

## REVIEWING THE IMPACT OF TORT REFORM AT A STATE AND NATIONAL LEVEL.

The Honourable Justice Anthony Whealy

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There was a front-page article in the Sydney Morning Herald on 30 April 2004. You probably noticed it since it was something of an eye-catcher for the medical profession. The headline was –

“Courts make it tougher to sue doctors”.

Those of you in the medical profession probably thought “and about time”. The headline, however, was quite misleading.

The particular decision was that of the New South Wales Court of Appeal. The cases before the Court involved moral, ethical and legal issues of the most difficult kind. The plaintiffs were children each born disabled to a catastrophic degree. They claimed damages being the harm they suffered by being born in their disabled condition. Neither child asserted that the medical practitioners had brought about their disabled condition. Rather, they claimed that, had the doctors properly diagnosed the particular circumstances that resulted in each being born disabled (maternal rubella and paternal AT3 deficiency, respectively), the suffering that each has had and will endure, and the needs and expenses that each has had to and will incur, would not have materialised. That is because the mother or parents of the children would have taken steps to ensure that, in the case of one child, she would not have been born; and in the case of the other child, - he would not have been conceived. Cases of this kind have come to be described, perhaps inaccurately, as “wrongful life” claims. The title of the cases was **Harriton (by her tutor) v Stevens; Waller (by his tutor) v James & Ors; Waller (by his tutor) v Hoolahan** (1).

Two of the judges (Spigelman CJ and Ipp JA) held that the medical practitioners did not owe the children duty of care of the kind asserted. The third judge, Mason P dissented.

It is fair to say that the decision of the New South Wales Court of Appeal, and the difficult issues involved in the decision, are likely to come before the High Court of Australia in the course of the next year or so. It is impossible however to predict, with any certainty, the view the High Court may take of the admittedly difficult problem posed by the two cases.

For present purposes however, the point I wish to make is a simple one: a careful reading of the Court of Appeal's decision – and it is a difficult decision in many respect – does not, in any sense, justify the headline attached to the article. All the majority decision did was to refuse to extend the existence and scope of duty of care. In effect, the decision was one to maintain the status quo. The claim that the decision, in some way, made it “tougher” to sue doctors was, by no stretch of the imagination, a fair or even accurate commentary.

One of the themes of this paper, as will be seen, is that there is often something of a gap between the rhetoric regarding law reform and the substance of the reform that has been achieved. This is not to say, however, that the reforms have not been substantial. Nor is it to say they have not achieved a considerable impact.

### **The objects of the paper**

The objects of this paper may be briefly stated as follows:

1. To describe briefly the background to the broad movement for Tort reform that emerged in Australia during 2001-2002.
2. To describe, as an important reference point, a number of the recommendations of the Ipp Report, (2) especially in relation to actions against Health Care providers, especially doctors.

3. To categorise the reforms that have been introduced by legislation throughout Australia since 2002. The emphasis, for practical purposes, will be on New South Wales Law, although details will be provided for other States and Territories.

4. To note the early direction of reform, based on a brief number of recent decisions in the field of medical negligence; and to ponder the future development of the law as it is likely to impact on negligence actions against doctors.

In preparing this paper, I would like to mention the assistance I have obtained from a considerable number of papers, articles and speeches that are available in the public arena. May I make particular reference to the papers prepared and delivered by the Chief Justice of New South Wales, the Honourable James Spigelman; and by the Honourable Justice David Ipp, a Judge of the Supreme Court of New South Wales and the Court of Appeal. (3)

### **A brief history – a change in emphasis**

When I began practice in the early 1960's, there was still a discernable bias in court decisions in negligence actions. It was generally in favour of the defendant. This was especially so in case of actions against professional people and in particular members of the medical profession. "Dr Knows Best" was not merely a moral truth embraced by patients and practitioners alike. It was, in the majority of cases, a starting point in cases where it was alleged that a doctor had been negligent in the treatment of his patient.

Gradually, over the course of the following thirty years, I noticed, as did many of my fellow practitioners, a significant swing in favour of plaintiffs. Anecdotally, it appeared that nine out of ten plaintiff's cases resolved in favour of the plaintiff or at least led to a generous settlement. Why was this so? The answer seems to be rooted in two major considerations. The first was the inevitable historic swing away from a defendant orientated system. The second factor appears to have undoubtedly related to the emergent underlying assumption, generally correct, that a defendant had the benefit of insurance. Spigelman CJ, in one of the papers to which I have earlier made reference, suggests that Judges may have proved more reluctant to

make findings of negligence, if they knew the consequence was likely to be to bankrupt the defendant and deprive him or her of the family home. It is hard to quarrel with this assumption.

The practical result of the major two factors I have identified, was this: a burgeoning number of both judge and jury decisions began to incur the wrath of the community generally. This mounting wave of concern, especially in the last ten years or so, was reflected in heated editorials in the newspapers and talkback radio commentary. Once it was accepted that insurance was generally available to defendants, an enlightened compassion for the injured and a desire to compensate handsomely those injured by the negligence of others tended to outweigh practical considerations as to the cost these attitudes might perhaps have on the community generally.

In this climate, public concern was expressed about a number of court outcomes. For example, a swimmer recovered damages against Waverley Council when diving into a sandbank on Bondi Beach. A number of pedestrians fell over and injured themselves on public roads or on footpaths in circumstances where it might have been thought that, by keeping their eyes open and their wits about them, they would not have been injured. In 1996, a general practitioner was held liable in these circumstances: he had been at his surgery one morning when a young woman, a stranger, knocked on his door and asked him to examine her brother who was lying on the roadway some three hundred metres away, having had a seizure. The doctor declined to attend to the young man on the basis that he was not his patient but, as I say, was held negligent nevertheless. In a celebrated diving case, a young man was injured when he dived into water at Rottnest Island. He hit his head on a submerged rock. It was a popular holiday spot and people had been diving there for a considerable period of time. The majority of the High Court held that the diver's injury was caused by the Authority's failure to warn of the presence of submerged rocks that were ordinarily plainly visible. (4)

### **A landmark case**

In a famous case that went to the High Court of Australia (**Rogers v Whitaker** (5)), the Court considered two controversial aspects of modern medical negligence cases.

These were, first, the scope and content of a doctor's duty to advise and inform a patient of the risks and implication of proposed treatment; and secondly, the High Court addressed the weight to be given to expert evidence by members of the medical profession on the issue of negligence, and the power of a Court to override that evidence and to substitute its own assessment of a defendant's conduct.

It is perhaps worth digressing for a moment to discuss the facts of this case. This is not only because the decision itself has evoked considerable sympathy for the medical practitioner involved; but because controversy has continued over the last twelve years in relation to the impact of the decision on negligence cases.

Dr Rogers was an ophthalmic surgeon. The plaintiff was his patient. The plaintiff had been nearly blind in her right eye since a penetrating injury at the age of nine but had lived a substantially normal and working life despite this disability. In 1983, at the age of 47, after a routine eye check-up in which reading glasses were prescribed, she was referred to the doctor for possible surgery. He advised the plaintiff that he could operate on her right eye to remove the scar tissue. This, he told her, would improve its appearance and would probably restore significant sight to that eye as well as assisting in preventing the development of glaucoma. Following the operation, not only was there no improvement in her right eye; but as well the plaintiff developed inflammation in the treated eye and inflammation and sympathetic ophthalmia in her left eye. This led, unhappily, to a total loss of sight in the left eye thus leaving the plaintiff almost totally blind. At the trial before Justice Campbell in the Supreme Court of New South Wales, the evidence was that there was slightly more than a one in fourteen thousand chance of sympathetic ophthalmia developing after such surgery. During the trial there was expert evidence that, although a body of reputable medical practitioners would in the light of the plaintiff's desire for information as to the likely outcome of the surgical procedures, have warned the plaintiff of the risk of sympathetic ophthalmia, there was also a solid body of medical opinion that, without a specific inquiry about the effect on the good eye, no such warning would have been given.

In the High Court of Australia, to which the unsuccessful doctor brought his appeal, there were two main legal issues in contest. The first issue of significance was the

examination by the High Court of the scope and content of the duty to inform a patient. If I may be permitted to quote the following brief passage from the decision (at 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 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”.

The second issue related to the “Bolam” test. This, I should interpolate, is a matter of considerable importance to the medical profession currently because the reforms that have recently been implemented in tort law have brought back a modified version of the Bolam test, notwithstanding that the High Court in **Rogers v Whitaker**, in general terms, rejected that test.

The Bolam principle (derived from the direction to the jury in **Bolam v Friern Hospital Management Committee** (1957) 1 WLR 582) has been stated in the following terms: -

“A doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice”. (Per Lord Scarman in **Sidaway v The Governors of Bethlehem Royal Hospital** (1985) AC at 881).

