The Litigation Threat to Surgical Practice: Legal Reform and Risk Management

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Abstract

There exists a considerable body of literature, across jurisdictions in the common law world, and including a wide variety of sources – from academic articles to presidential speeches – asserting the existence of a "medical litigation crisis". Surgery, in particular, is on the "front line" of this crisis, making it also a "surgical litigation crisis".

The research aims to first understand the nature and the extent of the threat that litigation poses to surgical practice. A critique of tort law in relation to surgical practice will be undertaken. A synthesis of the literature on the reform of tort law and medical malpractice law will be given including: no-fault medical injury claim systems; limitation of remuneration for non-economic loss and the establishment of special health courts and Alternative Dispute Resolution methods.

The research work and its publications will propose potential solutions to these litigation problems; investigate impediments to their realisation and examine practical strategies for the motivation of governments to engage in legislative reform, as well as examining the limitations of law for solving social problems. Changes to medical practice, such as strategies of eliminating medical error and risk management are also discussed.

Declaration

I certify that this work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. In addition, I certify that no part of this work will, in the future, be used in a submission for any other degree or diploma in any university or other tertiary institution, without the prior approval of the University of Adelaide and where applicable, any partner institution responsible for the joint-award of this degree.

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Contextual Statement

Aims Underpinning the Publications

There is a considerable body of literature that has appeared for some time[1] and across jurisdictions,[2] claiming that there is a "medical malpractice crisis" or a "medical liability crisis."[3] The literature ranges from academic articles in leading medical and law journals to US Presidential speeches and essays. Thus former US President George W. Bush in January 2005 stated his belief that the rise in US medical indemnity insurance premiums was a product of "litigation excess,"[4] a view supported by papers published in 2002 and 2003 by the US Department of Health and Human Services.[5] Interestingly enough in 2006,

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[1] C. Wood (ed.), *The Influence of Litigation on Medical Practice*, (Academic Press, London, 1977); P. Danzon, *Medical Malpractice: Theory, Evidence and Public Policy*, (Harvard University Press, Cambridge, MA, 1985); I. Hay, *Money, Medicine and Malpractice in American Society*, (Praeger Publishers, Westport, 1992); K. Abraham, *The Liability Century: Insurance and Tort Law from the Progressive Era to 9/11*, (Harvard University Press, Cambridge, MA, 2008).

[2] See for example, E. Dantas, "A Bridge Over Troubled Waters: The Development of Medical Malpractice Litigation in Brazil", *Chicago-Kent Law Review*, vol. 87, no 1, 2012, pp. 3-20; Z. Wang and K. Oliphant, "Yangge Dance: The Rhythm of Liability for Medical Malpractice in the People's Republic of China," *Chicago-Kent Law Review*, vol. 87, no 1, 2012, pp. 21-52; R. B. Leflar, "The Law of Medical Misadventure in Japan," *Chicago-Kent Law Review*, vol. 87, no 1, 2012, pp. 79-110.

[3] M. M. Mello (et. al.), "The New Medical Malpractice Crisis," *New England Journal of Medicine*, vol. 348, 2003, pp. 2281-2284.

[4] President George W. Bush, "President Discusses Medical Liability Reform and Health Care in Pennsylvania," January 5, 2005, at http://georgewbush-whitehouse.archives.gov/news/releases/2004/10/20041021-15.html

[5] US Department of Health and Human Services, *Update on the Medical Litigation Crisis*, September 25, 2002 at, http://aspe.hhs.gov/daltcp/reports/mlupd2.htm; US Department of Health and Human Services, *Addressing the New Health Care Crisis*, March 3, 2003, at http://aspe.hhs.gov/daltcp/reports/medliab.htm.

Hillary Rodham Clinton and then Senator Barack Obama, now US President, wrote in the leading medical journal, *New England Journal of Medicine*, that "ever-escalating insurance costs" mean that for some medical specialities, "high premiums are forcing physicians to give up performing certain high-risk procedures leaving patients without access to a full range of medical services."[6]

The "medical malpractice crisis" has been defined as "a period of volatility in the malpractice insurance market characterized by above-average increases in premiums, contractions in the supply of insurance and deterioration in the financial health of insurance carriers."[7] In the United States the term "crisis" has been applied to the early to mid-1970s period, involving major malpractice insurers leaving the market, creating a condition of scarcity of insurance availability.[8] This "crisis" was allegedly solved by the formation in many US states of insurance companies which were owned and operated by physicians, or alternatively, by joint underwriting associations, backed by the states.[9] The US crisis from the early to mid-1980s was a crisis of affordability produced by rapidly rising premiums and the crisis in the 2000s, and perhaps today, is one of both availability and affordability.[10] In the US context this crisis is often illustrated by a litany of "horror" statistics more than by robust theoretical argument. For example, 86 percent of US interventional specialist doctors have been named in a malpractice suit at least once[11]; the average US payment in

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[6] H. R. Clinton and B. Obama, "Making Patient Safety the Centerpiece of Medical Liability Reform," *New England Journal of Medicine*, vol. 354, 2006, pp. 2205-2208, cited p. 2205.

[7] C. H. Williams and M. M. Mello, "Medical Malpractice: Impact of the Crisis and Effect of State Tort Reforms," Robert Wood Johnson Foundation, The Synthesis project, Policy Brief, No. 10. May, 2006, p. 1, at http://www.rwjf.org/en/research-publications/find-rwf-research/2006/05/medical-malpractice.html.

[8] Mello (et. al.), cited note 3, p. 2281.

[9] As above.

[10] As above, p. 2282.

[11] M. M. Mello (et. al.), "Caring for Patients in a Malpractice Crisis: Physician Satisfaction and Quality of Care," *Health Affairs*, vol. 23, 2004, pp. 42-53.

malpractice claims increased by 52 percent between 1991 and 2003[12]; 76 percent of US obstetricians in 2003 reported a "litigation event" in their careers, usually for allegedly causing cerebral palsy[13]; almost 8 out of 10 US obstetricians-gynaecologists have been sued at least once in their career and almost half have been sued three or more times[14]; over 94 percent of cardiovascular or thoracic surgeons have been sued in Dale, Broward and Palm Beach counties, Florida[15], and every neurosurgeon in southern Florida (in 2004) had been sued on average five times.[16]

The medical liability crisis debate has also occurred in Australia. Dr Fiona Stanley, Professor of Paediatrics at the University of Western Australia and Australian of the Year for 2003, wrote in 1995 in the *University of Western Australia Law Review*, that litigation and fear of litigation has had an "extraordinary negative effect...on the practice of medicine and public health."[17] Professor Stanley claimed that "Courtroom trials are quintessentially singular, framing facts in isolation and demanding that scientific truths be rediscovered anew every time. They are often influenced by biased expert witnesses, who present an extreme and outrageous view which is not the general consensus of knowledge."[18]

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[12] A. Chandra (et. al.), "The Growth of Physician Medical Malpractice Payments: Evidence from the National Practitioner Data Bank," *Health Affairs*, January –June, 2005 (supp. Web exclusive), W5-240 – W5-249, cited p. W5-240.

[13] A. MacLennan (et. al.), "Who Will Deliver Our Grandchildren? Implications of Cerebral Palsy Litigation," *JAMA*, vol. 294, 2005, pp. 1688-1690, cited p.1688; G. D. V. Hankins (et. al.), "Obstetric Litigation is Asphyxiating our Maternity Services," *Obstetrics and Gynecology*, vol. 107, 2006, pp. 1382-1385.

[14] American College of Obstetrics and Gynecology, *Professional Liability Survey 2006*, (American College of Obstetrics and Gynecology, Washington DC, 2006).

[15] D. J. Palmisano, "The Hidden Cost of Medical Liability Litigation," *Annals of Thoracic Surgery*, vol. 78, 2004, pp. 9-13, cited p. 10.

[16] As above.

[17] F. Stanley, "Litigation Versus Science: What's Driving Decision-Making in Medicine?" *University of Western Australia Law Review*, vol. 25, 1995, pp. 265-282, cited p. 266.

[18] As above.

