of Quality and Safety* 360.

Part One of this article examines the relationship between patient safety and civil, occupational disciplinary, and criminal legal responses to patient harm. Part Two describes the methodology used to identify trends in judicial consideration of healthcare matters before and after the reforms. Part Three provides the results of the study and identifies trends. Part Four discusses those trends in the context of whether the reforms were required and/or effective. It considers the significance of adequate data as a pre-requisite for just and effective law reform.

Quantification reveals that the incidence of civil claims throughout the period was typically low and steady. Contrary to claims from the insurance sector, litigation did not advantage plaintiffs. Large damages awards were atypical, in contrast to advocacy by insurers at the height of the civil liability crisis. Criminal prosecutions arising in relation to negligent patient treatment remain extremely rare, notwithstanding public perceptions at the time of the Shipman, Patel, and other high-profile practitioner trials. Importantly, identification of the courts and the legal system as the cause of the problem driving legal reform are empirically unsustainable, providing a flawed basis for the legislative reform.

Courts and tribunals are hearing more healthcare matters. That is unsurprising. Changes to the occupational discipline frameworks, including creation of the National Health Practitioner Law regime, have resulted in increased reporting, if not incidence, of occupational discipline matters but do not on their own substantiate claims regarding an unprecedented decline in service quality or an existential threat to liability insurers. Instead, the data demonstrates that the medical negligence landscape for plaintiffs in Australia remains a harsh and generally unrewarding environment punctuated with rare high-value awards for catastrophic harm.

In drawing on that data this article provides a new perspective on both the crisis and the associated law reform, centred on responses to *Ipp*, and the relationship between civil ‘self-serving’ law responses to patient harm – typically reviled in public commentary – and the less-controversial ‘altruistic’ response of occupational discipline. It also distinguishes the objectives of private law tortious compensation of patients for harm and the less controversial public good of ‘cleaning up the profession’ of practitioners whose practice exposes patients to risk of harm.

PART ONE: SAFETY, IATROGENIC HARM AND LEGAL PATHWAYS

Tito examined funding of patients injured through medical negligence or misadventure. It identified both occupational regulation and civil remedies as having a significant role to play in responding to, and preventing, patient harms.¹² It identified aspects of occupational discipline as being essential to

¹² Review of Professional Indemnity Arrangements for Health Care Professionals (Commonwealth Department of Human Services and Health), *Consultancy for the development of information guidelines for health care professionals in the Event of an Adverse Patient Outcome: prepared by the Victorian Health Services*.

minimisation of patient harms, including improved credentialing quality assurance and risk management practices, and legislative protection for whistle-blowers.¹³ It also addressed practitioner concerns that disclosure of iatrogenic harm could be used as admission of liability in the event of subsequent civil claims, remarking that early disclosure of adverse events is in the patient's best interests and supports implementation of systemic preventative measures.¹⁴

Criminal prosecution, restricted to the most serious cases of patient harm, received minimal attention, arising only coincidentally to *Tito's* consideration of practitioner sexual misconduct, noting potential overlap between criminal prosecution and disciplinary procedures.¹⁵

A: Civil liability pathways

Rhetoric about a crisis in medical malpractice in Australia (either looming or realised) was widespread in the 1990s.¹⁶ Despite multiple submissions referring to a crisis, *Tito* was unable to find empirical evidence substantiating a 'claims crisis',¹⁷ noting instead the limited availability of data on litigation and settlement of civil disputes:

there appear to be fewer than 2000 tort claims commenced each year where health care negligence is alleged, and many of these never result in any payment of damages. Only a handful of cases where liability is disputed go to court each year and the majority of these appear to be won by the health professional. Most cases involve small payments, with few resulting in payments over \$500 000.¹⁸

Tito did, however, raise concerns about Australian medical indemnity organisations (MDOs), including lack of transparency and oversight governing their operation.

Presciently, it stated that rising MDO contribution rates:

have resulted mainly from corrections to long-term underfunding of MDO liabilities, and to increased damages in the small number of cases involving people with long-term care needs. While some MDOs

Commissioner and the Health Issues Centre, Victoria (1995); and Review of Professional Indemnity Arrangements for Health Care Professionals (Commonwealth Department of Human Services and Health), *Incident monitoring and risk management in the health care sector: Conference Proceedings, Melbourne 29–30 November 1994* (1994).

¹³ Review of Professional Indemnity Arrangements for Health Care Professionals (Commonwealth Department of Human Services and Health), *Compensation and professional indemnity in health care: Interim Report* (1993) 26–36.

¹⁴ Prue Vines, 'Apologising for Personal Injury in Law: Failing to Take Account of Lessons from Psychology in Blameworthiness and Propensity to Sue' (2014) 22(4) *Psychiatry, Psychology and Law* 624; and Stuart MacLennan and Robert Truog, 'Apology laws and open disclosure' (2013) 198(8) *Medical Journal of Australia* 411.

¹⁵ *Tito*, above n 8, 260.

¹⁶ Richard Tjong, 'The American litigation crisis is already here' (1995) 7(10) *Australian Medicine* 4.

¹⁷ *Tito*, above n 8, 14.

¹⁸ *Tito*, above n 8, 13. *Tito* noted that 'there are very many adverse patient outcomes which arise out of health care in the Australian health care system - probably considerably in excess of 400 000, with around 230 000 being preventable with current knowledge according to the results of the PIR's Quality in Australian Health Care Study. While many of them involve only minor disabilities, 30% resulted in a disability that was likely to prevent the person returning to work or normal activities for 1-12 months, and 20% resulted in some degree of permanent disability or death'.

appear to have improved their reserves to meet their underfunding, it appears likely that others have been less provident.

The evidence for a so-called claims crisis is scant - while the reporting of incidents has increased, this has been in response to direct efforts by MDOs to get early notice of potential claims, and does not, thus far, appear to be reflected in increased legal claims. Some MDOs have been making such claims publicly without the production of data to substantiate them. However, they do not appear to be basing their premiums on such increases, as premium rates in these same organisations have remained steady.

The fostering of such a crisis mentality can serve to deflect attention from irresponsible financial management by such MDOs, and can be used to disguise later rises in contributions which have, in fact, arisen because of this financial improvidence. Such improvident strategies can also be used by an organisation to increase cash-flow at the expense of longer term financial viability, if an organisation is short of funds. While these are all possible explanations, there is no publicly available data on the operations of MDOs against which to judge these possibilities.¹⁹

Despite *Tito's* cautions, claims about a medical liability crisis persisted. In 2002 the Commonwealth intervened to ensure medical practitioners insured by United Medical Protection (UMP)²⁰ and its principal reinsurer, HIH,²¹ remained indemnified. UMP's collapse coincided with extensive media coverage of a small number of high-value negligence cases,²² alongside research identifying premium costs and fear of litigation as critical workforce retention issues,²³ or triggers for defensive medicine.²⁴ That had political implications for medical workforce retention and access to, and cost of, medical care, particularly in remote and regional areas.

Coinciding with similar tensions in the context of occupier's liability and public authority liability, in 2002 Australia's governments convened the *Ipp* Review. Significantly, *Ipp* was *not* empowered to investigate causes of the negligence law 'crisis'.²⁵ The Ministerial Communique instead announced 'Unpredictability in the interpretation of the law of negligence is a factor driving up premiums';²⁶ *Ipp's* Terms of Reference did not permit further exploration.

¹⁹ *Tito*, above n 8, 13.

²⁰ Christopher Zinn, 'Australian government forced to bail out medical malpractice insurer' (2002) 324(7341) *British Medical Journal* 808.

²¹ David Kehl, 'Parliamentary Library E-brief: HIH Insurance Group Collapse', Parliament of Australia (2001).

²² *Simpson v Diamond & Anor* [2001] NSWSC 925, initial award of \$14,202,042 in damages, reduced to \$10,998,692 on appeal in *Diamond v Simpson (No 1)* [2003] NSWCA 67.

²³ Alastair H MacLennan and Michael K Spencer, 'Projections of Australian obstetricians ceasing practice and the reasons' (2002) 176(9) *Medical Journal of Australia* 425; The World Today, ABC Radio, 'Doctors leaving for early retirement', 26 August 2002, <http://www.abc.net.au/worldtoday/stories/s659054.htm>; and Zinn, above n 20.