This principle, in its original form, had given the defendant, in matters of diagnosis and treatment, the benefit of genuine differences of opinion in matters of medical expertise. The High Court however held that, in matters relating to the provision of advice and information, it was for the Court to adjudicate on the appropriate standard of care after giving weight to “the paramount consideration that a person is entitled to make his own decision about his life”, citing the words of Chief Justice King in **F v R** a 1983 decision in South Australia. The Court drew a distinction in this regard between cases involving diagnosis and treatment, on the one hand, and cases involving the provision of advice or information to a patient, on the other. The High Court’s view was that the question as to whether the patient had been given all the

relevant information to make a choice did not generally depend on medical standards or practice. The joint judgment described evidence of acceptable medical practice, in this area, as merely “a useful guide”. It also endorsed the proposition that the amount of information or advice to be given by a careful and responsible doctor depended upon a complex of factors:

“The nature of the matter to be disclosed; the nature of the treatment; the desire of the patient for information; the temperament and health of the patient; and the general surrounding circumstances.”

I have allowed myself to digress into this considerable detail in relation to **Rogers v Whitaker** because of the level of concern that arose at the time it was decided. In a very helpful article written recently by Thomas Addison, (6), the author referred to a statement by Callinan J in a later High Court case that the medical profession received the decision of the High Court in **Rogers** with “some consternation”. According to one medical commentator, the floodgates of informed consent litigation appeared to be opening, at least in the field of cosmetic plastic surgery. It is appropriate to comment, however, that the Addison paper itself drew two conclusions relevant to the present discussion. First, an overwhelming conclusion from the case law was that courts were not at all slow to characterise risks as material thus requiring the doctor to inform patients of those risks. Fifty-seven decided cases were examined in the period since **Rogers** and there were only seven cases in which courts had held a risk not to be material. Secondly, and more of interest to the legal profession, was the conclusion that the decision had not in fact opened the floodgates to a multitude of cases alleging a negligent failure to inform. As the author noted, a breach of a medical practitioner’s (admittedly onerous) duty of disclosure did not equate to liability in negligence for a failure to inform. Causation must also be established. The more recent approach of the courts, by 2001, had made it increasingly harder for patients to prove that they would not have undergone the particular treatment even if warned of the risk that eventuated. (7)

If I may allow myself an irrelevant aside, Dr Rogers was involved in a recent bout of litigation which concluded with a decision of the High Court. He was successful in maintaining his entitlement to a substantial sum of damages awarded in the District Court of New South Wales against the publisher of the Daily Telegraph which had

defamed him in relation to his treatment of Mrs Whitaker. The High Court noted that the unfortunate consequences suffered by Mrs Whitaker were not the result of any lack of care or skill in the performance of the operation that had been carried out by Dr Rogers even though imputations of this kind had appeared in the defamatory newspaper articles. It was probably a matter of inadequate consolation to Dr Rogers but it is interesting to note that, in the ultimate, he received a degree of vindication.

### **A brief history – public concern with Judicial decisions**

I shall have some more to say about the Bolam test later. For the moment, may I return to an examination of the historical swing of the pendulum away from defendants. The situation had changed markedly by the early 2000's. It is fair to say that undisciplined findings in relation to liability and what were perceived as overly large damages awards, fanned no doubt by politic statements and media coverage, excited a degree of fierce public resentment. Judges were perceived – myself included no doubt - as being unduly generous with insurers' money. Whether this criticism was justified or not, premiums rose sharply and insurance cover became difficult to obtain. In the areas of health care, sporting events, charitable fund raisings and public recreation there arose a degree of panic. There was much public consternation over the early retirement of medical practitioners and their refusal or threatened refusal to perform certain services, particularly obstetrics, in country areas. Developments in the insurance industry brought the matter to a head. As Chief Justice Spigelman noted in his paper – “by 2002 what had for many years been a buyers market in insurance had become a seller's market. At an international level there had been series of natural disasters which had drawn down the capital of insurance companies, particularly that of re-insurers. The events of 11 September 2001 in New York exacerbated this process. This coincided with the end of the share market boom which further reduced the capital available to insurance companies. Quite quickly, demand exceeded supply in the Global re-insurance market. This was immediately reflected in premiums and in decisions as to what kind of businesses to write and where.”

In this country there were, in addition, the problems sustained following the collapse of HIH. In the area of medical insurance, Australia's largest medical indemnity

insurer was faced with insolvency and was only saved by the financial support of the Commonwealth Government. In addition to a package of other remedies, the government has indicated it will subsidise premiums in certain fields of practice where the damages are large, such as obstetrics.

I have thus far dealt with this history briefly and in a very generalised way. There are some qualifications that need to be made. For example, although it was rarely reflected in the media reports of the time, there were, during the same period, many instances, particularly in the appellate courts throughout Australia, where extravagant findings on both liability and damages were remedied. This can be seen on a regular basis over the last ten or fifteen years. Secondly, there have been in existence for some time legislative schemes which had endeavoured, as one of their aims, to keep down, for example, third party insurance premiums in relation to motor vehicles. Thirdly, by 2001, New South Wales had also sought to make important changes to the common law for recovery in medical negligence cases. (8). This legislation had the unfortunate consequence, in the short term, of promoting a spate of claims before the cut-off date, a factor which threatened the liquidity of UMP. There remained, however, a clear need for reform on a broader basis.

### **The Ipp Committee Report**

Because of the reality of the insurance crisis, and for that matter the problems it spawned in the medical world, the Australian Government convened a series of meetings with ministers from all jurisdictions and a representative of municipal government. With surprising rapidity, a non-partisan accord was reached by all jurisdictions to consider the implementation of major reforms to Australian law, in a consistent manner, in an endeavour to restore confidence and a degree of affordability and predictability.

In Australia, there are six States and two Territories. Each has its own government with powers and responsibilities within its own jurisdiction. Then there is the Commonwealth with its range of powers and responsibilities in respect of all Australian jurisdictions.

The common law, including the law of negligence, falls within the jurisdiction of the States and Territories. States and Territories also have responsibility for the administration of their own court systems including the hearing of claims falling within their jurisdictions and the implementation of statutes relating to civil liability in their areas. There is, although there is no need for me to attempt to detail it here, an overlapping of responsibility between the Commonwealth and the States in certain areas of insurance. For example, the States and Territories have the control of compulsory third party motor vehicle insurance.

This level of potential disparity highlighted the need to have some sort of partisan or uniform approach to tort reform, otherwise it would be likely to achieve very little.

A significant contribution to setting the reform on the right path was the 2002 report commissioned by ministers to review the law of negligence. The committee was chaired by the Honourable Justice David Ipp and included Professor Peter Cain, Professor Don Sheldon and Mr Ian Macintosh. The report made sixty-one recommendations to governments on a principled approach to reforming the law.

At the Fourth Ministerial meeting in November 2002, ministers made a significant breakthrough, agreeing to a package of reforms to put in place a number of the main recommendations of the Ipp Report. Each jurisdiction agreed to introduce the necessary legislation as a matter of priority. The Australian Government confirmed that, within its own jurisdiction, it would amend the **Trade Practices Act 1974** to underpin the changes being made by States and Territories so as to avoid plaintiffs circumventing the range of reforms in other jurisdictions. The resultant legislative reforms in the various States and Territories of Australia, subsequently enacted, are at the heart of this keynote address. The topic of tort reform is however a vast one; and it may well be that certain parts of it only are of interest to this conference. But may I preface a brief analysis of the reforms of most interest to the medical profession by a brief overview of the changes. They may be broadly grouped into three types: -

First, there are changes to the law governing decisions on liability, including contributory negligence and proportional liability. Secondly, there are changes to the

amount of damages paid to an injured person for personal injury claims or for economic claims against a professional. Thirdly, there are new time limits and methods for making and resolving claims, including improved court procedures, control of legal conduct and legal costs. Each of the groups of reforms has elements that focus on, but are not limited to, personal injury claims thus impacting both on issues of public liability and medical indemnity.

### **The reforms generally – an example**

May I give an example of the first category: prior to the reforms, critics argued that the negligence arena in Australia had altered so that events with a very low probability of occurring could still be held to be foreseeable. In tort law, a basic principle is that a person owes another person a duty of care if the first person could reasonably have foreseen that, if he or she did not take care, the other would suffer either physical or economic injury or death. In **Wyong Shire Council v Shirt** (9), the High Court found that persons could be held liable for failure to take reasonable precautions to avoid foreseeable risks, that is risks which were other than farfetched or fanciful. Critics argued, perhaps not entirely correctly, that this benchmark may have required a person to take precautions against a risk of very low probability simply because it was foreseeable.

In general terms, the reforms were designed first to replace the test of foreseeability as established by **Wyong Shire Council v Shirt** with a test that persons can only be held liable for risks that are “not insignificant”. In addition, legislative changes were designed to bring about a situation where foreseeability is a necessary but not a sufficient condition for a finding of negligence. A person will not be liable merely by reason that a risk was foreseeable.