Professor Stanley discussed a number of examples to support her position, including cerebral palsy and obstetric care, where there was, and still is, concern about the magnitude of cerebral palsy litigation. The problem, as stated in a more recent paper by Johnson (et. al.), is that medical care advances have improved the life expectancy of persons with severe cerebral palsy, which has increased long-term care costs and increased the need for seeking legal action for financial support and compensation.[19] As Johnson (et. al.) note: "Medical indemnity costs for insurance have soared, particularly in obstetrics. In Australia, obstetricians pay some of the highest premiums for medical indemnity insurance since they are associated with about 18 % of the cost of claims, despite forming only 2 % of the physician group. Some USA insures declined to renew policies for doctors who had prior claims against them."[20] As an example of these difficulties, a small maternity hospital in South Australia, the Le Fevre Hospital, closed because its insurance was not sufficient to cover an AUS $ 5 million payout in a cerebral palsy case.[21]

The aim of this thesis by publication is to examine whether or not there is a litigation threat to surgical practice, as a subset of a more general medical litigation threat, and if so, to explore what can and should be done about it, to secure both justice for injured patients and the sustainability of the medical/surgical system. The methodology for undertaking this examination was a review of existing literature and available data from authoritative sources. Two books are submitted for publication: *The Surgical Litigation Crisis*[22] and the forthcoming *Medical Malpractice, Mistakes and*

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[19] S. L. Johnson (et. al.), "Obstetric Malpractice Litigation and Cerebral Palsy in Term Infants," *Journal of Forensic and Legal Medicine*, vol. 18, 2011, pp. 97-100, cited p. 97.

[20] As above.

[21] J. W. Smith and G. Maddern, *The Surgical Litigation Crisis: Medical Practice and Legal Reform*, (Edwin Mellen Press, Lewiston, New York, 2010), p. 3.

[22] As above.

Mishaps,[23] both published by the Edwin Mellen Press in the United States. Although the thesis title is "The Litigation Threat to Surgical Practice," the works are concerned with alleged litigation threats to surgical practice in the context of the wider issue of medical malpractice and litigation and any solutions to a "surgical litigation crisis" are likely to be relevant to aiding the more general "medical litigation crisis."

To keep this project to a manageable length, the candidate in the two submitted books has considered primarily the Australian and United States jurisdictions. These jurisdictions are the ones which the candidate knows best and much of the academic discussion of the problems of this thesis have been discussed in the United States context. The books have discussed similarities and differences between the two jurisdictions in these matters. In the foreword to *The Surgical Litigation Crisis*, the distinguished Australian jurist Hon. Geoffrey Davies AO (former Inaugural Judge of the Court of Appeal, Supreme Court of Queensland), after making a number of positive remarks about the candidate's book, says that the work's reliance upon American materials and arguments may have "Misled [the authors] into painting a bleaker picture of the civil justice system in Australia than the reality warrants."[24] On the contrary, *The Surgical Litigation Crisis* did not present a bleak enough picture, and *Medical Malpractice, Mistakes and Mishaps* attempts to provide this, as well as presenting a general jurisprudential argument for legal scepticism. Latter in this Contextual Statement the candidate will discuss a recent argument from Professor Davies' judicial peer, former Chief Justice of the Supreme Court of

[23] J. W. Smith and G. Maddern, *Medical Malpractice, Mistakes and Mishaps: Essays on Medical Litigation, The Mandatory Reporting of Health Professionals and the Limits of Law*, (Edwin Mellen Press, Lewiston, New York, forthcoming 2013).

[24] As above, p. iv.

South Australia, John Doyle, who also expresses legal scepticism about the sustainability of the Australian civil justice system.[25]

[25] J. Doyle, "Imagining the Past, Remembering the Future: The Demise of Civil Litigation," *Australian Law Journal*, vol. 86, no. 4, 2012, pp. 240-248.

Literature Review

1. Is There a Medical/Surgical Litigation/Liability Crisis?

There are considerable difficulties in attempting to give an objective answer to the question as to whether there is (or was) a medical/surgical liability/litigation crisis. For a start, few, if any papers using the term "crisis" attempt to define the term and operationalise it, outlining how we would recognise a crisis when we encountered one. In the submitted books, "crisis" is taken to have its ordinary English language meaning as an unstable or crucial period often associated with a threat.

Some, such as Tom Baker in *The Medical Malpractice Myth*[26], argue that there is too much medical malpractice through doctor-caused injuries, not too much litigation, so there cannot be a medical liability crisis as such. He cites a number of studies of iatrogenic occurrences, indicating a high rate of doctor-caused injuries in many jurisdictions.[27] Baker cites, for example, the Quality in Australian Health Care study, which claimed that iatrogenic injuries arose in one out of six hospital patients in Australia, with half of those injuries being allegedly preventable.[28] This thesis material discusses the question of medical error and prevention in some detail. Baker's conclusion that the liability system is not running amok is accepted. It is well recognised in the published literature that awards given by juries are not "skyrocketing" even in the United States[29];

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[26] T. Baker, *The Medical Malpractice Myth*, (University of Chicago Press, Chicago and London, 2005).

[27] L. T. Kohn (et. al.), *To Err is Human: Building a Safer Health System*, (National Academy Press, Washington DC, 2000); E. J. Thomas (et. al.), "Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado," *Medical Care*, vol. 38, 2000, pp. 261-271.

[28] R. M. Wilson (et. al.), "The Quality in Australian Health Care Study," *Medical Journal of Australia*, vol. 163, 1995, pp. 458-471.

[29] B. Black (et. al.), "Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988-2002," *Journal of Empirical Legal Studies*, vol. 2, 2005, pp. 207-260.

that US juries do not favour plaintiffs in medical malpractice cases (US plaintiffs generally win in about 30 percent of medical malpractice cases compared to 50 percent in other cases)[30] and that most cases of negligence do not even result in malpractice claims.[31] Nevertheless these facts do not disprove the existence of a medical/surgical liability crisis: merely because a "problem" could be greater or more serious does not show that the initial problem does not exist. A system may still be facing threats even if it is not in a state of meltdown.

It has also been accepted in both books presented for this examination that there is considerable merit in linking the medical/surgical liability/litigation crisis with the cycles of crises in the insurance business cycle.[32] "Shock events" such as 9/11 have also been relevant as William Sage observes: "global insurance shocks (including the terrorist attacks) made reinsurers reluctant to devote suddenly scarce capital to unpredictable areas such as medical malpractice."[33] However there is a connection to excess litigation, Sage believes: "Rising reinsurance costs affect not only primary malpractice carriers but also hospitals and nursing homes that self-insure basic risk but purchase excess coverage. Price shocks for reinsurance are exacerbated by the publicity that attends the largest jury verdicts, which in tight markets leads insurance actuaries to make the worse-case projections."[34]

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[30] M. K. Miller, "How Juryphobia and Fears of Fraudulent Claims Disserve Medical Malpractice Reforms," in B. H. Bornstein (et. al. eds), *Civil Juries and Civil Justice: Psychological and Legal Perspectives*, (Springer, New York, 2008), pp. 175-192, cited p. 180; P. G. Peters, "Doctors and Juries," *Michigan Law Review*, vol. 106, 2007, pp. 1453-1496; N. S. Marder, "The Medical Malpractice Debate: The Jury as Scapegoat," *Loyola of Los Angeles Law Review*, vol. 38, 2005, pp. 1267-1296.

[31] D. M. Studdert (et. al.), "Defensive Medicine and Tort Reform: A Wide View," *Journal of General Internal Medicine*, vol. 25, 2010, pp. 380-381, cited p. 380.

[32] T. Baker, "Medical Malpractice and the Insurance Underwriting Cycle," De *Paul Law Review*, vol. 54, 2005, pp. 393-438.

[33] W. M. Sage, "The Forgotten Third: Liability Insurance and the Medical Malpractice Crisis," *Health Affairs*, vol. 23, no. 4, 2004, pp. 10-21, cited p. 13.

[34] As above.