²⁴ Kerren Clark, 'Litigation: a threat to obstetric practice?' (2002) 9(3) *Journal of Law and Medicine* 303.

²⁵ Bruce Feldthusen, 'Posturing, tinkering and reforming the law of negligence - a Canadian perspective?' (2002) 8(2) *University of New South Wales Law Journal* 31-32; and Rob Davis, 'Forum: Reform of the Law of Negligence, 'The Tort Reform Crisis'' (2002) 25(3) *University of New South Wales Law Journal* 865.

²⁶ Commonwealth of Australia, 'Joint Communique: Ministerial Meeting on Public Liability' (30 May 2002).

The Ministers detailed measures directed at reform to contain costs, reduce costs, increase ‘certainty and predictability of costs of claims for insurers’, and manage ‘community expectations about personal responsibility and assumption of risk’.²⁷

Proposed measures included capping damages, shortening limitation periods and reviewing legal advertising practices. Proposals for insurance industry reform were less detailed, limited to calls to ‘respond promptly and constructively to issues facing particular groups in obtaining public liability cover and rising premiums’. The Communique omitted any discussion of the role of defendants (doctors, public authorities, occupiers or otherwise) in the ‘crisis’.

The Terms of Reference reflect capture of the Ministerial Group, demonstrated in the statement:

The award of damages for personal injury has become unaffordable and unsustainable as the principal source of compensation for those injured through the fault of another. It is desirable to examine a method for the reform of the common law with the objective of limiting liability and quantum of damages arising from personal injury and death.²⁸

Without a mandate to examine causes of the crisis, diagnosis was largely left to the media and affected stakeholders, with much blame (including by judges) directed at the courts.

One prominent judge thus described negligence law as ‘the last outpost of the welfare state’,²⁹ referring to peers as having ‘stretched the law’ and commenting

an element of welfare state paternalism, driven by the same sense of compassion, is not absent from day-to-day judicial decision making about when a person ought to receive compensation, even in our fault-based system.³⁰

Another used his retirement speech to criticise peers for allowing

tests for negligence to degenerate to such a trivial level that people can be successfully sued for ordinary human activity. We now have a compensation-orientated society in which people know that a minor injury may be a means of getting more money than they can possibly save in a lifetime. The incentive to recover from injury disappears with such a system. Self-reliance becomes a scarce commodity and society becomes divisive and weak. The judiciary has a lot to answer for this. It’s no use blaming the plaintiffs’ lawyers. We are the ones who have laid down the rules and given the judgements. The buck stops with us, not them. We are the ones who have let the quantum of damages get out of hand and who have lowered the barriers of negligence and causation. Common sense has long gone from the system in the area of tort and damages for personal injuries. When I say ‘we’, I mean all levels of adjudication right up to the High Court. Some of us have enjoyed playing Santa Claus forgetting that someone has to pay for our generosity.³¹

Responsibility for the ‘crisis’ was also variously attributed to litigious patients with unrealistic expectations,³² changes in legal practice rules permitting lawyers to advertise³³ and pursue baseless

²⁷ Commonwealth of Australia, ‘Joint Communique: Ministerial Meeting on Public Liability’ (30 May 2002).

²⁸ *Ipp*, above n 9, ix.

²⁹ *Reynolds v Katoomba RSL All Services Club Ltd* (2001) 53 NSWLR 43, [26].

³⁰ James Spigelman, ‘Negligence: The Last Outpost of the Welfare State’ (2002) 76 *The Australian Law Journal* 432, 433.

³¹ Justice James Thomas, Retirement Speech, Banco Court Qld Brisbane, 22 March 2002.

³² Pamela Burton, *Australian Medical Association submission to the Review Panel on the Law of Negligence*, 12 August 2002.

claims against doctors,³⁴ perceptions of hindsight bias,³⁵ unreasonable expectations attributed to judges and expert witnesses involved in litigation of civil claims, and overly permissive judges.³⁶

Shortcomings in insurance practices, or patient safety issues within the medical profession, were less frequently attributed with responsibility, notwithstanding *Tito*'s findings of systemic problems in both these areas.³⁷ Media reporting largely accepted that medical negligence claims were increasing exponentially without questioning what (if any) role the courts had in contributing to that increase, taking it as a matter of faith that courts were responsible.³⁸

Ipp provided 61 recommendations for reforming the law of negligence. Some were directly relevant to medical negligence claims; others less so. Many recommendations were subsequently implemented³⁹ with varying degrees of consistency as part of a legislative reform process in all Australian jurisdictions.⁴⁰ Most of those recommendations and the subsequent legislation were directed at limiting the courts' powers to further extend the law of negligence and to wind back some of the expansion. Some stakeholders – including former NSW Premier Carr, a champion of the proposed reforms⁴¹ - have described them as a 'success'.⁴²

Conversely, Justice Ipp has stated that he thinks some changes went too far.⁴³ A key critic of judicial decision-making during the 'crisis' acknowledged that the 'pro-plaintiff' tide of decision-making in

³³ Commonwealth of Australia, 'Joint Communique: Ministerial Meeting on Public Liability' (30 May 2002).

³⁴ Miranda Devine, 'Lawyers Delivered This Mess' *Sydney Morning Herald* (Sydney) 2 May 2002, 13.

³⁵ Thomas B Hugh and G Douglas Tracy, 'Hindsight bias in medicolegal expert reports' (2002) 76(6) *Medical Journal of Australia* 277; Jeanette Ward, Colin Thomson and Seham Girgis, 'The courts expect the impossible': medico-legal issues as perceived by New South Wales general practitioners' (2000) 7(3) *Journal of Law and Medicine* 273; and Bill Madden, 'Myths Of Explosion Prevent Solutions To Indemnity Crisis' *Sydney Morning Herald* (Sydney) 2 May 2002, 13.

³⁶ Spigelman, above n 30.

³⁷ Note that some experts and academics did refer to these issues, see for example Rob Davis, 'The Tort Reform Crisis' (2002) 25(3) *University of New South Wales Law Journal* 865; Harold Luntz, 'Reform of the Law of negligence: Wrong Questions – Wrong Answers' (2002) 25(3) *University of New South Wales Law Journal* 836; and Peter Cashman, 'Tort Reform and the Medical Indemnity 'Crisis'' (2002) 25(3) *University of New South Wales Law Journal* 888.

³⁸ Michael Kirby, Medical malpractice – An International Perspective of Tort System reforms – opening address to Royal College of Physicians, London 11 September 2000.

³⁹ *Civil Law (Wrongs) Act 2002* (ACT); *Civil Liability Act 2002* (NSW); *Personal Injuries (Liabilities and Damages) Act* (NT), *Civil Liability Act 2003* (Qld), *Civil Liability Act 1936* (SA), *Civil Liability Act 2002* (Tas), *Wrongs Act 1958* (Vic); and *Civil Liability Act 2003* (WA).

⁴⁰ Des Butler, 'A comparison of the adoption of the Ipp Review recommendations and other personal injuries liability reforms' (2005) 13 *Torts Law Journal* 203; and Minter Ellison, *Tort law reform throughout Australia: A brief review of recent amendments* (6th ed, December 2005).

⁴¹ Bob Carr, 'A New Agenda for Government' (2002) 14(3) *The Sydney Papers* 98, 107-108; Bob Carr (Premier), 23 October 2002 Civil Liability Amendment (Personal Responsibility) Bill Second Reading Speech *Legislative Assembly Hansard* (New South Wales Parliament) 5764.

⁴² Anne Davies and Michael Pelly, 'Carr's softer line on accident claims', *Sydney Morning Herald* (Sydney) 10 February 2005, 1.

⁴³ David Ipp, *The Politics Purpose and Reform of the Law of Negligence*. Paper delivered to Australian Insurance Law Association at Noosa on 17 May 2007.

the High Court had probably turned prior to the reforms.⁴⁴ In other words, the perceived ‘pro-plaintiff’ trend in judicial decision-making was probably self-correcting without legislative intervention, consistent with our findings based on examination of data rather than reliance on subjective impressions.