Under Part 1A Division 2 of the **Civil Liability Act 2002** – the New South Wales legislation – there are certain general and other principles relating to liability and negligence resulting from a failure to take precautions against a risk of harm. Under s 5B, a person will not be liable for harm unless the person knew or ought to have known of the risk; the risk was not insignificant and, in the circumstances, a reasonable person in that person’s position would have taken precautions against the

risk. Section 5C sets out the matters that the Court is to consider when determining whether a reasonable person would have taken precautions against the risk.

The matters in s 5C are a reference to what has been described as “the negligence calculus”. This is a statement of the factors which have to be balanced out in establishing whether failure to guard against a foreseeable risk should be deemed negligent (ie, determining whether the standard of care has been breached). The calculus has also been described as providing a framework for deciding what precautions a reasonable person would have taken to avoid the harm that has occurred; and what precautions the defendant could reasonably have been expected to have taken. There are four named components:

- The probability that the harm would occur if care were not taken
- The likely seriousness of the harm
- The burden of taking precautions to avoid the risk of harm; and
- The social utility of the risk creating activity (that is, is it more worthwhile to take risks for some activities than for others – for example, if life is at stake).

The calculus involves weighing the first two matters against the last two. It should be noted that there is nothing new or novel in these matters. They were the very matters mentioned by Mason CJ as relevant factors to be taken into account (see **Wyong Shire Council v Shirt** at 478).

The High Court of Australia had in relatively recent times, prior to the reforms, emphasised again the need to bring considerations of this kind to account especially in the context of assessing foreseeability (**Tame v New South Wales; Annetts v Australian Stations Pty Limited**) (10).

In the event, reforms of the kind I have set out above are now in place in all States and Territories with the exception of the Northern Territory (11).

## **Reforms – areas other than medical negligence**

This paper is, of course, concerned primarily with tort reform and its impact in the specific area of health care. Participants in this conference will be aware, no doubt, that the raft of reforms that came about following the Ipp Report embraced a much wider area than medical negligence. May I mention briefly a few of those areas: legislation has been passed in every jurisdiction, including the Commonwealth, protecting volunteers from liability for work carried out in community organisations; “Good Samaritans” have been protected in certain circumstances from civil liability when assisting injured persons in an emergency; significant limitations were placed on the right to recover damages for injury arising from participation in dangerous recreational activities. This limitation occurred in New South Wales, for example, where the harm was suffered as a result of the materialisation of “an obvious risk” of the activity. Moreover, a duty of care is not owed to a plaintiff in certain circumstances where, in relation to a recreational activity the risk was the subject of a “risk warning” to the plaintiff. The contributory negligence of a plaintiff, if it is sufficiently extensive, may defeat a claim brought against a wrong doer. These, as I say, are but a few of the areas of reform.

## **Reforms affecting the law of medical negligence – a modified return to Bolam**

This was of course, a specific area of concern for the Ipp Report. The proposal was to consider a number of general and specific measures intended to limit medical liability and damages. This was directly done to meet problems relating to recent increases in medical indemnity premiums and the effect of that matter on medical service generally. The Ipp committee recommended that the test for determining the standard of care in cases in which a medical practitioner was alleged to have been negligent in providing treatment to a patient should be:

“A medical practitioner is not negligent if the treatment provided was in accordance with an opinion widely held by a significant number of respected practitioners in the field, unless the Court considers that the opinion was irrational.” (Rec 3)

The first point to note is that this relates to treatment only. It does not relate to negligence arising from a duty to disclose relevant information prior to treatment being carried out. The second point is that the recommendation is in terms different from the Bolam test which applied in Australia until 1992; and which applied in England until its modification in 1998 in **Bolitho v City & Hackney Health Authority** (12).

The Ipp Report pointed to the fact that, when strictly applied, the Bolam test can result in outcomes which may be unacceptable by community standards. It may allow small pockets of medical opinion to play a determinative role in the setting of the requisite standard of medical treatment even in situations where the bulk of medical opinion would take a different view.

My earlier remarks relating to the judgment in **Rogers v Whitaker** will have brought home to you that, in the light of that decision, a Court's duty had been to consider the entirety of the expert evidence in relation to diagnosis and treatment to determine whether, in its view, the professional had acted negligently.

The modified Bolam formulation, recommended by the Ipp Committee, recognised that the current law did not automatically require a Court to defer to medical opinion, although it noted that, in the normal run of cases, it would normally do so. The new formulation was intended to give guidance as to the circumstances in which a court would be justified in not deferring to medical opinion. It adopted the word "irrational" on the basis that this was the proviso laid down by the English House of Lords in **Bolitho**. (A careful reading of **Bolitho**, however, suggests that the phrase adopted by the House of Lords was that the body of medical opinion should be "reasonable or responsible": Lord Browne-Wilkinson at 243). The Ipp Committee thought that the formulation of the recommendation in the terms adopted would give doctors as much protection as was desirable in the public interest. This was because the chance that an opinion which was widely held by a significant number of respected practitioners in the relevant field would be held irrational was very small indeed. On the other hand, if the expert opinion in the defendant's favour were held to be irrational, it seemed right that the defendant should not be allowed to rely on it.

In one form or another, the modified Bolam test has been adopted in New South Wales, Victoria, Queensland, South Australia and Tasmania. I understand that a Bill has been drafted to address the situation in Western Australia. I will not burden you with the precise language of the statutory enactments that have brought about this reform in a number of jurisdictions. I do point out that there are differences of expression in the various enactments. This lack of uniformity may have a tendency to impair consistency and promote legal argument at appellate level.

In New South Wales Division 6 of Part 1A of the **Civil Liability Act 2002** contains the following sections: -

**“Division 6 Professional negligence**

**50 Standard of care for professionals**

- (1) A person practicing a profession (“a professional”) does not incur a liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice.
- (2) However, peer professional opinion cannot be relied on for the purposes of this section if the court considers that the opinion is irrational.
- (3) The fact that there are differing peer professional opinions widely accepted in Australia concerning a matter does not prevent any one or more (or all) of those opinions being relied on for the purposes of this section.
- (4) Peer professional opinion does not have to be universally accepted to be considered widely accepted.

**5P Division does not apply to duty to warn of risk**

This Division does not apply to liability arising in connection with the giving of (or the failure to give) a warning, advice or other information in

respect of the risk of death of or injury to a person associated with the provision by a professional of a professional service.

You will see that the test in New South Wales applies not only to medical professionals but to all professionals.

By way of contrast, the Victorian situation (13) speaks of wide acceptance in Australia “by a significant number of respected practitioners in the field (peer professional opinion)”. Moreover, peer professional opinion can only be rejected by the court if it is determined to be “unreasonable” (14). (Victoria rejected the word “irrational” because it was ambiguous).

I have not unearthed any decisions of appellate courts applying the new modified Bolam test. But perhaps I may respectfully and hesitantly make a few observations about it. It is fair to say that the medical profession has expressed itself as most concerned to see a return to Bolam. The principal reason that this has been so, I think, is that the medical profession has taken the view that the High Court of Australia had substituted for the “Doctor knows best” test, a test that “Judges know best”. For reasons that I have briefly touched on, I do not think that this was really the case. Where the medical profession’s concern was justified, I think, was that a number of trial judges had, somewhat irrationally, refused to defer to medical opinion in circumstances where there was no warrant for rejecting that opinion.

There is no doubt that the modified Bolam test enshrined in the present legislation in the various States requires a court to take into account in an important manner an opinion widely held by a significant number of respected practitioners in the field. This opinion may well determine whether a medical practitioner is or is not negligent in relation to treatment provided to a patient. But it leaves the court with the undoubted task of determining for itself whether a particular opinion is “irrational” or, in some jurisdictions, “unreasonable”. Moreover, judicial experience suggests, lamentably perhaps, that expert evidence is often available to support contrary opinions held by a significant number of apparently respected practitioners in the field in relation to particular matters of treatment. This difficult situation is unlikely to change unless there is an overall legislative restructuring of the manner of the usage

of expert evidence in medical negligence cases. This is one recommendation of the Ipp Report that has not been taken up in the reforms.

For myself, I would have no real certainty that the presence of the modified Bolam test is likely to alter, in any dramatic way, the way in which medical negligence trials are conducted throughout the Australian court system. This is essentially because, in most important cases relating to treatment, the courts have, and now necessarily will, continue to take medical consensus and standards into account to a high degree. It will however help to dispel the perception that, in matters of diagnosis and treatment, medical opinions and practices carry no weight with Judges.

### **The modified Bolam test does not apply to the duty to inform**

May I now turn to the second aspect of this present topic. This is the fact that the modified Bolam test does not apply to claims of negligence against medical practitioners arising from an allegation that inadequate warning, advice or information has been given to a patient. Let me put it this way: the presence of the modified Bolam test in the New South Wales legislation, had it existed at that time, would not have saved Dr Rogers from sustaining the adverse judgment he did in the High Court twelve years ago. Nor would it do so today.