Nye (et. al.) in a study of Florida during the period of 1978-1987, concluded the the insurance under-writing cycle contributed to the "suddenness and the timing of price increases in malpractice insurance during the period 1983 through 1987,"[35] but the "primary cause of increased malpractice premiums measured over the last nine years is found to have been the substantial increase in loss payments to claimants."[36] The rate of increase in claims payments per physician was greater than the rate of premium increases, with the increase in the number and proportion of large claims resulting in a rise in the cost of average claims.[37] Florida, however, was the US state with one of the highest malpractice premiums in the United States over the study periods used by Nye (et. al.) and it could be argued to be exceptional; comparable studies of the entire United States are lacking. It is arguable, as Mello (et. al.) suggest that any monocausal account of this issue is likely to be flawed because a number of factors have come together to create, at least in the United States, a "perfect storm."[38] Tort liability and liability insurance, as Kenneth Abraham shows in *The Liability Century*, "have had a reciprocal, one-way ratchet effect on each other that has resulted in both increasingly large tort recoveries and increasingly large amounts of liability insurance that covers these liabilities."[39]

In the case of Australia, matters are even murkier. Prior to 2002 there had been widespread concern in the medical profession about a medical liability crisis which led in 2002 to the Australian Health Ministers Advisory Council requesting the Victorian Law Reform Commissioner, Marcia Neave, to produce a report on this alleged crisis. The Neave Report, *Responding to the Medical*

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[35] D. J. Nye (et. al.), "The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances," *Georgetown Law Journal*, vol. 76, 1988, pp. 1495-1561, cited p. 1499.

[36] As above.

[37] As above, p. 1554.

[38] Mello (et. al.), cited note 3, p. 2283.

[39] K. Abraham, *The Liability Century: Insurance and Tort Law from the Progressive Era to 9/11*, (Harvard University Press, Cambridge, MA, 2008), p.4.

Indemnity Crisis, was published on September 18, 2002.[40] Significantly the report noted the lack of reliable empirical data dealing with the issue of the medical indemnity crisis, which had led to "myths and misinformation," but nevertheless, as Danuta Mendelson has observed[41], even though there was no comprehensive body of empirical studies to determine the effects of various tort law reforms on the alleged "crisis," the Neave Report made various recommendations for tort reform including structured settlements, thresholds for compensable injuries, changes to limitation periods and damage caps.[42]

The Ipp, *Review of the Law of Negligence Report*, followed the Neave Report and was published on October 10, 2002.[43] The Panel chaired by Justice Ipp of the New South Wales Supreme Court was created by the Commonwealth, State and Territory governments to examine the law of negligence and what reforms should be made to it. The Report stated in its terms of reference: "The award of damages for personal injury has become unaffordable and unsustainable as the principal source of compensation for those injured through the fault of another. It is desirable to examine a method for the reform of the common law with the objective of limiting liability and quantum of damages arising from personal injury and death."[44] However, as this was a term of reference for a principles-based review of the law of negligence in Australia, the truth of this proposition was not supported by rigorous empirical evidence and

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[40] M. Neave (Chairperson), *Responding to the Medical Indemnity Crisis: An Integrated Reform Package*, (September 18, 2002), at http://health.act.gov.au/publications/reports/responding-to-the-medical-indemnity-crisis.

[41] D. Mendelson, "Australian Tort Law Reform: Statutory Principles of Causation and the Common Law," *Journal of Law and Medicine*, vol. 11, 2004, pp. 492-509, cited p. 492.

[42] As above.

[43] D. Ipp (et. al.), *Review of the Law of Negligence Report*, (October 10, 2002), at http://www.revof neg.treasury.gov.au/content/reports.asp.

[44] As above, p.vii.

nor was it critically examined.[45] Like the Neave Report, the Ipp Report recommended widespread changes to the law of negligence which are now statutorily represented in "Civil Liability" or "Civil Law" Acts (e.g. *Civil Liability Act 2003* (Qld); *Civil Law (Wrongs) Act 2002* (ACT)).

Davis has argued that for Australia at this time evidence from actual court filings indicated an increase in personal injury litigation in some jurisdictions and a decline in others, which could have be due to a variety of factors from population increase to changes in the monetary jurisdictions of the courts.[46]

There are some less controversial indications of the existence of a medical liability crisis. Beginning the discussion first with the United States, Mello (et. al.) have published an estimation of the cost of the US medical liability system.[47] The costs, expressed in monetary terms, do not consider the reputational and emotional costs of physicians being sued, but include indemnity payments (economic damages, noneconomic damages and punitive damages), administration expenses, plaintiff legal expenses, defendant legal expenses, other overhead expenses, defensive medicine costs, hospital services, physician/clinical services and other costs. The total cost of the US medical liability system was estimated to be US $ 55.6 billion in 2008 dollars or 2.4 percent of the total US health care spending, with defensive medicine costs estimated to be US $ 45.59 billion.[48]

"Defensive medicine" refers to the ordering of tests and procedures, not solely for medical reasons, but for protection against litigation. In the US

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[45] B. Bennett and I. Freckelton, "Life after the Ipp Reforms: Medical Negligence Law," in I. Freckelton and K. Petersen (eds.), *Disputes and Dilemmas in Health Law*, (Federation Press, Sydney, 2006), pp. 381-405.

[46] R. Davis, "The Tort Reform Crisis," *University of New South Wales Law Journal*, vol. 25, no. 3, 2002, pp. 865-870, cited p. 867.

[47] M. M. Mello (et. al.), "National Costs of the Medical Liability System," *Health Affairs*, vol. 29, 2010, pp. 1569-1577.

[48] As above, p. 1569.

defensive medicine is the largest single source of waste of health care funding,[49] with defensive medicine practices responsible for 20-50 percent of orders of additional medical tests.[50] A Harris Poll of practising US Physicians found that 79 percent of them practised defensive medicine because of fear of litigation.[51] A survey of 824 physicians (65 percent completed the survey) in Pennsylvania in May 2003 by Studdert (et. al.) of physicians practising in high litigation risk areas (such as emergency medicine, general surgery, orthopaedic surgery, neurosurgery, obstetrics/gynaecology and radiology), found that 93 percent of physicians practised defensive medicine, 43 percent used imaging technology when it was not clinically necessary to do so and 42 percent had restricted their practice in the previous three years (such as not performing procedures prone to complications) as a result of perceived litigation threat.[52]

Studies of the relationship between medical malpractice litigation and medical costs have shown that litigation is positively and significantly related to medical costs in the United States, with malpractice litigation accounting for approximately 2-10 percent of medical expenditures and the impact exceeding the dollar amount of settlements.[53]

Defensive medicine is practised in US states which have low malpractice risk as measured by objective criteria.[54] US physicians' malpractice concerns are not sensitive to US state malpractice reforms such as caps on noneconomic and

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[49] Pricewaterhouse Coopers Health Research Institute, *The Price of Excess: Identifying Waste in Health Care Spending*, (Pricewaterhouse Coopers LLP, New York, 2008).

[50] J. B. Green, "The Medical Malpractice Muddle," *Health Affairs*, vol. 29, 2010, p. 2355.

[51] Harris Interactive, at http://www.harrisinteractive.com/harris_poll/index.asp?PID=300.

[52] D. M. Studdert (et. al.), "Defensive Medicine among High-Risk Specialist Physicians in a Volatile Malpractice Environment,"*JAMA: Journal of the American Medical Association*, vol. 293, June 1, 2005, pp. 2609-2617.

[53] B. Roberts and I. Hoch, "Malpractice Litigation and Medical Costs in the United States," *Health Economics*, vol. 18, 2009, pp. 1394-1419, cited p. 1419; B. Roberts and I. Hoch, "Malpractice Litigation and Medical Costs in Mississippi," *Health Economics*, vol. 16, 2007, pp. 841-859.

[54] E. R. Carrier (et. al.), "Physicians' Fears of Malpractice Lawsuits are Not Assuaged by Tort Reforms," *Health Affairs*, vol. 29, 2010, pp. 1585-1592, cited p. 1585.

punitive damages.[55] Litigation fear continues to be of great concern, if not a grave fear of US surgeons; according to a American Medical Association survey conducted in 2007 and 2008 of 5,825 physicians, 42.5 percent of the respondents had been sued at least once; more than 20 percent at least twice and for respondents aged 55 years and older, 60.5 percent said that they had been sued once and 39.2 percent said that they had been sued at least twice.[56] However, 40 percent of US filed claims are groundless[57]; US physicians win 80-90 percent of jury trials with weak evidence of medical negligence, 70 percent of borderline cases and 50 percent of cases with strong evidence of medical negligence[58]; 80-90 percent of defensible claims are dropped or dismissed with no payment[59]; in neurosurgery and other surgical specialties, most plaintiff claims of merit are settled[60] and the majority of patients who are entitled to make a claim do not.[61] The medical/surgical litigation crisis is in large part a matter of physician perception or misperception, and an overestimation of the risk of being *successfully* sued.[62]

The litigation fear and stress factor is also seen in Australia, where studies of GPs and specialist physicians have shown that the threat of litigation is one of

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[55] As above, p. 1589. See also F. A. Sloan and J. H. Shadle, "Is There Empirical Evidence for 'Defensive Medicine'"? A Reassessment," *Journal of Health Economics*, vol. 28, 2009, pp. 481-491.