Subsequent reports have confirmed what was widely suspected by some experts at the time:⁴⁵ the ‘crisis’, such as it was, was an insurance crisis, rather than a medical negligence crisis. An Australian Senate committee report published shortly after *Ipp* identified international factors related to availability of reinsurance and reduced capacity in the wake of 9/11, and hardening of the insurance market as causes of the crisis, along with increasing costs of claims.⁴⁶

Before looking at baseline data in detail it is useful to consider the framework for civil liability regarding patient harm.

Reasonable care?

Notwithstanding difficulties in identifying a unifying common law theory regarding a duty of care,⁴⁷ recognition of duty between a treating healthcare provider and a patient has been uncontroversial.⁴⁸ The duty may extend beyond the basic treatment relationship in some circumstances but not others, including to unborn children⁴⁹ and third parties.⁵⁰ Recognition may be further complicated if the defendant practitioner is exercising a statutory power or duty, for example.⁵¹

The content of that duty, particularly with regard to the duty to warn, has proven more contentious.⁵² In *Rogers v Whittaker*, the majority judgment described it as:

a "single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment"; it extends to the examination, diagnosis and treatment of the patient and the provision of information in an appropriate case⁵³

⁴⁴ Spigelman, above n 30.

⁴⁵ See for example Rob Davis, ‘The Tort Reform Crisis’ (2002) 25(3) UNSW Law Journal 865; Peter Cashman, ‘Tort Reform and the Medical Indemnity ‘Crisis’’ (2002) 25 *University of New South Wales Law Journal* 888; Harold Luntz, ‘Reform of the Law of negligence: Wrong Questions - Wrong Answers’ (2002) 25 *University of New South Wales Law Journal* 836.

⁴⁶ Senate Economics References Committee, Parliament of Australia, *A Review of Public Liability and Professional Indemnity Insurance* (2002), [2.1].

⁴⁷ Identification of a unifying theme underpinning recognition has proven challenging: *Sullivan v Moody* (2001) 207 CLR 562, 579 [50].

⁴⁸ *Rogers v Whitaker* [1992] HCA 58; (1992) 175 CLR 479; and *F v R* (1984) 33 SASR 189.

⁴⁹ *X v Pal* (1991) 23 NSWLR 26.

⁵⁰ *Bi v Oei* [1999] NSWSC 1082; and *Cattanach v Melchior* [2003] HCA 38.

⁵¹ *Hunter and New England Local Health District v McKenna; Hunter and New England Local Health District v Simon* [2014] HCA 44.

⁵² *Hunter and New England Local Health District v McKenna; Hunter and New England Local Health District v Simon* [2014] HCA 44.

⁵³ *Rogers v Whitaker* [1992] HCA 58; (1992) 175 CLR 479, 483.

approving earlier statements in *Sidaway v Governors of Bethlem Royal Hospital*⁵⁴ and *Gover v South Australia*.⁵⁵

Ipp focussed on reforming the standard of care, rather than existence of a duty of care in a medical negligence context. Significantly it made extensive recommendations reforming recognition of a duty of care arising in the context of mental harms.⁵⁶ The impact of the reforms on medical negligence is significant in the context of third party plaintiffs who claim to suffer mental harm as a consequence of a practitioner's negligent treatment of a patient, or as a consequence of negligent provision of psychiatric care to a patient.⁵⁷

Negligent conduct?

Establishing that the practitioner's conduct breached the duty of care is determined by reference to an objective standard, typically the 'reasonable person in the defendant's position'. Controversially, in medical negligence the standard is more nuanced. In *Bolam v Friern Hospital Management Committee*,⁵⁸ the standard of care expected of a medical practitioner defendant was calibrated to accepted practice 'by a body of medical men'.⁵⁹ In *F v R*, the Full Court of the South Australian Supreme Court refused to apply *Bolam*. King CJ described the test as:

not whether the defendant's conduct accords with the standard of his profession or some part of it, but whether it conforms to the standard of reasonable care demanded by the law. That is a question for the court and the duty of deciding it cannot be delegated to any profession or group in the community.⁶⁰

In *Rogers v Whitaker*, the High Court also rejected *Bolam*, stating:

The law should recognize 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 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.⁶¹

Ipp acknowledged 'a significant body of opinion, especially among the medical profession, in favour of reinstating *Bolam* in its original form',⁶² but declined to recommend reinstatement, instead recommending:

⁵⁴ *Sidaway v Governors of Bethlem Royal Hospital* [1985] UKHL 1; (1985) AC 871, Lord Diplock at 893.

⁵⁵ *Gover v South Australia* (1985) 39 SASR 543, 551.

⁵⁶ *Ipp*, above n 9, 144, Recommendation 34.

⁵⁷ *Hunter and New England Local Health District v McKenna; Hunter and New England Local Health District v Simon* [2014] HCA 44; (2014) 253 CLR 270.

⁵⁸ *Bolam v Friern Hospital Management Committee* (1957) 1 WLR 582. See more broadly Carolyn Sappideen, 'Bolam in Australia - More Bark Than Bite?' (2010) 33(2) *University of New South Wales Law Journal* 386.

⁵⁹ *Bolam v Friern Hospital Management Committee* (1957) 1 WLR 582, 588.

⁶⁰ *F v R* (1983) 33 SASR 189, 194.

⁶¹ *Rogers v Whitaker* [1992] HCA 58; (1992) 175 CLR 479.

⁶² *Ipp*, above n 9, 38 at [3.5].

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.⁶³

The standard of care is also moderated against the ‘calculus of negligence’, which balances likelihood of the risk against the harm posed if the risk eventuates in determining what the ‘reasonable defendant’ would have done, typically requiring that it be ‘not farfetched or fanciful’.⁶⁴

Ipp’s Recommendation 28 modified and formalised that test, making it necessary for defendants to do more than merely fail to take precautions against a foreseeable risk to be liable in negligence. *Ipp* recommended raising the standard of likelihood of the risk eventuating from ‘not far-fetched or fanciful’ to ‘not insignificant’; requiring that the ‘reasonable person’ in the defendant’s position would have taken precautions against that risk; and itemising some considerations in making such a determination: the probability of the harm occurring, ‘the likely seriousness of that harm’; the burden of taking precautions; and ‘the social utility of the risk-creating activity’.⁶⁵

Damage attributable to negligence

At common law, there are limitations on the types of ‘damage’ recognised in negligence. Loss of chance of a better outcome will not sound in damages.⁶⁶ Harm sustained *in utero* will be recognised, but not until the child is born alive.⁶⁷ Conversely, wrongful life suits⁶⁸ have not succeeded in Australia.⁶⁹ Wrongful birth suits⁷⁰ were successful in some jurisdictions.⁷¹

Causation, that is proving ‘but for’ the defendant practitioner’s negligent act the harm would not have occurred, has likewise posed challenges for plaintiffs.⁷² Where the claim relates to the provision of information required to obtain consent, however, causation may prove more difficult, with plaintiffs failing to demonstrate that if they had been in possession of all the relevant information, they would not have consented.⁷³

Ipp recommended that findings of negligence causing harm in the form of personal injury or death require two elements:

⁶³ *Ipp*, above n 9, 42, Recommendation 3.

⁶⁴ *Wyong Shire Council v Shirt* [1980] HCA 12; (1980) 146 CLR 40.

⁶⁵ *Ipp*, above n 9, 106, Recommendation 28.

⁶⁶ *Tabett v Gett* [2010] HCA 12.

⁶⁷ *Watt v Rama* [1972] VicRp 40; [1972] VR 353.

⁶⁸ Claims brought by disabled child plaintiffs alleging that negligent pre-natal care offered to parents wrongfully deprived the parents of the opportunity to terminate the pregnancy, resulting in the child’s live birth.

⁶⁹ *Harriton v Stephens* [2006] HCA 15; (2006) 226 CLR 52; (2006) 226 ALR 391; (2006) 80 ALJR 791.

⁷⁰ Typically arising from alleged negligence in the provision of contraceptive or fertility treatment and decided under common law prior to statutory reform.

⁷¹ *G & M v Armellin* [2009] ACTCA 6.

⁷² *Barnett v Chelsea Hospital Management Committee* [1969] 1 QB 428.

⁷³ *Chappell v Hart* [1998] HCA 55; 195 CLR 232; 156 ALR 517; 72 ALJR 1344; and *Rosenberg v Percival* [2001] HCA 18; (2001) 205 CLR 434; 75 ALJR 734.