In this regard, the Ipp Committee said: -

“An important implication of the patient’s right to give or withhold consent is that the opinions of medical practitioners about what information ought to be given to patients should not set the standard of care in this regard. The giving of information on which to base consent is not a matter that is appropriately treated as being one of medical expertise. ... The Court is the ultimate arbiter of the standard of care in regard to the giving of information by medical practitioners”. [Para 3.38]

It must be said that liability for failure to warn had created a great deal of concern among medical practitioners. While this is an issue for all professionals, the committee recommended legislation in this area only in respect of medical practitioners; and that the obligation should be expressed as no more than an obligation to take reasonable care (Recommendation 6). This recommendation has

only been taken up in three of the jurisdictions. For example, in Queensland s 21 of the **Civil Liability Act 2003** provides that a doctor has a duty to advise the patient of information relevant to any risk of personal injury to that patient. The information must be sufficient to enable the patient to make an informed decision about whether to undergo the treatment and must also include information of the type the doctor knows or should know that the patient wants to be given. It is immaterial whether or not the patient seeks or requests the information. The duty extends to providing information to a person responsible for making any decision on behalf of a patient.

The Ipp Committee divided the duty to inform into “proactive” and “reactive”. It recommended an exemption from the proactive duty to inform of “an obvious risk”. The Committee considered that the reactive duty to inform was a matter best left to the common law. New South Wales has implemented part of this in that, as a general matter, no duty of care for failure to warn arises where there is an obvious risk (15). There are however important exceptions to this provision. For example, the section does not apply if the plaintiff has requested advice or information about the risk from the defendant. More importantly, from the point of view of medical practitioners, the section does not apply if the defendant is a professional and the risk is a risk of the death of, or personal injury to the plaintiff from the provision of a professional service by the defendant (s 5H(2)(a) and (c)).

Queensland and Tasmania have partially implemented the recommendation whereas other jurisdictions, at this stage, have not.

The general raft of reforms has taken on board another important issue. Its impact on medical negligence cases arises in relation to statements made by a plaintiff as to whether he or she would have had an operation (which ultimately led to damage) if an appropriate warning or relevant information had been provided at the time of consultation. Invariably, evidence is given by a plaintiff in these circumstances that he or she would not have undergone the operation or treatment. The legislation in New South Wales, for example, provides that if it is relevant to the determination of factual causation to determine what the person who has suffered harm would have done if the negligent person had not been negligent, the matter is to be determined subjectively in the light of all relevant circumstances. Any statement made by the

person after suffering the harm about what he or she would have done is inadmissible except to the extent (if any) that the statement is against his or her interest (16). Similar reforms appear in the legislation in Victoria, Queensland, Western Australia and Tasmania. This particular aspect of reform, as I have said, is of general application and is not limited to medical negligence cases.

It is apparent from a reading of the Ipp Report, that the committee formed the view that the medical profession viewed as unsatisfactory the then legal specification of the proactive duty to inform. This was because it gave insufficient guidance as to what information the medical practitioner has to give the patient in order to avoid legal liability for negligence. One complaint had been that medical practitioners spend more time giving patients information than in examining them. The Ipp Report did not recommend that detailed prescriptive legislative provisions should be framed in this regard. Such a course, it considered, would be impractical and undesirable.

Under current Australian law, the proactive duty remains the duty for the medical practitioner to put the patient in a position to make an informed decision about whether or not to undergo the treatment by telling the patient about material risks inherent in the provision of the treatment, and by providing other relevant information. A risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position would attach significance to it in deciding whether or not to undergo the treatment. The duty is not however, confined to information about risks but extends to other types of information that may be needed to enable patients to make an informed decision about their health.

### **Causation**

There has been a high degree of uniform response to the Ipp Report recommendation in relation to this issue.

In tort law, a person cannot be liable for damages for failure to take care to prevent injury or death unless negligent conduct on his or her part (whether by act or omission) caused the harm and unless that harm was not too remote from the negligent conduct.

The committee's recommendation (Rec. 29) in relation to these issues may be briefly stated as follows:

- The plaintiff always bears the onus of proving, on the balance of probabilities, any fact relevant to the issue of causation
- The two elements of causation should be separately considered – factual causation and scope of liability (or remoteness)
- The basic test of factual causation (the “but for” test) is whether the negligence was a necessary condition of the harm. In appropriate cases, however, proof that the negligence materially contributed to the harm or the risk of the harm may be treated as sufficient to establish factual causation even though the but for test is not satisfied.
- For the purpose of deciding whether the case is an appropriate one where negligence may be said to have materially contributed to the harm or the risk of the harm so as to be sufficient to establish factual causation, it is relevant to consider: -
  - (i) Whether (and why) responsibility for the harm should be imposed on the negligent party, and
  - (ii) Whether (and why) the harm should be left to lie where it fell

As I have said, most jurisdictions have implemented these recommendations (New South Wales (ss 5D, 5E); Victoria (ss 51, 52); Queensland (ss 11, 12); Western Australia (ss 5C, 5D); Tasmania (ss 13, 14); and the ACT (ss 45, 46)).

### **Causation – Recent cases**

There have been a number of recent cases in the New South Wales Supreme Court where the principles underlying these reforms on the issue of causation have been applied, notwithstanding that the reforms did not themselves apply to the litigation. In

addition, there has been one case where the **Civil Liability Act** did apply. I shall mention these briefly.

In **Ruddock v Taylor** (18), the New South Wales Court of Appeal considered an appeal from a verdict awarded by a District Court Judge against the appellants for the wrongful imprisonment of the respondent. It was not a medical negligence case. The Commonwealth of Australia had deprived Mr Taylor of his liberty on the sole basis that he was an alien. The High Court however decided, in separate litigation, that the Commonwealth had never been entitled to detain the respondent on the basis asserted by the Ministers.

The Court of Appeal upheld the decision of the District Court Judge both on liability and damages. Ipp JA agreed with the reasons of Spigelman CJ and Meagher JA. His Honour however, addressed the issue of causation. Ipp JA approached the matter in this way: in his view, there was first the factual aspect of causation. There was no doubt, on the facts of the case, that but for the ministerial decision to cancel Mr Taylor's visa, he would not have been thereafter placed in detention. Thus, the plaintiff succeeded on the first limb of the causation approach. On the second aspect of causation – the normative question – Ipp JA said that it was a fundamental purpose of the common law that the personal liberty of individuals should be protected. This reflected “a basic value with very deep roots in our society”. In the present case, the appellants had unlawfully deprived the respondent of his liberty. Accordingly, for normative reasons, Ipp JA considered the appellants ought to have been held liable to pay damages for the harm Mr Taylor suffered.

**Harvey & Anor v P D** (19) was an interesting and difficult case. It was not a case that was covered by the **Civil Liability Act**. This was because the proceedings had been launched before the commencement of the reform legislation. The appellants, Drs Harvey and Chen, appealed to the New South Wales Court of Appeal against a decision of Cripps AJ in favour of the plaintiff. The circumstances of the case were these: the plaintiff was a patient at a Marrickville Medical Centre for about fourteen months. In 1998 she attended the centre with her future husband for the purpose of seeing her doctor and having blood tests to ensure that neither person carried the HIV virus or any other sexually transmitted disease. This was because the pair was

proposing to get married. They were at the time in a sexual relationship but practising protected sex. Both the plaintiff and her boyfriend came to the centre for testing at the request of the plaintiff. The plaintiff was concerned about the status of her future husband because she believed that there was a higher risk that a person from his country of origin might be HIV positive than one from Australia. The plaintiff believed that she would have her partner's results and that he would have hers. But the topic was not in fact raised specifically by the doctor at the consultation. Both gave blood at the joint conference in the presence of each other and left the surgery. The doctor told them to return to his surgery in about a week's time when the pathology tests would be available.

About a week later the doctor received the plaintiff's pathology report which was negative for both Hepatitis B and HIV. The following day he received the boyfriend's report which was positive for both Hepatitis B and HIV. The plaintiff returned to the centre about a week or two after the initial consultation. She was handed a copy of her pathology report by the receptionist. She asked this person for a copy of her boyfriend's pathology report but was told it was confidential and it could not be given to her. It was common ground at the trial that the plaintiff should not have received her result from the receptionist but from a medical practitioner. The doctor in question failed to have a face-to-face meeting with either the plaintiff or her boyfriend immediately after the handing over of the pathology report. The doctor however, did speak to the plaintiff's boyfriend and told him he had tested positive. The doctor did not see this gentleman again nor did he speak to the plaintiff again although she continued to attend the centre on a couple of occasions where she saw a different doctor. She did so for the purposes of obtaining a contraceptive pill and some vaccines for travel purposes. The plaintiff's boyfriend deceived her when she asked him about his report and told her that he was free of any adverse virus or condition.