[56] A. Robeznicks, "The Fear Factor," *Modern Healthcare*, vol. 40, 2010, pp. 6-7, cited p. 6.

[57]S. L. Weinstein, "Medical Liability Reform Crisis 2008," *Clinical Orthopaedics and Related Research*, vol. 467, 2009, pp. 392-401, cited p. 392.

[58] P. G. Peters, "Twenty Years of Evidence on the Outcomes of Malpractice Claims," *Clinical Orthopaedics and Related Research*, vol. 467, 2009, pp. 352-357, cited p. 352.

[59] As above.

[60] C. A. Fager, "Malpractice Issues in Neurological Surgery," *Surgical Neurology*, vol. 65, 2006, pp. 416-421.

[61] A. Localio (et. al.), "Relation between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Medical Practice Study III," *New England Journal of Medicine*, vol. 325, 1991, pp. 245-251.

[62] A. G. Lawthers (et. al.), "Physicians' Perceptions of the Risk of Being Sued," *Journal of Health Politics, Policy and Law*, vol. 17, 1992, pp. 463-482.

the most severe work-related stresses.[63] A survey was conducted by Nash (et. al.) of 1,499 GPs insured with UNITED Medical Protection (now Avant), with 530 GPs being proceduralists and 970 nonproceduralists, with 266 not participating, and of the 1,239 GPs surveyed, 566 responded.[64] It was found, among other things that 48 percent had considered early retirement from medicine because of medicolegal factors. Increased test ordering was made by 73 percent of the sample; increased referral to specialists by 66 percent and 49 percent avoided particular invasive procedures in response to perceived medicolegal threats.[65] Nash (et. al.) in another paper reported both a widespread practice of defensive medicine and substantial concerns about medicolegal issues among respondents, with 33 percent considering abandoning medicine, 40 percent considering early retirement, 18 percent feeling emotionally separated from patients and 32 percent considering reducing working hours.[66] Doctors who had experience of a medicolegal matter had these concerns more than doctors who had not.

Studdert (et. al.) have observed that there are "fundamental problems of misalignment' in the medical liability system that "go far beyond defensive medicine,"[67] with the most serious being "the well-documented mismatch between negligent injuries and malpractice litigation," where most "instances of negligence do not result in malpractice claims, many malpractice claims do not involve negligent injuries, and the outcomes of malpractice claims often do not match the merits of the claim."[68] Defensive medicine is driven by this

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[63] P. L. Schattner and G. J. Coman, "The Stress of Metropolitan General Practice," *Medical Journal of Australia*, vol. 169, 1998, pp. 133-137.

[64] L. Nash (et. al.), "GPs' Concerns about Medicolegal Issues: How it Affects their Practice," *Australian Family Physician*, vol. 30, no. 1, 2009, pp. 66-70.

[65] As above, p. 70.

[66] L. Nash (et. al.), "Perceived Practice Change in Australian Doctors as a Result of Medicolegal Concerns," *Medical Journal of Australia*, vol. 193, 2010, pp. 579-583.

[67] D. M. Studdert (et. al.), "Defensive Medicine and Tort Reform: A Wide View," *Journal of General Internal Medicine*, vol. 25, 2010, pp. 380-381.

[68] As above, p. 380.

misalignment and mismatch because "physicians cannot feel secure that practicing reasonable care will protect them from being sued."[69]

The plaintiff or injured patient perspective of this fundamental problem of misalignment and mismatch is that the medical liability system in both the United States and Australia is neither just nor efficient in dealing with people injured by medical errors.[70] Medical errors may arise from skill-based lapses, or knowledge-based mistakes, whereas adverse events are generally seen as unexpected outcomes of medical treatment resulting in a longer-than-expected hospital stay, injury of even death.[71] Both books submitted for this examination, *The Surgical Litigation Crisis*, and *Medical Malpractice, Mistakes and Mishaps*, discuss in some detail various studies of rates of adverse events and medical errors. In the case of the United States, granted that all such studies have methodological limits, reviewers have concluded that there is "an *epidemic* of potentially preventable iatrogenic death in the United States."[72] The term "epidemic" is used by Brooks, for example.[73] The Institute of Medicine Report, *To Err is Human* (2000), claimed that between 44,000 and 98,000 Americans die annually as a result of medical errors – which are more than those who die from automobile accidents.[74] Although this report has been extensively criticised[75] there is general agreement that the extent of US and Australian injuries incurred

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[69] As above.

[70] Baker, cited note 26.

[71] T. B. Hugh, "Surgical Risk Management," *ANZ Journal of Surgery*, vol. 77, 2007, pp. 807-808, cited p. 807.

[72] D. M. Studdert (et. al.), "Beyond Dead Reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado," *Indiana Law Review*, vol. 33, 2000, pp. 1643-1686, cited pp. 1660, emphasis added.

[73] J. Brooks, "US Grapples with Solutions to Preventable Medical Errors," *Canadian Medical Association Journal*, vol. 180, no. 7, 2009, pp. E4-E5.

[74] Kohn (et. al.), cited note 27.

[75] C. J. McDonald (et.al.), "Deaths Due to Medical Errors are Exaggerated in Institute of Medicine Report," *JAMA*, vol. 284, 2000, pp. 93-95; R. A. Hayward and T. P. Hofer, "Estimating Hospital Deaths Due to Medical Errors," *JAMA*, vol. 286, 2001, pp. 415-420.

during hospitalisation is extremely costly. A recent study estimated that the "social cost" ("based on what people are willing to pay to avoid such risks in non-health care settings")for the US, is from US $393 billion to US $958 billion, equivalent to 18 percent and 45 percent respectively of the 2006 total US health care spending.[76]

The "social cost" of adverse events and medical errors in Australia is also high. The Quality in Australian Health Care Study involved a review of 14,179 medical records of admissions of 28 hospitals in New South Wales and South Australia in 1992.[77] It was found that 16.6 percent of admissions associated with an adverse event resulted in either disability or a longer hospital stay for the patient, caused by health care management errors. Fifty one percent of the adverse events were considered by the reviewers to have a high probability; 77.1 percent of the disabilities were resolved within 12 months, but 13.7 percent of the disabilities were permanent and 4.9 percent resulted in the death of the patient.[78]

In the United States there have been a number of important studies of the failure of not only the medical liability system, but of the sustainability of the civil litigation system itself.[79] The two books presented for examination develop this critique. *The Surgical Litigation Crisis* in its foreword contains a criticism by Professor Davies that the US material may have made the candidate offer a bleaker picture of the Australian civil justice system than is justified. This criticism will now be addressed in the context of showing the difficulty which injured patients, and others have in pursuing "justice" through the civil justice system.

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[76] J. C. Goodman (et. al.), "The Social Cost of Adverse Medical Events and What We Can do about It," *Health Affairs*, vol. 30, 2011, pp. 590-595.

[77] R. Wilson (et. al.), cited note 28.

[78] As above, p. 458.

[79] See C. Crier, *The Case Against Lawyers*, (Broadway Books, New York, 2002); P. K. Howard, *Life Without Lawyers*, (W. W. Norton, New York, 2009).

Former Australian Federal Attorney-General, Robert McClelland, and New South Wales Chief Justice Tom Bathurst, both see middle income earners in Australia facing what McClelland describes as a "lack of access to justice."[80] They have both observed a trend of middle income earners being unable to afford legal representation and appearing as unrepresented litigants. This is occurring in a variety of cases such as administrative law and claims for damages for compensation and may involve, as McClelland puts it having "to put your house on the line."[81] Legal AID is only available for individuals with a net annual income of less than AUS $16,000, after tax and other allowable deductions, and applicants need to meet asset and merit tests, as well as lacking the ability to pay for their own legal assistance by means of a loan. For legal AID a family of two adults and two children with only one adult working has to have an annual net income of less than $49,000. The means test is not annually adjusted for the CPI (consumer price index), which means that over time with a rise in the general level of prices, more people in need will fail to meet the income and assets tests. Consequently, middle income people will not qualify for Australian Legal AID and will become self-represented litigants. In Australian family law matters, the number of unrepresented parties is already around 30 percent.[82]

Former Chief Justice of South Australia, John Doyle, sees an end to civil litigation in the higher courts, within the time of the generation of practitioners being admitted to practice now; that is, within the next 40 years and this trend may continue into the lower courts (e.g. the Magistrates Court).[83] "Civil actions"

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[80] C. Merritt, "Court Costs 'Put Justice Out of Reach,'" *The Australian*, May 18, 2012, pp. 29-30. A rise in fees for Federal courts has also created concerns about access to justice: C. Merritt, "Hikes in Court Fees Endanger Access to Justice," *The Australian*, February 22, 2013, pp. 33-34.