- (i) ‘factual causation’, whether the negligence played a part in bringing about the harm; and
- (ii) ‘scope of liability’, the normative issue of the appropriate scope of the negligent person’s liability for the harm, after establishment that the negligence was a factual cause of the harm. ‘Scope of liability’ covers issues, other than factual causation, referred to in terms such as ‘legal cause’, ‘real and effective cause’, ‘commonsense causation’, ‘foreseeability’ and ‘remoteness of damage’.

That was consistent with the High Court in *March v Stramare*⁷⁴ stating the ‘but for’ test was not the only test of causation under Australian law. It also reflected criticisms that courts were recognising harms too remote from the negligent act complained of.

Other recommendations included reducing limitation periods for personal injury and death,⁷⁵ reforming and capping the availability of damages,⁷⁶ and legal costs.⁷⁷ These were of particular significance for medical negligence claims, as claims arising from obstetric and paediatric procedures typically had high damages awards, based on the long life-expectancy and high care needs of some plaintiffs, and long limitation periods, based on the age of plaintiffs.⁷⁸

Limitations of the recommendations

Echoing *Tito*, an under-appreciated *Ipp* finding was the lack of empirical data supporting some claims made by vested interests:⁷⁹

Many different changes could be made to the current law of negligence to further the objectives stated in the first paragraph of the Terms of Reference. Many bodies and individuals with differing interests and objectives have made submissions to the Panel as to the changes that should be made. Such changes were often recommended on the basis of assertions about their likely effects but typically they were not supported by reliable and convincing empirical evidence. The vast majority of the assertions were based merely on anecdotal evidence, the reliability of which has not been tested.⁸⁰

Significant features of *Ipp* should be considered in any evaluation of the effectiveness of its recommendations. Firstly, *Ipp* was conducted in an extremely short timeframe: three months separated release of the Terms of Reference and the Final Report. Secondly, the Final Report cautioned that

because of “the dearth of hard evidence” the Panel’s recommendations are based primarily on the collective sense of fairness of its members, informed by their knowledge and experience, by their own

⁷⁴ *March v Stramare (E. and M.H.) Pty Ltd* [1991] HCA 12; (1991) 171 CLR 506.

⁷⁵ *Ipp*, above n 9, Recommendations 23-25.

⁷⁶ *Ipp*, above n 9, Recommendations 46-61.

⁷⁷ *Ipp*, above n 9, Recommendation 45.

⁷⁸ *Simpson v Diamond & Anor* [2001] NSWSC 925; *Diamond v Simpson (No 1)* [2003] NSWCA 67; above n 22.

⁷⁹ *Ipp*, above n 9, 32, [1.38-1.40].

⁸⁰ *Ipp*, above n 9, 32.

researches and those of the Panel's Secretariat, and by the advice and submissions of those who have appeared before the Panel and who have made written representations to it.⁸¹

Ipp sought to ‘strike a balance between the interests of injured people and those of injurers’ that ‘seems to be fair’ and ‘on the basis of what we have been told, likely to be widely acceptable in the community at large’.⁸²

Panel members drew on personal experience, and their beliefs and perceptions of community standards, to fill in the significant gaps in the available evidence.

In the absence of hard data about the causes of the crisis, evaluation of the effectiveness of the implementation of the reforms has been problematic. The data highlighted in later pages of this article is thus significant.

B: Occupational discipline pathways

Much of *Tito* focussed on occupational discipline and professional regulation as mechanisms for minimising or responding to patient harm. Despite those recommendations, widespread reform of health practitioner regulation did not occur in Australia until the mid 2000s, culminating in the National Health Practitioner Law of 2010.

A traditional characteristic of medicine as a profession is professional autonomy – the practice of review and regulation of the profession and its practitioners, by the profession, rather than outsiders. Although formally recognised through legislation as recently as 150 years or so ago, there is evidence that medicine has been largely autonomous in setting its own regulatory standards regarding discipline, ethical breaches, and education, for the past several hundred years. Consistent with changing models in many jurisdictions of a ‘social contract’ between the profession and society, there has increasing movement from ‘pure’ self regulation towards more formalised models governed by legislation (often involving co-regulation), prompted partly by perceived failures of the profession to respond to particular defects and scandals,⁸³ or – more specifically in the case of the US – due to changes in relationships between the profession and other social structures, including government financing models of healthcare.⁸⁴

Perhaps unsurprisingly, professions including medicine have traditionally resisted pressure to move away from self-regulation towards greater transparency, evident in opposition to oversight of practice

⁸¹ *Ipp*, above n 9, 32.

⁸² *Ipp*, above n 9, 32.

⁸³ Mary Dixon-Woods, Karen Yeung and Charles L Bosk, ‘Why is UK medicine no longer a self-regulating profession? The role of scandals involving “bad apple” doctors’ (2011) 73(1) *Social Science & Medicine* 1452.

⁸⁴ Fabrice Jotterand, ‘The Hippocratic Oath and Contemporary Medicine: Dialectic Between Past Ideals and Present Reality?’ (2005) 30(1) *Journal of Medicine and Philosophy* 107.

by non-practitioners, including the courts,⁸⁵ notwithstanding that the courts have long played a role in reviewing medical practice.⁸⁶

Occupational regulation and discipline, encompassing control over access to the profession, credentialing, registration, and ongoing oversight and maintenance of professional standards, is attractive as a target for intervention to reduce patient harms because it provides a pre-emptive mechanism that potentially operates before harm has occurred to patients.⁸⁷ Ironically, a key driver for reformed occupational discipline and regulation in many jurisdictions including Australia has been criminal prosecution of ‘rogue’ practitioners: action against practitioners arising from harm inflicted on others (both patients and third parties) directly relevant to their suitability to practice. Some of those acts were intentional; others were consequences of extreme negligence. Australia’s *Patel*⁸⁸ and *Reeves*⁸⁹ trials (for manslaughter, grievous bodily harm, negligently causing harm, unlawful killing, and fraud, and grievous bodily harm and sexual and financial offences) attracted national media attention and High Court adjudication. Roger Dean, a nurse, was convicted of multiple charges of murder resulting from nursing home arson;⁹⁰ general practitioner Michael McGrane,⁹¹ former psychiatrist Jean Eric Gassy,⁹² and nurses Keng Hwee (Kathy) Yeo⁹³ and Walter Marsh⁹⁴ were all convicted of murder. Overseas jurisdictions similarly experienced serious and/or large-scale criminal wrongdoing on the part of practitioners, most notoriously Harold Shipman, suspected of killing over 200 patients in the United Kingdom between 1975 and 1998.⁹⁵ Other incidents, such as those at Stafford Hospital in the United Kingdom, arose as a consequence of systemic failure to report and respond to risks,⁹⁶ prompting proposals to create special offences for healthcare practitioners who cause harm or fail to peers for report serious risks to patient safety.⁹⁷

Prompted in part by analysis of ‘red flags’ identified during those criminal proceedings, occupational regulation, particularly discipline, has been transformed in recent years, moving to a national system

⁸⁵ James C Mohr, ‘American Medical Malpractice Litigation in Historical Perspective’ (2000) 283(13)

Journal of the American Medical Association 1731; and Peter D Jacobson and M Gregg Bloche, ‘Improving Relations Between Attorneys and Physicians’ 294(16) *Journal of the American Medical Association* 2083.

⁸⁶ J B Post, ‘Doctor versus patient: two fourteenth-century lawsuits’ (1972) 16(3) *Medicine and History* 296; Robert Field, ‘The Malpractice Crisis turns 175: What lessons does history hold for reform?’ (2011) 4 *Drexel Law Review* 7; and Carlton B Chapman, ‘Stratton vs. Swonlond: The Fourteenth-Century Ancestor of the Law of Malpractice’ (1982) 45 *Pharos* 20; William Blackstone, *Commentaries on the Laws of England* (University of Chicago Press, 1979) vol III, 122.

⁸⁷ Bismark et al (2013); Paterson; Spittal et al (2015) above n 11.

⁸⁸ *Patel v The Queen* [2012] HCA 29.

⁸⁹ *Reeves v The Queen* [2013] HCA 57.