Santow JA found that the trial judge had been correct in concluding that the doctor owed both his patients a duty to address, in the course of the initial joint consultation, the need for consent to disclosure, the manner of disclosure and the possibility of discordant results. Secondly, Santow JA found that if the boyfriend had not been prepared to have his results made available to the plaintiff she would have discontinued her relationship with him. In that circumstance, the trial judge had been

correct to conclude that, had the doctor carried out his duty to his patient, the plaintiff would not have continued her relationship with her boyfriend and would not have contracted the HIV virus as she subsequently did. Santow JA applied the second limb of the test of causation adopted in Ruddock v Taylor. The normative question to be asked, he said, is ought the defendant be held liable for the harm sustained, to which the answer was “Yes”.

Ipp JA also applied the two stage test on causation. It was his view that the doctor had been negligent in failing to counsel the plaintiff personally when she attended to receive her tests results. It was wrong to leave it to the receptionist to deliver the results (20). As an alternative, he should have arranged for another doctor to counsel her if he were not available. It was Ipp’s view that the doctor’s conduct was an essential springboard to the boyfriend’s deceit and in that respect the negligent conduct of the doctor was undoubtedly an historical cause of the plaintiff’s loss. Moreover, Ipp JA thought it would be “quite wrong” to allow the appellants to rely on the doctor’s breach of duty so as to defeat causation.

Spigelman CJ agreed with Santow JA that there was negligence in the conduct of the initial joint consultation and this had led to the damage suffered by the plaintiff.

There was another important issue in the case. After the plaintiff became aware that she was HIV positive, she divorced her partner/boyfriend. Later she commenced a relationship with another man who was also HIV positive. She made an informed decision to have a child, even though she knew that she was HIV positive. Fortunately, the child was conceived and born without contracting the Aids virus. The facts established that, because of her condition, the plaintiff would be able to care for the child until about 2014 but not after that date. The plaintiff had unsuccessfully sought damages before the trial judge for the cost of future child care for the child during those later teenage years.

Santow JA thought that it was reasonable, in the abstract, for the plaintiff to have a child in the circumstances outlined above. He noted, however, that that was not the end of the matter. There was a second question that had to be answered; this was whether, accepting it may have been reasonable for the plaintiff to have the child,

was it reasonable to hold the doctors liable? Thus, it was necessary to consider the appropriate scope of liability for the consequence of the tortious conduct: that is to say, necessary to consider the appropriate scope of the duty of care. This was to be determined by applying a normative principle. Santow JA thought that, whether one puts the matter in the neutral terms of “legal concerns” or in the more influential sense of “legal policy, albeit still awaiting final recognition as binding principle”, it was his view that the trial judge had been correct in denying this head of damages. He concluded that the doctors had been involved in the causal link between negligence and the later injury (demonstrated by loss of capacity to care for the child in its teenage years). However, he thought that the causal link was too attenuated and its quality altered in a normative sense by the plaintiff’s considered decision to have the child, knowing of her condition. In short, while it was reasonable from her point of view to have the child, it was unreasonable to hold the doctors legally responsible for the financial consequences of this decision.

Ipp JA dealt with this difficult issue quite shortly. He accepted that the trial judge had been plainly correct in finding that there was an historic involvement between the negligence of the doctors and the particular loss claimed by the plaintiff relating to the care of the later born child. The real issue, he said, related to the normative question. This was whether, having regard to all the circumstances and in particular the plaintiff’s fully informed decision to have the child, causation recognised by the law had been established? This led his Honour to consider questions of policy. His Honour thought that the law should not provide an incentive to children being born in such circumstances. He said that, in his view, “the law should not provide any encouragement to deliberate decisions to have children in circumstances where those children could at birth be infected with HIV”. Thus, he answered the normative question in favour of the doctors on this issue.

Spigelman CJ generally agreed with Santow JA. In relation to the issue relating to the care costs for the later born child, he agreed with Ipp JA, subject to two observations. First, he said the two-limbed test for causation was apt in the circumstances of the case. But, the Chief Justice said, he wished to reserve his position on its more general application. Secondly, he rested his conclusion in relation to the normative issue on the plaintiff’s informed decision to have the child.

He did not find it “necessary or appropriate” to give weight to the other policy factors to which Ipp JA had referred.

The next series of cases to which I wish to make reference were decided in the New South Wales Court of Appeal on 29 April 2004. Again, these cases did not involve the direct application of the **New South Wales Civil Liability Act 2002**. The appeals related to two separate actions which were heard together. They were the “wrongful life” cases to which I made reference at the commencement of this paper (**Harriton v Stevens; Waller v James; Waller v Hoolahan** (1)).

I shall not repeat the facts agreed for the purpose of the legal analysis in the decisions of the Court of Appeal. They are set out at the beginning of my paper, as will be recalled.

The issues in the appeals before the New South Wales Court of Appeal were of the most profound and difficult kind. This paper is no place to discuss in detail the complexities of the legal issues. Relevantly, however, Ipp JA again applied the two-limbed causation test to the issue of the appeal. The first question he asked was whether the omissions of the medical practitioners were a historical (factual) cause of the children’s damage. Ipp JA acknowledged that this was not ordinarily a difficult issue but it was so in the present circumstances. This was because, while it was true that the respondent’s conduct had led to the appellants’ birth, that conduct did not have any effect on the foetus in each case. Nothing the medical practitioners did had resulted in the existence of the disabilities. Rather, the conduct of the respondents failed to prevent the birth of the appellants “with disabilities”. Notwithstanding this conceptual difficulty, his Honour ultimately came to the conclusion that the respondents had caused the children’s’ loss by causing them to be born in a disabled condition. However, his Honour had no difficulty in coming to a conclusion that, in relation to the second limb, that is the application of normative considerations, the doctors should not be held liable for the appellants’ damage. In this regard, Ipp JA referred to a number of policy matters that were, in his view, determinative of the normative issue.

Spigelman CJ essentially founded his decision on the proposition that the scope of duty of care owed by the doctors to the children did not extend to make the doctors liable as such a claim did not reflect values generally, or even widely, held in the community. He agreed, albeit with some qualifications, with the general reasoning of Ipp JA that the interests of appellants did not attract the protection of the law.

Mason P, in a careful and thoughtful judgment dissented from the conclusion reached by the other judges of appeal. It was his view that the doctors did owe a duty of care to Keeden and Alexia of the kind asserted. He also concluded that policy considerations ought not acquit the respondents of causal responsibility for the appellants' injuries. In a passage of considerable interest, his Honour (at para 164) wrote:

“Ipp JA suggests that acceptance of the appellants' claims involves the common law going beyond the “keep out” signs erected by Parliaments throughout the country in their recent response to the pressures on insurance funds said to stem from the march of tort law. This, with respect, is extra-legal analysis. I do not deny that legislation may exercise a gravitational pull upon the development of legal principle in particular fields ... but I know of no legal principle that directs the common law to pause or to go into reverse simply because of an accumulation of miscellaneous statutory overrides”.

In this regard, Mason P noted that Part 11 of the **Civil Liability Act 2002** (s 70-71) effectively reversed the High Court's decision in **Cattanach v Melchior** (21) (a “wrongful birth” claim where the parents had sued for damages, namely the cost of rearing a perfectly healthy child born to them but born in consequence of the negligent failure by a doctor to warn of certain consequences associated with a sterilisation operation the mother had been contemplating). The New South Wales Parliament had expressly refrained from precluding “any claim for damages by a child in civil proceedings for personal injury ... sustained by the child prenatally or during birth (s 70(2)”. Even the capping of parental claims, Mason P noted, “does not preclude the recovery of any additional costs associated with rearing or maintaining a child who suffers from a disability that arises by reason of the disability”. (s 71(2)).

In short, Mason P saw no pattern or guidance in the spate of statutory modification operating in areas other than the one presented for determination in the appeals then before the Court.

The last case I wish to refer to in this context is one in which the **Civil Liability Act 2002** had direct application. This was the case of **Finch v Rogers** (22), a first instance decision of Kirby J. The claim was one seeking damages for medical negligence arising from delayed treatment after surgery following diagnosis of testicular cancer. As a consequence of the delay, it was alleged that the plaintiff required four cycles of chemotherapy instead of three. It was claimed that the fourth cycle brought with it ototoxic and neurotoxic effects causing significant damage to the plaintiff which would not have occurred had the treatment been confined to three cycles.

Breach of duty was admitted but the issue was whether the plaintiff's disablement was caused by the defendant's breach of duty. There was thus involved, as the principal issue, the question of causation.

The decision is interesting for a number of other reasons but I will confine my comments to the causation aspect of the **Civil Liability Act**.

Kirby J referred to the relevant passage in **Ruddock v Taylor**. He found that the defendant's negligence was a necessary condition of the harm that ensued to the plaintiff. Thus, he found that it was factually caused by the negligence. Secondly, Kirby J decided that it was "appropriate that the scope of the defendant's liability extend to the harm so caused". He said that Dr Rogers himself recognised that a failure to detect an early change in the tumour may have created the need for more chemotherapy than might otherwise have been needed.