[81] As above (May 18, 2012 article), p. 29.

[82] As above.

[83] Doyle cited note 25.

means all common law cause of action and statutory claims.[84] Doyle goes to great pains to be clear that this system "will come to an end"[85]; "the present system is doomed"[86]; "the problems in the common law system are too deep seated, and that in any event it has outlived its usefulness."[87] Doyle discusses a number of factors which "doom" the system, largely because they all increase costs.

Even though in general litigation 90 percent or more cases settle before trial, this is often not because a satisfactory compromise is reached, but rather because the parties realise that they cannot afford adverse cost orders if they lose or the stress of a trial is too much.[88] High costs arise in part from the use of highly qualified professionals and the "idea that the cost of civil litigation in the higher courts was in the past within the reach of the average wage earner is a myth."[89] High levels of costs arise from the method of dispute resolution which is trial-directed, but where less than 5 percent of cases actually go to trial.[90] Great costs are incurred preparing for an event that rarely occurs. As well, the time taken for parties to work through the interlocutory process also increases costs.[91] Law has also become increasingly complex and cases often have multiple causes of action. The option of alternative causes of action has arisen often from the build-up of statute law, as parliament responds to a social problem by creating a new body of laws.[92] *Medical Malpractice, Mistakes and*

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[84] As above, p. 241.

[85] As above, p. 246.

[86] As above.

[87] As above.

[88] As above, p. 242.

[89] As above, p. 243.

[90] As above.

[91] As above, p. 244.

[92] As above.

Mishaps, in chapters 6 and 7, provides an example of this with the law of the mandatory reporting of health professionals.

Doyle notes that another factor leading to the complexity of law (and ultimately to increased costs), has been a movement in the law to "individualised justice," that is, "justice perfectly attuned to the facts and circumstances of each particular case."[93] In the past courts applied general rules frequently and were less concerned about delivering justice precisely geared to the facts of the individual case, and the hard outcomes that sometimes arose, were accepted. This changed with developments in law such as unconscionability, promissory estoppel and misleading and deceptive conduct in trade and commerce, resulting in an increase in complexity of the law, and again, increased costs.[94]

Doyle says that the system of pleadings is inadequate and does not define the dispute or offer a framework for the trial but "conceal rather than expose the real dispute," often presenting a "confusing set of alternatives or cumulative claims."[95] A good example of this point is the Patel case, discussed in detail in chapter 7 of *Medical Malpractice, Mistakes and Mishaps*, where the High Court of Australia quashed Patel's conviction for manslaughter and unlawfully doing grievous bodily harm and ordered a retrial because of a miscarriage of justice, ultimately arising from, it is argued here, a poorly prepared prosecution case.[96] The High court said that the particulars supplied in the original trial were likely to be "legally incoherent," as the "many alternative bases relied upon for findings of guilt would necessitate individual assessments of causation which might not be consistent with each other."[97] In the more recent retrial,

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[93] As above.

[94] As above.

[95] As above, p. 245.

[96] *Patel v The Queen* [2012] HCA 29 (August 24, 2012).

[97] As above at [66].

Queensland Supreme Court judge Fryberg, in December 2012, told Queensland prosecutors that their case against Patel was "incomplete and embarrassing" and he ordered them to rewrite particulars of the manslaughter charge. Counsel for Patel had applied to have the manslaughter charge permanently stayed, as the particulars criticised by Fryberg J were the third version presented by the prosecution.[98] This is an example of a very high profile case pursued with the full legal resources of the state, and yet where matters went very wrong.

In summary, there is a medical/surgical liability crisis in both the United States and Australia, at least in the minimum sense that health professionals believe and act as if there were real and pressing litigation threats to medical and surgical practice. In both jurisdictions there is strong evidence of high rates of medical errors and adverse events, raising the problem of justice for injured patients. The presented books set out to seek to find a resolution of this dilemma, of sustaining physician confidence, but also seeking justice as far as possible for injured patients. In other words, the thesis material attempts a reconciliation of the so-called plaintiff and defendant positions in the medical liability crisis debate.[99]

2. The Argument of the Thesis

The argument of *The Surgical Litigation Crisis* is that even though there are methodologically challenging issues and a lack of objective data, there is a medical malpractice crisis, and also a surgical litigation crisis, which is more acute in the United States than Australia. From the physicians' perspective, especially in Australia, this crisis is substantially one of perception and fear of

[98] S. Elks, "Crown's Patel Case Embarrassing: Judge," *The Australian*, December 21, 2012, p. 5.

[99] I Hay, *Money, Medicine and Malpractice in American Society*, (Praeger, Westport, 1992); A. Mason, "Reform of the Law of Negligence: Balancing Costs and Community Expectations," *University of New South Wales Law Journal*, vol. 25, no. 3, 2002, pp. 831-835.

litigation. However, there are defects in the litigation system as outlined above, which are problematic not only in the area of health care, but which affect other areas of commercial life as well. These liability defects result in the problems of misalignment and mismatch discussed above, among other difficulties, producing not only stress and anxiety for physicians, but suboptimal results for afflicted patients.

A no-fault system would address many of these problems, especially aiding injured patients who at present "fall through the cracks" of the medical liability system. *The Surgical Litigation Crisis* (chapter 3), and *Medical Malpractice, Mistakes and Mishaps* (chapter 1), develop a case for the limits of torts, inadequately dealing with the medical liability crisis, and hence a case for a no-fault system.

Regarding the issue of the limitation of torts, most US states and Australian states, have enacted general tort reforms and medical malpractice tort reforms, including such reforms as: caps limiting non-economic damages; reform of the joint and several liability rule (the rule that in certain cases plaintiffs may sue several defendants to recover all or part of their damages); statute of limitation changes; limits on attorney contingency-fees; reform of the collateral-source rule (allowing defendants to deduce plaintiff payments from other sources e.g. health insurance); periodic payment reforms (insurers can pay out the award over time rather than in a lump sum); pre-trial screening panels, and other reforms.

There are differing opinions in the literature about the effects US tort reform has had on relative prices and profitability in the medical malpractice insurance industry, ranging from little effect at all,[100] to some effect.[101] Caps on non-

[100] F. Sloan, "States' Responses to the Malpractice Insurance 'Crisis' of the 1970s: An Empirical Assessment," *Journal of Health Politics, Policy and Law*, vol. 9, 1985, pp. 629-646; T. K. Floyd, "Medical Malpractice: Trends in Litigation," *Gastroenterology*, vol. 134, 2008, pp. 1822-1825, cited p. 1822.

[101] P. Danzon, "The Frequency and Severity of Medical Malpractice Claims: New Evidence," *Law and Contemporary Problems*, vol. 49, 1986, pp. 57-84.

economic damages reduce the average size of awards by 20 to 30 percent, but do not appear to affect claims frequency or have a significant economic effect on total payments.[102] Avraham details why: "One of the main reasons is that lawyers probably adapt their legal strategies to the new legal regime. After all, this is exactly what they are paid to do. Their strategies, whether selecting different types of cases, focusing on different types of claims, delaying settlements, or making efforts to mobilize a reversal of the reform, are probably effective in keeping the bottom line unchanged."[103]

Malpractice reforms have generated inequities, especially damage caps, which discriminate against the most severely injured.[104] Damage caps violate the "cardinal principle of distributive justice, "that welfare should not be distributed from those who are worse off, to those who are better off,[105] one of the moral incoherencies of the tort system.[106] Tort reform in Australia, as Vines says, "has been predicated on an assumption that the ideas of personal responsibility underlying the tort of negligence are wrong, and that the costs of negligence law must be reduced, but there has been no examination of the validity of the assumptions about the law, and no examination of the ideas of personal responsibility underlying the insurance process."[107] There is no comprehensive Australian literature, as found in the United States, examining whether the process of tort reform in Australia has been a "success" in achieving its "objectives."