⁹⁰ *R v Dean* [2013] NSWSC 1027.

⁹¹ *R v McGrane* [2002] QCA 173.

⁹² *R v Gassy* [2004] SASC 338.

⁹³ *R v Yeo* [2002] NSWSC 315.

⁹⁴ *R v Marsh* [2012] NSWSC 208.

⁹⁵ Smith, above n 4.

⁹⁶ Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009, *Final Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (2013) (Francis Report).

⁹⁷ Berwick, above n 4.

of credentialing and registration designed to enhance early identification of at-risk practitioners.⁹⁸ Observations from several jurisdictions, including Australia, indicate that some practitioners account for a disproportionately high number of occupational disciplinary matters.⁹⁹

Passage of the Health Practitioner Regulation National Law resulted in a statutory framework governing 14 healthcare professions, administered by the Australian Health Practitioner Regulatory Agency (AHPRA) in conjunction with national boards for each profession. Activities and responsibilities under the National Law include registering practitioners, and investigating complaints related to practitioner health and conduct, by patients and others, in conjunction with Health Complaints Commissions. Specific reforms introduced mandatory peer-notification regimes. Combined with movement of occupational discipline hearings into formal tribunal jurisdictions, including with appellate jurisdiction to the courts (and, recently, far more extensive reporting of tribunal and board decisions), these reforms have converted occupational discipline into a formal legal mechanism for redress and prevention of patient harms, supplementing the courts' role in dispute resolution through civil litigation, notwithstanding that remedies typically do not include compensation for the patient.

C: Civil, occupational or both?

Significantly, however, although occupational discipline by the profession and civil liability determined by the courts overlap insofar as they both entail evaluation of professional practice, they differ in terms of their objectives. Occupational discipline provides a response to actual or potential harm. Practitioners whose conduct exposes patients to risk can fall foul of the occupational disciplinary pathways, as well as those who occasion harm to a patient. In that sense, they are as much about prevention of harms to patients (and to the integrity of the profession) as anything else. Correspondingly, they are more publicly-oriented in terms of the consequences of an adverse finding, typically focussing on retraining, or suspension or even termination of the practitioner's registration, in the interests of protecting public safety.

Civil liability – most commonly arising in claims of tortious medical negligence – serves different purposes. Consistent with broader principles of negligence law, its objective is to compensate patients for the consequences of harms they have suffered. Remedies are financial compensation: harmed patients are awarded damages intended to restore them to the position they would have been in had it not been for the negligence of the practitioner. An 'adverse' outcome for a practitioner of a medical negligence claim is not punitive, nor is it intended to protect the public; rather, its focus is primarily restricted to the patient who is claiming they were harmed.

⁹⁸ Bismark, above n 10.

⁹⁹ Bismark et al (2013); Paterson; Spittal et al (2015) above n 11.

This difference in objectives and outcomes perhaps explains why ‘legal’ mechanisms, such as negligence claims, are more controversial than (self)-regulatory mechanisms such as occupational discipline, notwithstanding the increased legalisation of the latter in recent years. The former is easily perceived as being essentially self-serving, motivated by personal ‘gain’ on the part of the patient (disregarding the fact that compensation only restores them to their ‘rightful’ position, rather than provides a ‘benefit’), while the latter is viewed as being the response of a caring profession to ‘altruistic’ concerns motivated by protection of public safety, raised by patients, or members of that profession, who have no prospect of receiving a financial ‘benefit’ as a result of raising those concerns.

D: The role of the courts – a symptom or a cause?

The aftermath of the Ipp reforms and implementation of the National Health Practitioner Laws raise challenging questions. Did the reforms change the role of the courts? What was that role previously? Have the reforms ‘improved’ the situation? At the time of *Ipp* and *Tito*, hard data confirming or refuting theories about the causes and effects of the crises in confidence in the medical profession were unavailable.

Further hampering efforts to evaluate the role of the courts, and the effects of the reforms, is the way in which proxy data that did exist – both at the time, and since – has been collected and presented. This is in part attributable to changes in the way insurers counted claims as a consequence of structural changes to the medical indemnity sector as it transitioned from being a mutual provider to an insurer in the 1990s. Particular difficulties arose during the transition from cash accounting to claims based accounting practices, and inconsistencies in industry practices in accounting for claims incurred, but not yet made, in the immediate aftermath of UMP’s collapse.¹⁰⁰

Media reporting of rates and increases in the number of claims is typically lacking in detail, such as the stage of the complaint, or its severity. Data collections, such as the Medical Indemnity National Collection (MINC), initiated subsequently, provide a better empirical basis for understanding trends in patient safety and harm, and their relation to legal liability, than was available at the time; however they are still incomplete. The MINC is a dataset of public and private medical indemnity claims open at any point during the identified financial year reporting period.¹⁰¹ It includes information on the mode of finalisation of claims. There are a number of endpoints for prospective claims once they are received by insurers. These include discontinuation of both potential claims, and claims where the affected person has commenced pursuing their claim; settlement, using a range of court and statute based alternative dispute resolution processes, as well as traditional negotiation; and court finalisation.

¹⁰⁰ Australian Health Ministers Advisory Council Medical Indemnity Working Group, *Why Premium Costs have increased for professional indemnity in health Care*, Background Paper (2002); *Tito*, above n 8, chapter 9.

¹⁰¹ The MINC covers most of Australia; notable gaps exist in the Western Australia dataset.

An increase in the number of potential claims notified to an insurer does not necessarily lead to an increase in matters going to litigation, as noted in *Tito*.¹⁰² It may reflect changes in reporting behaviours of policyholders, or reporting requirements of insurers, for example. Similarly, the claimed increase in reports to insurers should also be viewed in the context of access to the legal system. *Tito* noted that access to legal remedies was a significant barrier to many patients adversely affected through medical treatment,¹⁰³ a situation that has only deteriorated further with the passage of time. Similarly, coarse-grained reporting of damages decontextualized from reliable data on frequency skews the magnitude of such awards, suggesting trends that may not exist.

Interestingly, the MINC Report for 2012-2013¹⁰⁴ found that 97% of all *potential* notified claims were resolved or closed *without* court involvement. Either the claim was never pursued by the patient, it was settled through alternative dispute resolution at an early stage, or it was abandoned for some other reason.¹⁰⁵ This figure is a decrease from the 2008 report, whereby 6% of all closed claims were finalised by a court. Similarly, the majority of claims in 2013-14 (57%) were settled or otherwise resolved for less than \$100,000.¹⁰⁶ In 2007-08, two thirds of claims were closed for less than \$10,000.¹⁰⁷

Perhaps most telling, however, is the number of claims: in 2007-08, the collection reported 12,349 claims,¹⁰⁸ in 2012-13 it reported 13,666, representing an increase of 11%.¹⁰⁹

In comparison, the number of services processed by Medicare in 2007-2008 was 278.7 million;¹¹⁰ in 2013-2014 it had risen to 358.3 million,¹¹¹ an increase of nearly 30%. Importantly, the number of services leading to a possible claim being notified to an insurer is a tiny fraction of all services being provided. Of that tiny fraction, an even smaller percent (around 5% of the subtotal) results in court involvement.

This suggests that since the Ipp reforms only a very small number of adverse events eventually result in litigation, an observation that is consistent with observations from other jurisdictions.¹¹²

Following on from this observation, a secondary question in considering the significance of the courts in contributing to the crisis is what is the fate of those disputes once they are listed for hearing in a

¹⁰² *Tito*, above n 8, 215 [7.21].

¹⁰³ *Tito*, above n 8, at chapter 7.

¹⁰⁴ Australian Institute of Health and Welfare, *Australia's medical indemnity claims 2012-2013* (2014).

¹⁰⁵ *Ibid*, 16.

¹⁰⁶ *Ibid*, Table 3.9.

¹⁰⁷ Australian Institute of Health and Welfare, *Australia's medical indemnity claims 2007-2008* (2009).

¹⁰⁸ *Ibid*.

¹⁰⁹ Australian Institute of Health and Welfare, *Australia's medical indemnity claims 2012-2013* (2014).

¹¹⁰ Australian Department of Human Services, *Medicare annual report 2007-2008* (2009).

¹¹¹ Australian Department of Human Services, *Medicare annual report 2013-2014* (2015).