### **Causation - Conclusions**

It may be argued that causation reforms have not in substance altered the law as it previously existed. It can be said with some confidence, however, that uncertainty existed, so far as causation was concerned, about the necessity of applying both

tests in circumstances where the factual test was met. The reforms are likely to improve the understanding of this area of the law by providing both a clear legislative statement as to the principles applicable on the issue of causation and a clear methodology of approach. The aim is to place a question mark over the imposition of liability where the defendant's conduct was only remotely responsible for the loss.

The decisions to which I have referred point the way to the manner in which courts in New South Wales, at least, are likely to approach the causation issue in the new legislation. The "normative" question remains, in some respects, an uncertain one. The cases leave unresolved the ambit of pure policy based on moral and ethical grounds; the scope of "legal policy not yet settled" into principle; and the scope of legal principle itself and its capacity to unsettle the reach of policy. At the very least, it may be hoped that the resolution of those difficult issues will occur in a more structured and consistent manner than has occurred in the past.

### **Miscellaneous Reforms**

I propose now to consider very briefly a number of individual matters of reform under this heading. I do not suggest, that, for this reason, they are in any way unimportant or insignificant. Quite the contrary: within the framework of the various matters I shall now mention reside the very best hope for legitimate and principled control of the tort law "blow out" and its disastrous impact on the availability and affordability of insurance.

### **Apologies**

The first matter I will mention is, in my view, an important one. At a recent Health Care Seminar conducted during the Insight programme on SBS television, the issue of an apology by a medical practitioner came to the fore. Many of those involved in the forum made the point that dissatisfied patients are looking, more often than not, for a simple explanation and, if required, an apology where treatment has gone wrong. A number of experienced health practitioners at the conference indicated that this was simply not possible because of the legal ramifications involved in an apology.

Yet every jurisdiction has now legislated to prevent liability arising out of a simple apology, either by making the apology itself inadmissible or by providing that an apology may not be construed as an admission of liability. The definition of apology, for example, in the New South Wales legislation is very wide. Section 68 provides –

“Apology means an expression of sympathy or regret, or of a general sense of benevolence or compassion, in connection with any matter whether or not the apology admits or implies an admission of fault in connection with the matter”.

All this seems eminently reasonable and suggests that an important problem has been remedied. A closer analysis, however, reveals that there remain problems that may need to be resolved in at least two areas.

First, there is a difference of terminology in the definition of “apology” as it appears in a number of the jurisdictions. May I give an example. The **Queensland Civil Liability Act 2003** contains s 71. It is in the following terms: -

“An ‘expression of regret’ made by an individual in relation to an incident alleged to give rise to an action for damages is any oral or written statement expressing regret for the incident to the extent that it does not contain an admission of liability on the part of the individual or someone else”.

This might be described as a narrow definition. Definitions of this kind are to be found in Western Australia (Part 1E s 5AF); Victoria (s 14I and 14J) whereas there is wide definition in the Australian Capital Territory (s 13).

Let me give a practical example of the problem: a doctor in New South Wales might say to a patient “I am sorry for what happened. It was my fault”. This statement would fall within the definition of an apology in s 68 of the New South Wales Act. By virtue of s 69, it would not constitute either an express or implied admission of fault or liability, notwithstanding that it was expressed in terms that clearly admitted fault. Nor would it be relevant to the determination of fault or liability in connection with a later damages claim. It would not in fact be admissible in any civil proceedings as evidence of the fault or liability of the doctor in connection with the proceedings.

If a Queensland doctor were to make the same statement in a Queensland hospital to a patient, the first part of the expression would not be admissible but the second part arguably would be so as to amount to an admission of liability against the doctor.

The broad consequence of the distinction I have attempted to draw is that, despite assurances that uniform legislation would be provided in the various jurisdictions, there are in fact differences of expression throughout which are capable of having significantly different consequences for the outcome of litigation, depending on the State or Territory involved.

The second point I wish to make is one that may be made shortly. An admission of liability by a doctor in the context of an apology may, depending on the terms of the relevant insurance policy, entitle an insurer to decline to meet its contractual obligations under the policy. A doctor would want to examine very carefully his policy before deciding what he should say in terms of rendering an apology. This is one of the difficulties that the legislation has sought to avoid but I am by no means confident that it has achieved its result.

There may be scope, depending on the view taken at a broad policy level, for the Commonwealth to intervene in relation to the **Insurance Contracts Act** to prevent insurance companies from declining liability where an apology in wide terms has been proffered to the patient. This could be achieved in those jurisdictions where the “apology” definition is expressed in its wider form.

### **Limitations of action**

The next matter I wish to mention relates to an important area of reform. This concerns limitations of action. The Ipp Report mentioned that there was a negative perception of negligence law that arose from the view that people can unfairly be sued many years after an incident. For example, the time which may pass between the actions of an obstetrician or midwife who delivers a child and the last date on which the child may be able to sue has been a matter of concern.

The committee recommended that the date from which time should run should be the date of discoverability. In ordinary circumstances, the limitation period is three years running from and including the date on which the cause of action is “discoverable” by the plaintiff.

The date of discoverability under these recommendations, is not when the claimant in fact discovered the damage and that the damage was caused by the negligence of another, but rather when a reasonable person in the claimant’s position should have made the discovery. There should be, the Committee recommended, an ultimate “long-stop” bar of 12 years from the time the negligent occurrence happened. This could be extended at the discretion of the court but not beyond the three years after the cause of action was discoverable.

The Ipp Committee also gave anxious consideration to the difficult question as to whether the limitation period should be suspended in the case of minors and incapacitated persons. After giving the issue careful consideration, the committee came to the view that it would be in the overall interest of the community that, as a general rule, the limitation period should run against minors and incapacitated persons. This was subject to the exception that the limitation and ultimate bar periods should not run against minors not in the custody of a parent or guardian; and should not run against incapacitated persons in periods during which no administrator had been appointed in respect of the person. The relevant knowledge, for the purposes of determining when the limitation period commences, would be that of the parent, guardian or administrator, as the case may be and not that of the minor or incapacitated person.

Where the parent or guardian is the defendant, the committee recommended that the limitation period would only commence when the plaintiff turned 25.

New South Wales and Victoria have incorporated these recommendations into their **Limitation Acts** (see ss 50C, 50D/F, 62A, 62B of the **Limitation Act 1969 (NSW)** and ss 27D/M of the **Limitations Act 1958 (Vic)**). Queensland has implemented the provisions suspending limitation period during the time of disability; and the recommended provisions have also been incorporated into the **Commonwealth’s**

**Trade Practices (Personal Injuries and Death) Bill (No 2) 2004.** So far, the other jurisdictions have not followed. This is despite the Ipp Report recommendation that “any sensible reform of the law relating to claims for personal injury or death arising out of negligence should include limitation rules that, as far as possible, are of general application and have nationwide effect”.

### **Mental trauma**

A third area of major interest is the codification of the law in relation to mental harm issues. Where a baby is born with catastrophic injuries in circumstances where there is an arguable claim for negligence against the medical practitioner involved, this, in the past, has often led to additional actions being brought by the parents for damages for so called nervous shock. An important recommendation by the Ipp committee in this regard was that a committee of experts be appointed to develop a set of guidelines for assessing psychiatric illness for legal purposes. In particular, there was a recommendation that the expert panel should be instructed to develop options for a system of training and accreditation of forensic psychiatric experts. This was thought desirable, indeed necessary, particularly in the area where expert evidence was necessary to detect the presence of a recognised psychiatric illness. So far as I can ascertain, no jurisdictions have implemented this recommendation.

In general, the response to the Ipp Report in relation to mental harm has been to enshrine in statute the standard view of the majority opinion in the well known High Court cases of **Tame v New South Wales**; **Annetts v Australian Stations Pty Ltd**. No duty is owed to a person unless the defendant ought to have foreseen that a person of normal fortitude might suffer a recognised psychiatric illness. This is to be determined in accordance with “the circumstances of the case”.

In New South Wales and South Australia, the legislature has gone beyond the Ipp recommendations by restricting recovery for pure mental harm to persons who directly witnessed a person being killed or injured or put in peril or who were a close family member of the victim (**Civil Liability Act 2002 (NSW)** s 30).

It is worth noting that the Ipp Report proposal in relation to consequential mental harm has been taken up by all jurisdictions except Western Australia, Queensland and the Northern Territory. The committee gave consideration to situations where there was consequential mental harm from physical injury giving rise to a claim for damages for economic loss such as loss of income or the cost of care. The committee proposal was that to recover such damages the plaintiff would have to establish that the defendant owed the plaintiff a separate duty to avoid inflicting mental harm, as well as the original duty to avoid inflicting physical harm. In some respects, this recommendation demonstrated a tendency which was against the trend of contemporary medical views by attempting to treat mental harm as an entirely separate phenomenon from physical harm. However, the committee thought it very important to distinguish between damages for non economic loss and damages for economic loss in this area.