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[102] C. H. Williams and M. M. Mello, cited note 7.

[103] R. Avraham, "An Empirical Study of the Impact of Tort Reforms on Medical Malpractice Settlement Payments," *Journal of Legal Studies*, vol. 36, 2007, pp. S183-S229, cited p. S222.

[104] D. M. Studdert (et. al.), "Are Damage Caps Regressive? A Study of Malpractice Jury Verdicts in California," *Health Affairs*, vol. 23, 2004, pp. 54-67.

[105] M. J. Mehlman, "Malpractice Reforms: Are They Fair?" *Clinics in Perinatology*, vol. 32, 2005, pp. 235-249, cited p. 241.

[106] R. L. Abel, "A Critique of Torts," *UCLA Law Review*, vol. 37, 1989-1990, pp. 785-831, cited p. 793.

[107] P. Vines, "Tort Reform, Insurance and Responsibility," University *of New South Wales Law Journal*, vol. 25, 2002, pp. 842-848, cited p. 848.

The candidate agrees with Burkle that the tort-based medical malpractice system is a "decaying system" which does not meet one of its assigned goals in "providing adequate legal assistance to patients who have been injured by negligent care."[108] In the Australian context Natelie Gray has argued that the tort-based medical malpractice system "is leading to medical decision-making which is legally, rather than clinically, indicated; is making it less likely that doctors will receive constructive criticism; and is adversely affecting the doctor-patient relationship and in turn patient outcomes."[109] Both *The Surgical Litigation Crisis* (chapter 3) and *Medical Malpractice, Mistakes and Mishaps* (chapter 1), put the case for a comprehensive no-fault system for both the United States and Australia, along the lines of New Zealand's *Injury Prevention, Rehabilitation and Compensation Act 2001* (NZ), and address standard criticisms such as that of excessive cost.[110] Nevertheless, there is little hope of no-fault systems being adopted in the foreseeable future in these jurisdictions, as Professor Harold Luntz, one of Australia's leading tort scholars has said: "retention of the common law seems sacrosanct. …No longer does the Woodhouse call for 'community responsibility' resonate among politicians and the public."[111] Although some of this sentiment has been revived in Australia with the National Disability Insurance Scheme (NDIS), at present the NDIS faces a cost blow-out of AUS $ 10.5 billion by 2018-2019 due to up to 45

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[108] C. Burkle, "Medical Malpractice: Can We Rescue a Decaying System?" *Mayo Clinic Proceedings*, vol. 86, 2011, pp. 326-332, cited p. 327.

[109] N. Gray, "Reforming the Relationship between Medicine and the Law of Tort," *Journal of Law and Medicine*, vol. 11, 2004, pp. 324-330, cited p. 324.

[110] S. Todd, "Privatization of Accident Compensation: Policy and Politics in New Zealand," *Washburn Law Journal*, vol. 39, 2000, pp. 404-495; D. M. Studdert (et. al.). "Can the United States Afford a 'No-Fault' System of Compensation for Medical Injury?" *Law and Contemporary Problems*, vol. 60, 1997, pp. 1-34.

[111] H. Luntz, "Looking Back at Accident Compensation: An Australian Perspective," *Victoria University of Wellington Law Review*, vol. 34, 2003, pp. 279-292, cited p. 292.

percent pay increases to social and community workers over eight years, and the scheme may not survive a change in government.[112]

The approach taken in both books is based on a jurisprudence of legal scepticism, recognition of the theoretical and practical limits of law and legal reasoning. The legal sceptic maintains that many of the most important legal questions cannot be decided by the methods of legal reasoning. This sceptical tradition in law and public policy runs from Thrasymachus (in Plato's *Republic*), to Hobbes, through to Critical Legal Studies (CLS)[113] and to individual figures such as Richard Posner[114] and Steven D. Smith[115]. Opposed to legal scepticism, as Posner puts it, are "a vast number of natural lawyers, legal conventionalists and formalists, including Cicero, Coke, Blackstone, and Langdell, not to mention the majority of contemporary lawyers, judges, and law professors."[116] Argument for legal scepticism parallels some of the arguments for more general epistemological scepticism in philosophy, such as the lack of coherence of fundamental concepts in many areas of law,[117] such as causation,[118] and the more general problem of the lack of unifying principles in areas of law such as negligence.[119] In chapters 8 and 9 of *Medical Malpractice, Mistakes and Mishaps*, the critique is directed to methods of reasoning, both inductive (probabilistic) and deductive, summarising the philosophical critique which the

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[112] J. Kehoe, "Disability Plan Could Top $ 10 Bn," *The Weekend Australian Financial Review*, August, 18-19, 2012, p. 1.

[113] J. Boyle (ed.), *Critical Legal Studies*, (Dartmouth, Aldershot, 1992).

[114] R. Posner, "The Jurisprudence of Skepticism," *Michigan Law Review*, vol. 86, 1988, pp. 827-891.

[115] S. D. Smith, *Law's Quandary*, (Harvard University Press, Cambridge, MA, 2004); S. D. Smith, *The Disenchantment of Secular Discourse*, (Harvard University Press, Cambridge, MA, 2010).

[116] Posner, cited note 114, p. 827.

[117] P. A. Alces, "The Moral Impossibility of Contract," *William and Mary Law Review*, vol. 48, 2007, pp. 1647-1671.

[118] Mendelson, cited note 41.

[119] J. J. Spigelman, "Negligence: The last Outpost of the Welfare State," *Australian Law Journal*, vol. 76, 2002, pp. 432-451, cited p. 442.

candidate has worked on for over 20 years as a professional philosopher.[120] Emeritus Professor Robert Fogelin (Professor of Philosophy and Sherman Fairchild Professor in the Humanities, Dartmouth College), reviewed these chapters for the publisher Edwin Mellen Press and said in review; "There is a widespread belief that logic and probability theory are rigorously developed disciplines, free of the difficulties found in other disciplines. This invites the idea that a discipline can be placed on a firm footing by grounding it in the rigorous procedures of, say probability theory. Following the pattern of the previous chapter [chapter 8], the authors go about showing that the supposed privileged status of these disciplines is an illusion. Logic, for example, has profound difficulties of its own, as witnessed by the plurality of competing logical systems and the existence of paradoxes that admit of no intuitively plausible solutions. As the authors shrewdly point out, in grounding legal argument in formal logic, legal reasoning bears burdens it never dreamed of: solving or getting around the Curry paradox, for example."[121]

In less abstract terms, the doctrine of legal scepticism is developed in both submitted works in a number of places. The limitation of torts has already been mentioned. Chapter 2 of *Medical Malpractice, Mistakes and Mishaps*, based on a paper published by the candidate and Guy Maddern in the *ANZ Journal of Surgery*,[122] discusses the High Court decision of *Chappel v Hart* (1998) 195 CLR 232, a judgment setting out the common law position in Australia on the matter of the negligent failure to disclose medical risks. The chapter defends

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[120] J. W. Smith *Reason, Science and Paradox,* (Croom Helm, London, 1986); J. W. Smith, *Essays on Ultimate Questions*, (Avebury, Aldershot, 1988); J. W. Smith, *The Progress and Rationality* of Philosophy, (Avebury, Aldershot, 1988).

[121] Professor Robert Fogelin, email to candidate, June 19, 2012: robert.fogelin@dartmouth.edu.

[122] J. W. Smith and G. Maddern, " The Negligent Failure to Disclose Medical Risks," *ANZ Journal of Surgery*, vol. 81, 2011, pp. 664-665.

Hugh[123], who argues that the case is an example of the gulf which exists between the ideas of medical malpractice litigation and surgical realities, a gulf which "occasionally results in serious defects in the presentation and judicial understanding of medical expert evidence and sometimes produces legal outcomes that seem nonsensical to practising clinicians."[124] Hugh examined the medical evidence of *Chapple v Hart* and found the majority view of the High Court of Australia defective from an evidence-based medicine perspective, because the injury to Mrs. Hart (right vocal cord palsy (VCP)) is likely to be the only recorded case where VCP arose after her specific operation (Dohlman operation). Hugh rightly observes that this is a case where the limitations of the use of expert scientific evidence in the court are displayed.