¹¹² Vines, above n 14.

court? Does the patient plaintiff typically win, or are there procedural barriers in play? How big are the awards of damages being made by the courts? Establishing answers to these questions is one of the aims of the current study.

Previous reviews of the role of the courts in contributing to the negligence ‘crisis’ have examined the reforms broadly. Stewart and Stuhmcke recently published the results of their study into the interpretation of the reforms by the High Court in the decade since their implementation.¹¹³ In a report commissioned by the Law Council of Australia, Wright examined trends in personal injury litigation in Australian States and Territories prior to, and subsequent to, the reforms.¹¹⁴

Our study takes a different approach, examining the courts’ involvement in medical negligence claims pre- and –post the Ipp reforms, against the broader backdrop of legal responses to patient harms, including criminal prosecution and occupational discipline.

No authors have specifically examined medical negligence claims. It is the contention of this article that there are unique characteristics of medical negligence that make it appropriate to examine specific trends in medical negligence before and after the reforms.

This article offers such data over the period before and after implementation of the *Ipp* reforms, and the National Health Practitioner laws and related changes to occupational discipline and reporting of those matters, in Federal and state/territory courts and tribunals.

PART 2: METHODOLOGY

This study sought to cover all Australian state and mainland territory jurisdictions in examining the role of the courts in regulating health practitioners over a twenty-five year period spanning *Ipp*. It accordingly covered all reported judgments arising from the provision of medical care – including occupational discipline and criminal matters, as well as civil claims.

The aim was to determine what role the court plays in adjudicating disputes involving practitioners, and what trends can be detected in the role the courts play over time. More specifically, we considered the question of whether the significance attached to the role of the courts in driving reform of medical negligence law during the Ipp review was appropriate.

¹¹³ Pam Stewart and Anita Stuhmcke, ‘High Court Negligence Cases 2000–10’ (2014) 36(4) *Sydney Law Review* 585; and Pam Stewart and Anita Stuhmcke, ‘Lacunae and Litigants: A Study of Negligence Cases in the High Court of Australia in the First Decade of the 21st Century and Beyond’ (2014) 38(1) *Melbourne University Law Review* 151.

¹¹⁴ E W Wright, ‘National Trends in Personal Injury Litigation: Before and After ‘Ipp’ (Report commissioned by the Law Council of Australia)’ Justice Policy Research Centre, 26 May 2006.

Our intention was to create a robust dataset with national coverage (ie beyond the High Court) over a period that is sufficient to allow identification of trends in civil and criminal litigation involving health professionals, where the relevant conduct is directly related to patient care or safety. Previous studies¹¹⁵ have identified the difficulties in using other metrics of litigation, noting the issues in accessing commercially-sensitive detailed data from insurance companies.

We constructed a dataset by interrogating electronic databases (AustLII, Casebase, judgments posted on court and tribunal websites) using search strings incorporating each of the regulated health professions, and other terms including crim*, negligen*, disc*, patient*, hosp*, trespass, to identify any judgments potentially relevant to our study, between the years 1989-2013 inclusive. Judgments were then read and incorporated into our dataset, or discarded if not relevant.¹¹⁶ The electronically-derived dataset was then crossmatched against judgments identified by manual search of all hardcopy court reports for the relevant years, to ensure that no relevant judgments were missed as a consequence of migration to electronic data repositories.

Relevant judgments were coded thematically, by year of judgment; type of matter (civil – negligence or trespass; criminal – type of charge; occupational discipline); nature of judgment (procedural or substantive); jurisdiction; outcome; damages, sentence or penalty (where appropriate); nature of claim (procedural: extension of limitation; amendment of claim; application for dismissal; application for summary judgment; or substantive: harm; duty of care; breach of duty; causation; damages) elements of offence/disciplinary charge); subspecialisation/ occupational discipline of the defendant; jurisdiction; and procedural history.

The dataset we compiled reflects *reported* judgments only; small value claims decided before lower level courts not subsequently appealed to Supreme Court or higher level may not be represented, as they do not appear as reported judgments in any of the data repositories.

Similarly, there are instances where procedural issues were reported, but no substantive conclusion appears within the published data repositories, or where findings of liability are reported, but awards of damages are not. We infer that these matters were either abandoned or settled subsequent to the published judgment, noting that in many cases settlements are governed by confidentiality provisions.

PART 3: RESULTS AND DISCUSSION

Involvement of the courts in medical matters

¹¹⁵ Wright, above n 114, 7; *Tito*, above n 8; *Ipp*, above n 9, 32 [1.38-1.40].

¹¹⁶ Examples of ‘irrelevant’ judgments include motor vehicle accidents where much of the evidence presented was medical; cases of fraud against Medicare by practitioners, etc. These were discarded as the wrongdoing alleged was not directly relevant to the provision of care to a patient, or directly connected to patient safety.

Total published judgments

Courts, tribunals, and disciplinary bodies published 2044 final judgments during the period 1 January 1989 to 31 December 2013. Disciplinary matters accounted for 1305 judgments; 711 were civil claims, including negligence and trespass, and 28 related to allegations of criminal misconduct. The number of reported judgments involving practitioners increased dramatically over the course of the study: in 1989, there were just four reported judgments involving medical practitioners; by 2013, the number reported in a calendar year increased to 182.

The increase is almost entirely due to increases in reporting of disciplinary and civil matters. Numbers of reported judgments arising from criminal proceedings remained small (average: 1.08/year) and steady across the study period. Reporting of civil matters, in contrast, increased across the time frame: from 1989 through to 1994, the number of published judgments per year was under ten; from 1995 until 2000 reported judgments fluctuated between 22 and 35. Judgments peaked in 2001 at 53, before averaging out at 38.5 for the remainder of the study period.

Reporting of disciplinary matters, in contrast, increased steadily every year, with the exception of 2008 and 2013, which saw decreases in the number of reported judgments on the previous year of ten and 32, respectively. (Figure 1: Published judgments by year and matter type, 1989-2013).

Disciplinary proceedings

The study reference period encompasses the transition of occupational disciplines from high levels of jurisdictional and occupational diversity, towards greater uniformity. Many of the previously operating occupational discipline boards have now been consolidated into occupational divisions of civil and administrative tribunals, leading to increased consistency in the publication of judgments. Complete records of the judgments of some boards and disciplinary bodies are available on AustLII for the entire period of the study; for other jurisdictions and occupations, records of judgments are only available from the mid-nineties (or later) onwards.

Notwithstanding the incompleteness of the early data, from the judgments that are available it can be seen that the increases in disciplinary matters that do occur across the period of the study are more than merely an artefact of reporting. Those disciplines and jurisdictions for which a complete dataset exists show an increase in the number of judgments reported yearly across the period of the study.

In 2010, a national model of health practitioner regulation was implemented, under AHPRA. Consistent with our findings that published disciplinary reports increased throughout the reference period, AHPRA reports an overall increase in the number of complaints and investigations since it

commenced in 2010.¹¹⁷ Although this may in part account for the increase in publication of judgments, it does not account entirely for the increases seen. Patterns of increase differ between jurisdictions: some jurisdictions (NSW, Qld) experienced an increase in judgments over time, including prior to implementation of national law. Other jurisdictions (Vic, SA) experienced peaks in judgment publication, rather than a continuing increase in the number of judgments being reported. (Figure 2: Disciplinary proceedings by jurisdiction over time)

We suggest that the increases in reported occupational discipline matters may be attributable to multiple factors including changes in publication practices brought about as a result of the consolidation of multiple occupational discipline boards into a single occupational division of a tribunal in several jurisdictions (eg Vic, ACT, Qld, WA) and resulting changes in reporting practices; increased awareness of mechanisms for complaint about practitioners as a result of the transition to the national registration model; and changes to the professional standards governing each of the regulated occupational disciplines.