Section 30(3) of the **Civil Liability Act 2002** provides that any damages to be awarded to a plaintiff for pure mental harm are to be reduced in the same proportion as any reduction in the damages that may be recovered from the defendant by or through the victim on the basis of the contributory negligence of the victim. Importantly, there is no liability whatsoever to pay damages for pure mental harm resulting from negligence unless the harm consists of a recognised psychiatric illness (s 31).

### **Damages - Generally**

I turn now to a consideration of a very important aspect of the reforms which have occurred throughout Australia. This is the calculation of personal injury damages and the particular reforms which have taken place in this area. It will be well understood that there are differences in the various jurisdictions throughout Australia and that therefore, for the purposes of this paper, I shall deal with the general topic without descending into precise detail. The kind of changes that have been introduced include the following:

- Establishment of thresholds of a percentage of permanent impairment below which a person may not sue at all

- Establishment of an indexed maximum for the recovery of economic loss
- Establishment of a threshold and maximum for recovery of non economic loss
- Restrictions on the recovery of damages for gratuitous services
- Fixing and in all cases reducing the rate of interest that can be awarded
- Fixing and increasing the discount rate established by the courts for the determination of the present value of future loss

It is fair to say that all jurisdictions have enacted controls and caps on damages awards but uniformity has not been entirely achieved.

### **Damages: The threshold and cap**

New South Wales has enacted the Ipp Committee's recommendation, namely a threshold for general damages in terms of 15% of a most extreme case. Victoria has set a threshold of 5% for personal injury and 10% for psychiatric injury, whereas Western Australia has set a fixed amount threshold. On the other hand, the capping of general damages is a reform which has been accepted by almost every jurisdiction, although a sliding scale has been introduced in most cases. In New South Wales, for example, the maximum amount for non-economic loss (\$350,000) is indexed on an annual basis. The indexation is geared to the percentage change in the amount estimated by the Australian Statistician of the average weekly total earnings of fulltime adults in New South Wales over the four quarters preceding the date of the annual declaration.

### **Damages: Loss of earning capacity**

In addition, the Ipp Report proposed a cap on damages for loss of earning capacity in order to provide high earners with an incentive to ensure against loss of the capacity to earn above the limit. The proposed cap was twice the average annual fulltime adult ordinary time earnings. ("Average adult earnings") As it has turned out, the new legislation capping civil damages around the Australian jurisdictions has found this to be too limited. All jurisdictions, with the exception of Tasmania and South

Australia, have chosen three times the average adult earnings as their limit. South Australia has selected a cap of \$2.2 million. Tasmania has selected a cap of 4.25 times average weekly earnings.

### **Damages: Gratuitous Services**

Two of the major components in major injury cases have shown themselves to be the cost of future care and the cost of gratuitous services. The latter, in particular, has been blamed by many commentators as a specially significant factor in the escalation of damages awards over the last quarter of a century. Past gratuitous care damages also have had applied to them an interest component.

Damages for the costs of medical care are determined on the basis of reasonableness; (New South Wales (s 13) and Queensland (s 55)). The committee had recommended that reasonableness be determined by reference to public hospital facilities and Medicare scheduled fees. This recommendation has not been adopted. In relation to gratuitous services, these have now been restricted in New South Wales, South Australia, Western Australia and the Northern Territory. There is no limit in the ACT. Tasmania had already abolished such damages. A number of the other jurisdictions had already restricted damages for gratuitous services in compensation schemes relating to motor accidents.

This has been, admittedly, an emotive issue. The genuine situation of a mother caring twenty-four hours fulltime over many years for a profoundly disabled child has understandably evoked a sympathetic response from the court assessing damages. On the other hand, the proliferation of claims for gratuitous damages, even in relatively minor cases or in cases where injury has been of a relatively short duration, plainly has had a significant impact on the insurance industry.

The present situation in New South Wales is that no damages may be awarded to a claimant for gratuitous attendant care services if the services are provided, or are to be provided (a) for less than six hours per week, and (b) for less than six months. There must have been shown a reasonable need for the services to be provided; the need must have arisen solely because of the injury to which the damages relates;

and it must be shown that the services would not have been provided but for the injury.

Where the services are provided (or are to be provided) for not less than forty hours per week, the amount of damages that may be awarded must not exceed a certain figure. This is calculated by reference to the average weekly total earnings for all employees in New South Wales. Where the services are for a lesser time, there is a maximum hourly rate provided. Section 18 of the **New South Wales Act** provides that a court cannot order the payment of interest on damages awarded for gratuitous attendant care services.

### **Damages: Present value of future loss**

The calculation of the present value of future loss is effected by a prescribed discount rate of 5% in most jurisdictions. The committee had recommended a discount rate of 3% and the establishment of a regulatory body with the power to change the discount rate. This has not prevailed. The point to note is that the higher the discount rate the smaller the lump sum for future loss will be.

The imposition of a threshold on general damages, and a number of the other changes to which I have made reference, have clearly proved to be effective in reducing the number and cost of smaller claims. For example, filings in the District Court of New South Wales, where the majority of lower claims are heard, has dwindled significantly over the last 12 months.

### **Damages: Structured settlements**

The final topic under this heading is the subject of structured settlements. Typically, a court in Australia awards a lump sum for future economic loss or future expenses that will be incurred. The award proceeds on the assumption that the plaintiff is likely to invest the lump sum and receive income from the investment. There are two reasons for this historical fact quite apart from matters of legal principle: the lump sum compensation is more tax advantageous than an income stream; secondly, courts did not have the power to make structured settlement of awards.

The States and Commonwealth have moved to reform this situation. The reforms have been designed to remove the tax impediment to structured settlements; and to enable State and Territory courts to order structured settlements.

The **Taxation Laws Amendment (Structured Settlements and Structured Orders) Act 2002** amends the **Income Tax Assessment Act 1997**. It provides an Income Tax exemption for annuities and certain deferred lump sums paid under structured settlements to seriously injured persons. The exemption is only available where certain eligibility criteria are met. The Act is designed, in addition, to ensure that life companies are exempt from income tax on income derived from assets that support structured settlement annuities and lump sums.

All State and Territories have enacted legislation to encourage and facilitate structured settlements in personal injury damage cases. For example, Division 7 of Part 2 of the **New South Wales Act** contains provisions to encourage and facilitate structured settlements in personal injury damages cases, including provisions for the court to notify the parties of the terms of any proposed award so as to give the parties a reasonable opportunity to negotiate a structured settlement (s 23). Moreover, a legal practitioner must advise, in writing, a plaintiff who proposes to negotiate a settlement of a claim for personal injury damages about the availability of structured settlements and the desirability of the plaintiff obtaining independent financial advice about structured settlements and lump sum settlements of the claim (s 25).

### **Trade Practices and Fair Trading laws**

The **Commonwealth Trade Practices Act 1974** (“TPA”) and similar provisions under State and Territory law relating to fair-trading prohibit unfair practices in trade and commerce. This extends to misleading and deceptive conduct. In the main, these laws have only been rarely used in death or personal injury cases.

No doubt with the ingenuity of lawyers in mind, the Commonwealth perceived that there was a potential for conduct in contravention of the provisions of the **Trade**

**Practices Act** being used as the basis of claims for negligently causing death or personal injury. There was a concern that astute legal practitioners might attempt to circumvent the reforms carried out in the States and Territories by recourse to the Trade Practices legislation.

For this reason, the Commonwealth proposed amendments to its Trade Practice legislation to prevent individuals, and the ACCC in a representative capacity, from bringing civil actions for damages for personal injuries or death resulting from contraventions of Division 1 of Part V of the TPA. If these proposals are implemented, plaintiffs will have to continue to seek damages for personal injuries or death by pursuing a right of action under State and Territory civil law rather than by relying on the TPA. The proposals are presently “stalled” in the Senate.

The **Fair Trading Act 1987 (NSW)** has been amended to prevent the recovery of damages under that Act for death or personal injury resulting from misleading and deceptive conduct. There is similar legislation also enacted in Queensland and Tasmania but not in other jurisdictions so far (23).