Chapter 5 of *Medical Malpractice, Mistakes and Mishaps*, discusses the problems of expert evidence further, examining cerebral palsy litigation in the United States and Australia, with the dual problems of "rogue experts" (junk science) and adversarial bias.[125] The candidate follows Davies in seeing a substantial contribution made to deal with these problems of expert evidence through the *Uniform Civil Procedure Rules 1999* (Queensland) and *Uniform Civil Procedure Rules 2005* (New South Wales). The rules eliminate "rogue" experts through measures including the selection of experts by agreement between disputing parties; or if there is no such agreement, by the court; by requiring experts when appointed who disagree to be able to produce a joint report stating the areas where they agree, disagree, and why, and requiring such experts to be sworn together and to be able to question each other. The problem discussed above, raised by Hugh, where the expert gave only a generalised

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[123] T. B. Hugh, "Surgical Sense and Legal Non-Sense – *Chappel v Hart* Revisited," *ANZ Journal of Surgery*, vol. 79, 2009, pp. 554-557; S. V. Fernandes, "Re: *Chappel v Hart res judicata*?" *ANZ Journal of Surgery*, vol. 80, 2010, pp. 568-569.

[124] Hugh, as above, p. 554.

[125] G. L. Davies, "Court Appointed Experts," *Queensland University of Technology Law and Justice Journal*, vol. 5, 2005, pp. 89-101.

response without being asked to search the literature, is best dealt with, it is argued in the thesis material, by lawyers improving the quality of their cross-examination of scientific experts.

These theoretical and case-based difficulties support a legal scepticism with respect to the medical/surgical liability crisis. As Charles Sampford, who sees the law as a disordered set of rules, principles and institutions, rather than an ordered one,[126] has said, a sceptical lawyer should assist clients "to steer a course that was well clear of uncertainty, away from the institutions of law."[127] Likewise, the solutions proposed by the books submitted for this examination largely focuses upon changes to medical and surgical practice, rather than ideal changes to the law.

The most important area for change is for strategies to reduce medical and surgical errors, which potentially lead to litigation in the first place. Chapter 2 of *The Surgical Litigation Crisis* and chapter 3 of *Medical Malpractice, Mistakes and Mishaps*, discuss strategies of error elimination and risk management. The medical profession should attempt to replicate the error-reduction and quality-control strategies used by other non-medical complex systems such as aviation.[128] Systems factors such as inexperience, lack of technical competence, communication failure and failure to systematically perform adequate checks, are among the factors contributing to medical error. Effective risk management will involve, among other things, credentialing medical staff, incident monitoring and tracking, complaints monitoring and tracking, infection control and documentation in the medical record. For surgery, use of the WHO 2008

[126] C. Sampford, *The Disorder of Law*, (Basil Blackwell, Oxford, 1989).

[127] C. Sampford, "Law, Ethics and Institutional Reform: Finding Philosophy, Displacing Ideology," *Griffith Law Review*, vol. 3, 1994, pp. 1-38, cited p. 7.

[128] D. J. Maurino (et.al.), *Beyond Aviation Human Factors*, (Avery, Aldershot, 1999).

guidelines for surgical practice have been found to lead to substantial drops in both the postoperative complication rate and death rate.[129]

Medical errors can be reduced, but not completely eliminated. Chapter 4 of *Medical Malpractice, Mistakes and Mishaps* puts the case for the importance of apologies and open disclosure in medicine. Patients, as Greene puts it, "want information about how and why the mistake occurred and how recurrence will be avoided and they want assurances that the physician felt regret about the error."[130] Apologies and open disclosure though constitute more than mere litigation protection, and are important parts of "therapeutic jurisprudence,"[131] helping us to live with less law. More will be said in the conclusion of this document about this.

Chapters 6 and 7 of *Medical Malpractice, Mistakes and Mishaps*, adds to the limits of law thesis in the context of medical malpractice through an examination of the mandatory reporting laws for Australian health professionals, through state and territory versions of the *Health Practitioner Regulation National Law Act 2009*. Chapter 6 gives a detailed outline of this law, and a critique and chapter 7 discusses the health system failures that gave rise to this law, in particular the case of "Dr Death," Jayant Patel. Registered health practitioners, employees of health practitioners and education providers are required to report "notifiable conduct" to the National Agency, the Australian Health Practitioner Regulation Agency (AHPRA) as soon as practicable. Section 140 of the *Health Practitioner Regulation National Law Act* defines the concept of notifiable conduct for a registered health practitioner, and includes four cases: (a) practised the practitioner's profession while intoxicated by alcohol and/or

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[129] E. N. DeVries (et. al.), "Prevention of Surgical Malpractice Claims by Use of a Surgical Safety Checklist," *Annals of Surgery*, vol. 253, 2011, pp. 624-628.

[130] E. Greene, "Can We Talk? Therapeutic Jurisprudence, Restorative Justice and Tort Litigation," in B. H. Bornstein (et. al. eds.), *Civil Juries and Civil Justice: Psychological and Legal Perspectives*, (Springer, New York, 2008), pp. 233-256, cited p. 242.

[131] D. B. Wexler, *Therapeutic Jurisprudence: The Law as a Therapeutic Agent*, (Carolina Academic Press, Durham, 1990).

drugs; or (b) engaged in sexual misconduct in connection with the practice of the practitioner's profession; or (c) placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or (d) placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards. Although there has been substantial opposition from health care professionals to mandatory reporting, which can also be seen in jurisdictions such as the United States,[132] there is little critical jurisprudence relating to these laws. Based on the candidate's paper with Guy Maddern, published in the *ANZ Journal of Surgery*,[133] a critique of this law is presented showing its indeterminacies, vagueness and inconsistencies. The argument draws upon the legal scepticism of chapters 8 and 9.

Mandatory reporting laws were parliament's response to a series of health system failures, the best known being the case of Dr Jayant Patel at Bundaberg Base Hospital. Mandatory reporting laws were said by politicians and much of the media to be needed to break the "protection racket" which physicians allegedly have for their own kind (police lore, for example calls this the "blue line code"[134]). However, a review of the Patel case shows that this is not true; that the problems leading to Patel (and others) arose from policies pursued by Queensland Health, and that surgeons and nurses were concerned about Patel's behaviour and voluntary reporting of Patel by a nurse did occur. The *Queensland Public Hospitals Commission of Inquiry (No. 2)* (The Davies Commission), made no mention in its recommendations of any need for mandatory reporting, but was highly critical of the economic rationalist hospital model adopted by

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[132] J. S. Weissman (et. al.), "Error Reporting and Disclosure Systems: Views from Hospital Leaders," JAMA, vol. 293, 2005, pp. 1359-1366.

[133] J. W. Smith and G. Maddern, "Surgical Ethics, Law and Mandatory Reporting," *ANZ Journal of Surgery*, vol. 81, 2011, pp. 855-856.

[134] G. R. Rothwell and J. N. Baldwin, "Whistle-Blowing and the Code of Silence in Police Agencies: Policy and Structural Predictors," *Crime and Delinquency*, vol. 53, 2007, pp. 605-632.

Queensland Health. The chapter also discusses the many legal errors in the trial of Patel, leading ultimately in *Patel v The Queen* [2012][135] to the High Court of Australia holding that Patel's manslaughter and unlawfully doing grievous bodily harm convictions, be quashed and a retrial ordered. It has already been mentioned in this review that Queensland prosecutors, in preparing particulars for the retrial, have been criticised by Queensland Supreme Court judge Fryberg for presenting an "incomplete and embarrassing" case against Patel, even in the retrial. This illustrates a basis for the legal scepticism forming the central jurisprudence of these works submitted for this examination.

Conclusion: The Research, Overall Significance and Contribution to Knowledge

The two books submitted for this PhD examination have examined the dual problems of physicians' perceived threats to medical and especially surgical practice, and justice for injured patients. The medical/ surgical liability crisis is not likely to be resolved by any of the *piecemeal* legal changes reviewed in the submitted books; if anything, the crisis will continue. A *substantial* legal change, such as the introduction of a no-fault system, is another matter; however this sort of large-scale legal reform is contrary to the economic rationalist culture prevailing in both Australia and the United States and we are not likely to see no-fault systems introduced any time soon in these jurisdictions, despite their merits.

Changes to the law reviewed in the two submitted books, including tort law reforms (both in the United States and Australia), have been of questionable benefit in dealing with the medical/surgical liability crisis. Evidence reviewed in

[135] *Patel v The Queen* [2012], cited note 96.