A further change likely to affect the number of complaints, if not published judgments, is the introduction of mandatory notification laws, which require healthcare professionals to advise the registering body of concerning conduct they observe in their colleagues. The introduction of these laws in 2010 is unlikely to be a factor in accounting for the increase in number of published judgments observed in this study, however, due to the time lag between initial reporting of a complaint, and finalisation of a matter before an occupational discipline tribunal.¹¹⁸

Analysis of published disciplinary judgments by occupation shows that medical practitioners (34%) and nurses (27%) dentists (11%) pharmacists (12%) and psychologists (9%) account for 93% of all published judgments. (Figure 3: Occupational discipline by profession). Comprehensive data on the number of practitioners registered in each occupation is not available for the relevant time-frame;¹¹⁹ however based on numbers of practitioners currently registered (95,690 medical practitioners; 312,204 nurses and midwives; 19,912 dentists; 27,339 pharmacists; 30,561 psychologists), the incidence of a practitioner in any occupational class being involved in disciplinary proceedings is less than 1%. Despite widely-held concerns by practitioners, the numbers who appear before a tribunal or a board facing allegations of misconduct are extremely small. (Figure 3: Published disciplinary judgements by occupation)

¹¹⁷ Australian Health Practitioner Regulation Agency, *Regulating health practitioners in the public interest: Annual Report 2012/13* (2014).

¹¹⁸ Bismark, above n 10.

¹¹⁹ Australian Health Practitioner Regulation Agency, *Regulating health practitioners in the public interest: Annual Report 2012/13* (2014).

Bismark et al observed that disciplinary complaints are not uniformly distributed across the practitioner population, with a small proportion of practitioners responsible for a large percentage of complaints.¹²⁰ Our findings demonstrate that this observation extends to published judgments in both civil and disciplinary matters, with a small number of practitioners appearing before the relevant court, disciplinary board or tribunal to address multiple unrelated complaints.

Civil claims

The 711 published civil judgments related to 562 events in which negligence and/or trespass were alleged to have occurred. Many were procedural, addressing issues of legal process rather than substantive findings of liability (n=404), and resulted in the plaintiff's claim being dismissed. Common reasons for dismissal included failure to disclose a cause of action (eg negligence or trespass), and expiry of the limitation period. Other procedural matters commonly related to evidence and applications to amend the statement of claim lodged with the courts to better reflect the legal basis of the dispute. (Figure 4: Published civil judgements by year and outcome)

Of those cases that proceeded to final judgment (n=357), 157 resulted in a finding for the defendant practitioner, and 150 resulted in a finding for the plaintiff. Some of the concerns about inadequate data identified in Ipp and Tito were well founded. Our data shows that there was a rapid increase in the number of claims for medical negligence brought before the courts from 1989 to 2002 (from 2 in 1989, to 37 in 2002, peaking at 45 in 2001), and that numbers of judgments published by the courts have stabilised to around 30 per year in the decade since legislative reforms began taking effect in 2002. Approximately half of those judgments are procedural (average =13/year), rather than final (verdict on liability for plaintiff or defendant). Some writers have speculated that the increase is a direct result of the decision in *Rogers v Whittaker*;¹²¹ others have disputed any such association.¹²²

In the period between 1989 and 1999, 60% of final verdicts on liability were in favour of the plaintiff, while 60% of final decisions between 2003-2013 were in favour of the defendant. Yule has observed that statutory limitations on damages have had greater significance than restricting negligence in medical negligence.¹²³

Of the 150 findings for plaintiffs, 119 included an award for damages in the published judgment; the remainder were presumably settled confidentially once liability was resolved. The total value of damages awarded by the courts over the 25 year period was \$123,225,516.00, an average of \$1,035,508.54 when divided across the 119 cases which included damages. Split into the periods pre

¹²⁰Bismark, above n 11.

¹²¹ Spigelman, above n 30, 433.

¹²² David Ipp, 'Themes in the law of torts' (2007) 81 *Australian Law Journal* 609.

¹²³ Jennifer Yule, 'Defences in medical negligence: to what extent has tort law reform in Australia limited the liability of health professionals?' (2011) 1 *Journal of the Australasian Law Teachers Association* 53.

and post legislative reform, however, damages awards averaged \$672,318.96 per judgment for published judgments with damages awards in the period 1989-2002, and \$1,458,129.14 per judgment for published judgments with damages awards from 2003-2013. (Figure 5: Civil damages awarded by year).

Damages were not evenly distributed across successful claims. Successful obstetric, paediatric, or gynaecological care claims (n=26), accounted for over half (52%) of the damages awarded between 1989-2013, \$63,488,149.59.

Such awards are typically high value, frequently involving child plaintiffs with lifelong physical or intellectual disability, affected during or shortly after birth. Damages generally included substantial sums to cover the costs of lifelong – sometimes around the clock – care.

Much legislative reform specifically targeted these claims, particularly reductions to limitation periods for infant plaintiffs, and statutory caps on damages associated with costs of care. Despite reductions, there are still long lag times permitted for claims of this type to be brought before the courts – up to twelve years in some jurisdictions – meaning that claims under the pre-reform framework may still come before the court. The high value of these kinds of claims means that it may be years before the full impact of the reforms in curbing damages payments can be fully assessed.

Consistent with insurance industry figures, which estimate 96% of claims are resolved without court involvement, total numbers of judgments are small: major fluctuations in trends can be attributed to as little as a single judgment.

Criminal charges

Our study identified just 28 trials for criminal offences by a healthcare practitioner directly relevant to the care of a patient. Our search methodology excluded matters where the defendant was a healthcare practitioner whose profession was not linked to the offence (for example drink driving charges, domestic violence matters), or those matters arising from fraud directed against the Commonwealth (that is Medicare or other), rather than a patient, as our focus was on the courts role in regulating the conduct of the profession in treating patients. We included cases where the wrongdoing was against a potential witness to, or reporter of, inadequate care provided by the practitioner to the patient. The small number of cases (n=28) and the wide scope of charges, ranging from murder and manslaughter, to sexual assault and physical violence, to fraud and property charges, provides little scope for detailed quantitative analysis; it does, however, raise some interesting points for further consideration.

Of the 28 cases, categorisation of the primary charge into broad categories (sexual offences; murder; manslaughter; assault (not sexual); arson; fraud; witness intimidation) reveals that the most prevalent

category of offending is sexual assault (n=14). Further analysis revealed many allegations related to multiple complainants or instances, or both. In all cases the complainants were predominantly or exclusively patients. Eleven trials ultimately resulted in conviction of the professional; 2 led to retrials, and one (the only one featuring a single complainant based on a single alleged instance) resulted in an acquittal.

Murder (n=5) was the next most common category. In four of the five judgments, it was apparent that the victim either had information about the offender that could potentially form the basis of an occupational disciplinary matter, or had been involved in an occupational disciplinary matter regarding the offender previously.¹²⁴ In the fourth case, the murder charges arose from the consequences of a fire deliberately set by the offender in a nursing home in a bid to divert attention from irregularities in his handling of restricted drugs.¹²⁵ In all five cases the offender was convicted.

There were three judgments on manslaughter charges during the relevant period. In each instance, the death of the victim was alleged to have arisen from the gross negligence of the defendant practitioner in caring for the patient. In the only case to have resulted in a conviction, the patient was also the defendant's infant daughter.¹²⁶ In the other two cases, the defendant was acquitted over the death of a complex patient during dental sedation;¹²⁷ interestingly, occupational disciplinary proceedings brought against the defendant demonstrate that the incident was by no means an isolated occurrence of substandard practice, and he was ultimately barred from practice.¹²⁸ The final matter (that of Dr Jayant Patel, initially charged with multiple counts of manslaughter arising at Bundaberg Hospital) was the most high-profile and complex of all criminal matters in the study. The subject of a trial, a retrial, and several government enquiries, ultimately Patel was acquitted of manslaughter, but pleaded guilty to fraud.¹²⁹

Both instances of non-sexual assault resulted in acquittal. In the first, a nurse allegedly withdrew extubation prematurely;¹³⁰ in the second, a nursing assistant misplaced medication, enabling the patient to overdose.¹³¹

The remaining judgments relate to charges of theft from a patient; falsifying documents for a patient; arson; and intimidation of a witness. In the latter case, the witness was preparing to give evidence at an investigation into the sexual relationship between the offender and a patient.

¹²⁴ *R v McGrane* [2002] QCA 173; *R v Gassy* [2004] SASC 338; *R v Yeo* [2002] NSWSC 315; and *R v Marsh* [2012] NSWSC 208.

¹²⁵ *R v Dean* [2013] NSWSC 1027.