### **Reforms affecting pre-litigation procedures, lawyers and costs**

There have been a number of reforms implemented, which I need not detail, affecting pre-trial procedures. These reforms were designed to improve pre-litigation procedures and encourage early settlements. A second raft of reforms is aimed at the solicitors and barristers conducting litigation. For example, a solicitor or barrister in New South Wales must not provide a legal service on a claim or defence unless he or she has reasonable grounds for believing, on the basis of proof of facts and a reasonably arguable view of the law, that the claim or defence has reasonable prospects of success (**Legal Professional Act 1987**). A contravention of this prohibition is capable of being unsatisfactory professional conduct or professional misconduct for the purposes of disciplinary proceedings. Moreover, where legal services are provided in contravention of the prohibition, the solicitor or barrister can be ordered to repay costs that the client has been ordered to pay to another party and can be ordered to indemnify another party against costs payable by that other party. There is similar provision in the Australian Capital Territory (ss186-190 **Civil**

**Law (Wrongs) Act 2002**. As yet, other jurisdictions have not put in place like provisions.

A number of jurisdictions have implemented reforms aimed at restricting advertising by the legal profession in connection with certain damages claims. This has occurred in New South Wales, Queensland and Western Australia. In addition, there have been reforms restricting the recovery of legal costs by both plaintiffs and defendants in relation to small to medium size claims. These changes have reflected the philosophy that is desirable to reduce the cost of resolving small claims so as to promote the allocation of resources to provide support and assistance where it is most needed, that is in cases of catastrophic or more serious injury. The reforms were frankly designed to make legal action less attractive for smaller claims. There is no doubt that reforms in this area have been a major reason for the “dry-up” of the smaller to medium negligence actions.

Changes of this kind have occurred in **New South Wales (Legal Professional Act 1987)**; **Personal Injuries Proceedings Act 2002 (Queensland)**; **Western Australia (Legal Practitioners) Act 1893** and in both the Australian Capital Territory and the Northern Territory.

### **Medical Indemnity**

As I mentioned at the outset of this paper, the problems experienced in the medical indemnity insurance market over recent years reflect those found in the general insurance world. There had already been expressed concern regarding the fact that the High Court of Australia’s interpretation of the **Insurance Contracts Act 1984** was causing difficulties for insurers (24). This was especially so for insurers providing “long-tail” classes of insurance. The Federal Government is currently considering amendments to the Act with a view to ensuring that claims made insurance continues to operate as intended.

With the near collapse of Australia’s largest medical defence organisation, UMP, the problems of under provisioning for “long-tail” claims were exacerbated. Premiums rose sharply at the same time as some medical practitioners threatened to cease work in hospitals and others contemplated early retirement. Actuarial calculations at the time, based on a number of judgments for high damages, provided an alarm

signal to the Directors of UMP that future damages awards were likely to be beyond financial reach. This, coupled with the reinsurance problem in the general insurance industry, made it clear that steps had to be taken to enable doctors to have access to secure and affordable medical indemnity insurance in the future.

One of the responses to this crisis, as this paper has endeavoured to point out, was the concept of tort reform. I doubt that anybody who examined the matter carefully imagined that tort reform, of itself, was a complete cure to the problems in the medical indemnity industry. The Australian Government, as a consequence, has introduced a range of reforms to meet the issues involved in the broader issue of medical indemnity insurance. This has included legislation to bring medical indemnity providers within the general insurance industry prudential regulatory regime. It has also included the promise of premium support for doctors whose premiums are high relative to their income. As I understand it, general surgeons are paying up to \$70,000 or more for annual insurance even as I speak. The issue of premium support is accordingly a most encouraging one.

In relation to the broader issue, the Australian Government has provided guarantees that have allowed UMP to trade its way back into business. Indeed, I understand the Directors of UMP are presently confident that the steps taken by the Australian Government have substantially rectified the aspect of under provisioning and the threat of inadequate reinsurance. Time alone will tell whether these cautiously optimistic expectations will be realised.

## **Conclusion**

The broad areas of tort reform outlined in this paper occurred as a result of perceptions of crisis in the insurance world generally, including the field of medical indemnity insurance. Whatever the merits of the debate, it became clear that reforms were required on a principled and balanced basis so that the needs of the community might be urgently addressed as well as the legitimate rights of injured persons to seek reasonable redress against those responsible for their loss or damage. To a reasonable extent, I believe that the reforms have been principled. This is particularly in the area where there has been a statutory codification of the law as stated by recent decisions of the High Court. On the other hand, a number of the

reforms, no doubt considered genuinely necessary, have been more in the nature of “one off” stratagems to appease public indignation and dissatisfaction with outcomes perceived to be unreasonable.

It is certainly true that the Commonwealth Government and the various State and Territories have moved very quickly to address the insurance crisis. The potential for delay and obfuscation was present, as is often the situation in the area of legislative change. It is a credit to all concerned that the reforms have moved at such an extraordinarily rapid pace. One flaw, however, I think can be detected in the process. It is something I have briefly dwelt on during this paper. The reforms have not always been uniform across the jurisdictions and the language of the statutory enactments has been, to a degree, quite different in some areas. While this is understandable having regard to Australia’s political system, the consequent lack of uniformity carries with it a certain degree of uncertainty of outcome. This in turn has the capacity and potential to increase costs for both litigants and insurers.

The big question is – have the reforms been successful in driving down insurance premiums; or at least, in ensuring a degree of stability in the medical indemnity side of the insurance equation? It is too early to answer these questions in any definitive sense.

There is no doubt that the negligence court lists in, for example, the District Court of New South Wales have been halved during the last two years. In New South Wales, the number of actions commenced for medical negligence is definitely down. On the other hand, there appears to be a more significant number of notifications of medical claims in the Queensland court system during the same period. It is really too early for the reformers to claim complete victory.

It is my belief that tort reform will have a significant impact on the presence of small to medium claims in negligence actions generally. There is likely to be a similar impact on smaller claims for damages arising out of medical negligence. I am not as confident that the impact will be as significant on the larger claims especially those relating to catastrophic injury. The reforms relating to the calculation of damages will also have an impact on these larger claims but they will still remain as large claims.

For example, Dr Megan Keaney, the major claims manager for UMP, produced in 2003 a comparison between the Court of Appeal's award in **Simpson v Diamond** (pre-reform) and the amount which she calculated as likely to have been payable under the **Civil Liability Act 2002** had it been applicable to the claim. The Court of Appeal's award in favour of Calandra Simpson was a total of \$10.9 million (approximately). The recalculation carried out by Dr Keaney brought the damages total down to \$8.372 million, still a very considerable sum.

I would like to conclude on a cautionary note. When the rhetoric surrounding tort reform has died down – on both sides – there will clearly remain a need for the medical profession and those involved in attendant health care services, including those concerned with the administration of hospitals, to reflect upon these matters: two of the strongest factors in retaining indemnity insurance within affordable limits remain, first, the need for the imposition of improved levels of education for risk management in all areas of health practice; and secondly, the maintenance of professional standards of the highest calibre. Unless those things occur, no amount of tort reform will save the situation. The pendulum will swing back, inevitably, in favour of plaintiffs with the prospect of increased medical indemnity costs a reality once more.

## **ENDNOTES**

1. (2004) NSWCA 9
2. Review of the Law of Negligence (“Ipp Committee”) 2002
3. Spigelman CJ: Negligence: The Last Outpost of the Welfare State (2002 76 ALJ 432; Negligence and Insurance Premiums (Spender Mason Trust Lecture 27.5.03); DA Ipp Policy and the swing of the Negligence Pendulum (2003) 77 ALJ 732; Associate Prof Prue Vines: Faith Hope and Personal Injury (Aust. Civil Liability Vol 1 No 1); Reform of Liability Insurance Law in Australia (Commonwealth of Australia 2004). My thanks also to Professor Barbara McDonald, Pro-Dean Sydney University Law School, for her invaluable advice and assistance.
4. Nagle v Rottneest Island Authority (1993) 177 CLR 423
5. (1992) 175 CLR 479
6. Negligent failure to inform (2003) 11 Torts Law Journal 165
7. Rosenberg v Percival (2001) 205 CLR 434; O’Brien v Wheeler NSWCA 23 May 1997 (unreported); Johnson v Biggs (2000) NSWCA 338; Bridge v Pelly (2001) NSWCA 31
8. Healthcare Liability Act 2001
9. (1980) 146 CLR 40
10. (2002) 211 CLR 317
11. Civil Liability Act (NSW) 2002 s 5C; Wrongs Act (Vic) 2003 s 48(2); Civil Liability Act (Qld) s 10; Civil Liability Act (WA) Part 1A, Div 2; Law Reform Act 2004 s 32(2); Civil Liability Act (Tas) s 11(2); Civil Law (Wrongs) Act 2002 (ACT s 43(2))
12. (1998) AC 232
13. Wrongs on other Acts (Law of Negligence) Act 2003 s 59(1)
14. *ibid* s 59(2)
15. Civil Liability Act 2002 (s 5H)
16. *ibid* ss 5D(3)(a) and (b)
17. NSW (s 5H); Queensland (s 21) and Tasmania (s 21)
18. (2003) NSWCA 262

19. (2004) NSWCA 97
20. As to the duty of a receptionist in a medical practice: see *Alexander v Heise* (2001 NSWCA 222). In that case the doctor and his receptionist were found not liable in circumstances where it had been alleged that the receptionist had failed to detect a need to make an urgent appointment for a sick patient to see the doctor
21. (2003) 199 ALR 131
22. (2004) NSWSC 39
23. Fair Trading Act (Qld); Civil Liability Act (Tas)
24. *FAI General Insurance Co Limited v Australia Hospital Care Pty Limited* (2001) HCA 38

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