Medical Malpractice, Mistakes and Mishaps, indicates that even after tort reforms, physicians have a fear of litigation which impacts upon their medical practice through actions such as defensive medicine. Other legal reforms, such as the mandatory reporting laws for health professionals in Australia, fail to solve the problems which the laws were originally devised to address. It has been argued in *Medical Malpractice, Mistakes and Mishaps*, that this body of law is lacking in justification and coherence, the laws suffering from numerous technical difficulties.

The works submitted for examination are influenced by the maxim of the great Jewish philosopher Baruch Spinoza (1632-1677) who said: "He who tries to fix and determine everything by law will inflame rather than correct the vices of the world."[136] The works are also influenced by the thought of the former Chief Justice of South Australia, John Doyle, discussed in this Review, where he sees civil litigation itself as doomed because of an array of internal, technological and economic factors. Doyle sees Alternative Dispute Resolution mechanisms as becoming increasingly important. Philosophically this is part of the therapeutic or "Comprehensive Law Movement" which has reacted against the existing adversarial culture and proposes that lawyers should become empathetic problem-solvers who negotiate, mediate and reach consensus without engaging in the civil "warfare" of litigation.[137] The aim of the law with respect to civil disputes, especially in the area of medical malpractice, will be to maximise the welfare of both parties of the dispute rather than to decide the matter by the present Darwinian struggle of the survival of those with the deepest pockets. Some early signs of the emergence of this post-law position are discussed in the concluding chapter of *Medical Malpractice, Mistakes and Mishaps*.

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[136] Spinoza quoted from A. Roth and J. Roth, *Devils' Advocates: The Unnatural History of Lawyers*, (Nola Press, Berkeley, 1989), p. 54.

[137] See Wexler, cited note 131.

What then is the overall significance and contribution to knowledge made by this thesis material? Rather than the candidate offering a subjective speculation about this, it is possible to cite in conclusion the peer-review remarks of some eminent scholars who offered endorsements for the publisher Edwin Mellen Press, for the most substantial work of the two submitted, *Medical Malpractice, Mistakes and Mishaps*.

Professor Stanley Fish, Davidson-Kahn Distinguished Professor of Humanities and Professor of Law, Florida International University, Miami wrote: "Debates about medical malpractice usually take a polemical shape, with lawyers and unhappy patients on one side and medical professionals on the other. In their new book, Joseph Wayne Smith and Guy Maddern eschew polemics in favor of a detailed analysis of the relevant statistics and a bracing, but not nihilistic thesis about the law's inability to settle questions that are often more psychological and cultural than they are legal. An impressive achievement."[138]

Emeritus Professor Robert Fogelin, Professor of Philosophy and Sherman Fairchild Professor in the Humanities, Dartmouth College, has already been cited in praising the candidate's technical work in arguing for legal scepticism. He concludes his three page review for Edwin Mellen Press by writing: "This is a work of high technical sophistication and scholarly sweep that winds up on the side of good sense. It is an important book that should reorient the field of legal studies by bringing it back into contact with its primary subject matter: legal practice with its strengths and weaknesses."[139]

Professor Robert Dingwall, School of Social Sciences, Nottingham Trent University wrote: "This is a valuable, thoughtful and comprehensive

[138] Professor Stanley Fish, email to candidate, June 19, 2012: fish@fiu.edu

[139] Emeritus Professor Robert Fogelin, email to candidate, June 19, 2012: robert.fogelin@dartmouth.edu.

contribution to the continuing international debate about how medical and legal systems can best compensate for adverse outcomes of medical treatment."[140]

Professor David M. Studdert of the University of Melbourne Law School, who has published extensively in the field of research of this thesis, wrote: "Smith and Maddern cover an impressive amount of medico-legal terrain. They raise important questions about the proper role of law in shaping health policy."[141]

Professor James W. Jones, Visiting Professor, Center for Ethics and Health Policy, Baylor College of Medicine, wrote: "Smith and Maddern crafted a comprehensive scholarly examination of the Rube Goldberg machine known as medical tort law. The examination is conducted from multiple viewpoints: the distribution of compensation, the effects on physicians' practice, the weakness of tort law, the problem of medical mistakes, and the philosophy of the legal process. The book makes a strong case for further reform of an inefficient and ineffectual system."[142]

Professor Ian Freckelton, School of Law, Monash University wrote: "Building on their arguments in *The Surgical Litigation Crisis: Medical Practice and Legal Reform*, Smith and Maddern in this work challenge us to rethink the alignment between law and medicine. They argue for a reduced role for traditional medical litigation and the adoption of no fault dispute resolution schemes in a climate of open disclosure and, where appropriate, apology. Their work is a clarion call for practitioners, policy-makers and reformers alike to reflect on the counter-therapeutic aspects of the contemporary relationship between the practice of medicine and the law."[143]

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[140] Professor Robert Dingwall, email to candidate, June 27, 2012: robert.dingwall@ntlworld.com.

[141] Professor David M. Studdert, email to candidate, November 6, 2012: d.studdert@unimelb.edu.au.

[142] Professor James W. Jones, email to candidate, June 6, 2012: jwjones@bcm.edu.

[143] Professor Ian Freckelton, email to candidate, November 1, 2012: i.freckelton@vicbar.com.au.

Professor Gary D. Hankins of the University of Texas Clinic OBGYN, Galveston, Texas, wrote: "This treatise is a must read for all healthcare providers and policy makers involved in Obstetrical Care. It is well researched, well written and thought provoking. It can serve as a road map to a better tomorrow for all."[144]

Professor Kerry Breen, Department of Forensic Medicine, Monash University, wrote: "This is a refreshing, incisive, insightful and thoroughly researched critique of the frailties of the legal system, especially in regard to the impact of the system on the practice of medicine in the 21st century. It deserves a wide audience, particularly all those in the legal and medical professions who are involved in medical litigation, medical indemnity and medical regulation."[145]

Finally, Dr Kevin White, Reader in Sociology at the Australian National University, in a review for Edwin Mellen Press concluded with these words: "Overall the arguments made in this book are fascinating, rigorous, thought provoking and insightful. Its grasp of law, jurisprudence and philosophy is outstanding and the marshalling of a huge range of literature across these three fields is truly magisterial. I have no doubt that legal scholars and medical practitioners will find it required reading and that unlike many academic works, it will lead to practical purchase on the problems of medical practice."[146]

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[144] Professor Gary D. Hankins, email to candidate, May 30, 2012:ghankins@UTMB.EDU.

[145] Professor Kerry Breen, email to candidate, November 3, 2012: kerry.breen@bigpond.com.

[146] Dr Kevin White, email to candidate, November 2, 2012: Kevin.White@anu.edu.au.

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Title of Manuscript Submitted:

Joseph Wayne Smith and Guy Maddern, *The Surgical Litigation Crisis: Medical Practice and Legal Reform*, (Edwin Mellen Press, Lewiston, New York, 2010), copyright, Joseph Wayne Smith and Guy Maddern.

Publication status: This is a published work.

Statement of contribution: The candidate made the majority contribution in terms of the conceptualisation, documentation and realisation of the work, and preparation and submission for publication, and is the lead author of the book.

Certification by candidate that the statement of contribution is accurate:

Signed……..Dated……

Co-author name and address: Professor Guy Maddern, Discipline of Surgery, University of Adelaide.

Statement of contribution: contributed to planning of the book and provided critical evaluation, and guided research on technical surgical aspects of the project such as surgical risk management.

Certification by co-author that the statement of contribution is accurate and permission is given for the inclusion of the work in the thesis:

Signed……..Dated……...

Statement of Authorship (2)

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Title of Manuscript Submitted:

Joseph Wayne Smith and Guy Maddern, *Medical Malpractice, Mistakes and Mishaps: Essays on Medical Litigation, The Mandatory Reporting of Health Professionals and the Limits of Law*, (Edwin Mellen Press, Lewiston, New York, forthcoming, 2013).

Publication status: This is a forthcoming work in pre-publication at the time of the examination.

Statement of contribution: The candidate made the majority contribution in terms of the conceptualisation, documentation and realisation of the work, and preparation and submission for publication, and is the lead author of the book.

Certification by candidate that the statement of contribution is accurate:

Signed……..Dated……

Co-author name and address: Professor Guy Maddern, Discipline of Surgery, University of Adelaide.

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Joseph Wayne Smith

and

Guy Maddern

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