¹²⁶ *Sam, Thomas v R; Sam, Manju v R* [2011] NSWCCA 36.

¹²⁷ *R v Pegios* [2008] NSWDC 105.

¹²⁸ *HCCC v Pegios (No 1)* [2009] NSWDT 1.

¹²⁹ *Patel v R* (2012) 247 CLR 531; (2012) 290 ALR 189; (2012) 86 ALJR 954.

¹³⁰ *R v Anderson* Vic SC 601 (5 Dec 1997).

¹³¹ *Shalhoub v Director of Public Prosecutions* [2002] NSWSC 874.

Although the numbers are small, several observations can be made.

Firstly, health practitioners are very rarely being tried for criminal offences directly linked to quality of care (28 cases over a 25 year period, against a current registered population of health practitioners of 592,470).¹³² This suggests that either practitioners are not committing many offences; they are not detected in committing those offences; or that they are being detected, but not tried for those offences. No data to support or refute any of these hypotheses is available. Furthermore, those offences they are being tried for rarely overlap with the provision of negligent care: the acts complained of in most of the sexual assault cases, for example, are difficult to conceive as being in any way related to provision of care, as they tend to be at the more extreme end of the spectrum of sexual assault activities. Similarly, the deaths of the victims in each of the single victim murder cases arose from the victim's ability to punish professional misconduct, either as a gatekeeper of the profession, or by providing evidence of occupational misconduct on the part of the defendant.

Those categories of offences most likely to flow from provision of extremely negligent care: manslaughter and assault (not sexual) account for just five of the judgments, and only resulted in one conviction. It is extremely rare, therefore, for a practitioner to be found to have acted so negligently that the courts will be satisfied beyond reasonable doubt that the care amounted to manslaughter or non-sexual assault. Fears of criminal liability arising from negligence in the provision of care are therefore exaggerated.

Secondly, qualitative analysis of criminal judgments involving practitioners indicated overlap with occupational discipline. In some instances, issues which ideally would have been reported and investigated by occupational disciplinary bodies prior to offending were identified; in others, the criminal conduct was intended to avoid detection of occupational misconduct, targeted individuals who were potential whistleblowers of serious occupational misconduct. Furthermore, cross-matching against disciplinary proceedings reveals that only a small number of the complaints against a particular practitioner were the subject of criminal proceedings, notwithstanding that the practitioner may have had a substantial history of conduct raising the concern of occupational disciplinary bodies and peers. Although based on a very small number of instances, this observation suggests that mandatory reporting laws designed to mitigate harm through early intervention are a logical step; our data also suggests that those laws should consider the implications of mandatory reporting for whistleblower protection.

PART 5: CONCLUSION

¹³² Australian Health Practitioner Regulation Agency, *Regulating health practitioners in the public interest: Annual Report 2012/13* (2014).

This study set out to examine the role of courts, tribunals, and disciplinary bodies in resolving civil, disciplinary, and criminal matters related to patient harm. The examination provides an empirical basis for assessing claims about an actual or impending crisis of medical negligence that ‘required’ widespread legislative reform to curtail ‘inappropriate’ activity by the courts.

Consistent with MINC data, we find that across all jurisdictions over a 25 year period only a few patient harm matters are being resolved in this way. Our findings indicate that the role of the courts in resolving medical negligence claims is overemphasised, and largely indirect. Although the courts have significant indirect influence on outcomes through the influence of precedential judgments, their direct role in finalisation of disputes is limited.

If there was a crisis in medical negligence law, the data needed to evaluate the effectiveness of the response, must be found elsewhere than with the courts. It is possible a significant number of low-value claims are appearing before the lower level courts where reporting is not routine, and the decisions of these courts are not being appealed.¹³³ Added to the obvious number of claims finalised outside of court through confidential settlement, it becomes apparent that fears of the courts forcing healthcare providers into practicing defensive medicine are misguided. Any such influence is far more likely to be coming from insurers, who have oversight and control of the finalisation of the outstanding 96% of all potential claims.

Our findings, compared with insurance sector reporting, confirm that perceptions of the responsibility of the courts and the legal system for the medical negligence ‘crisis’ are vastly overstated, and that the medical negligence landscape for plaintiffs in Australia remains (and indeed always was) a harsh and generally unrewarding place, punctuated with rare high-value awards for catastrophic harm, typically associated with paediatric or obstetric specialist activity.

Despite significant overlap between the three areas of dispute, tracking of a single event through each of the legal pathways potentially available is not possible. Mapping a specific practitioner’s engagement with legal and occupational discipline pathways throughout their career is similarly problematic, noting that we identified a number of practitioners with multiple allegations of negligence and occupational misconduct. (Those ‘red flags’ are not necessarily associated with practice in specialities that might be deemed to be riskier and thus attract more litigation, successful or otherwise). Lack of detail about complaints and disputes resolved through other mechanisms, such as investigative resolution of disciplinary matters and settlement of negligence claims, results in a lack of transparency.

¹³³ This seems unlikely, noting that data obtained elsewhere detected substantial drops in the number of disputes being filed in jurisdictions such as the New South Wales District Court in the aftermath of the reforms, but cannot be discounted. See for example District Court of NSW, *Annual Review 2002* (2002) 23.

Making detailed information publicly accessible, or at least taking steps to ensure that regulatory bodies with access to the data do have robust data-sharing systems in place, would potentially avoid the issue of inconsistent reporting between bodies and across systems allowing practitioners with career-long histories of problematic practice to escape detection, and promote patient safety. Although privacy implications of system-wide whole-of-career monitoring of individuals are acknowledged, they must also be balanced against effective regulation in the context of patient safety.

Based on our findings, it is not apparent that the legislative reforms adopted to contain medical liability lobbied for by the profession were necessary or equitable. As has been noted by others, including Spigelman CJ in one of the jurisdictions most aggressive in its statutory reform of medical negligence law, evidence suggests that the so-called ‘pendulum of negligence’ was swinging back towards defendants at the time of the ‘crisis’ independent of any reforms.¹³⁴

Furthermore, the emphasis on ‘pro-plaintiff’ or ‘pro-defendant’ trends of the courts ignores the reality of procedure: it is the plaintiff who makes the running to bring the case to trial. In many of the cases where the latest published outcome was procedural, the effect of the judgment was to strike out the plaintiff’s claim. Frequently this was because of expiration of the limitation period. In a significant group of others in the litigation examined for this article the plaintiff’s claim was struck out due to a defect in pleading, generally occurring in cases where the plaintiff was self-represented.

Limitation periods were typically reduced as part of the reforms. The legal profession also received criticism over its role in contributing to the ‘crisis’, with suggestions that reforms to contingency and conditional billing laws had led to unscrupulous practitioners taking on ‘hopeless’ cases. There is a logical inconsistency between additional ‘hopeless cases’ (presumably unwinnable) and concerns over the increase in premiums, portrayed as a consequence of undisciplined courts awarding high damages in cases that evidently were not hopeless, at least in the view of the judges determining them. Moves to limit plaintiff access to legal advice, and reduce limitation periods, ultimately are misguided. Rather than addressing the causes of the harm and minimising its consequences, they only serve to deny those victims justice. A defective pleading drafted by a plaintiff without legal training does not mean that harm was not done. Likewise, passage of time does not eliminate the consequences of harm that burdens a patient with a lifelong disability. Similarly, imposition of caps on damages does not reduce the harm suffered by plaintiffs; ultimately, caps are more likely to shift financial burdens away from the parties who caused harms, onto plaintiffs or the taxpayer.

Questions about who bears such burdens have a policy component but, broadly speaking, both Australian legislatures and courts during the past sixty years have held that medical practitioners and

¹³⁴ Spigelman, above n 30.

associated entities such as hospitals appropriately take some responsibility for harms rather than relegating all burdens to injured patients and their families.

If medical negligence insurance costs were spiralling out of control in the late 1990s and early 2000s, as has been alleged, the courts were not responsible for the pressures. The data does not support an inference that medical practitioners overall were behaving more negligently or that the quality of practitioners was declining.

In 1995, *Tito* called for improved reporting as a foundation for informed policy-making.¹³⁵ Twenty years later, defects in the available data make these recommendations as relevant as they were initially.

¹³⁵ *Tito*, above n 8, 13 and [69].