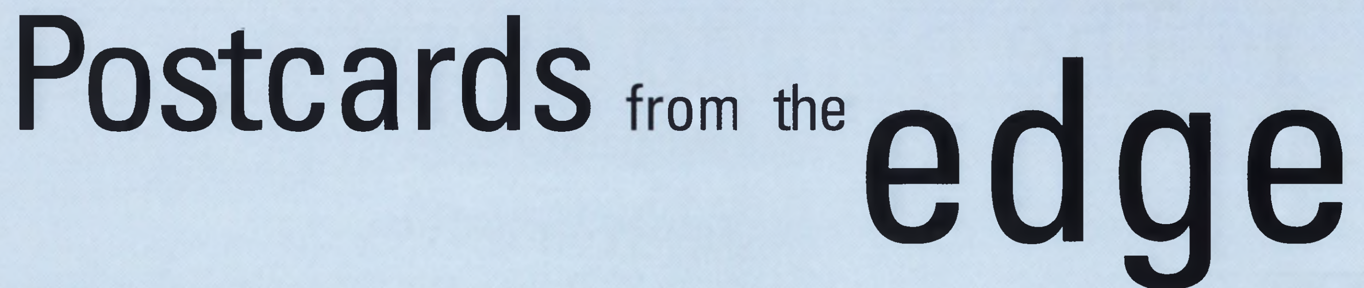

Postcards from the edge

Current issues in medical negligence litigation across the world

What are the medical negligence litigation issues in some of the major jurisdictions across the world? How far have developments overseas found their way into Australia, and are some of our recent and proposed changes appearing elsewhere? Bill Madden asked correspondents from England, Germany, Italy, Japan and South Africa to describe the latest trends in their countries and summarises the current situation in Australia.

FRANCES McCARTHY
REPORTS FROM ENGLAND

England has faced a huge amount of change in the world of personal injury claims, though it pales in comparison to the scale of the problems being experienced in Australia. We have been battered with an onslaught in the media alleging we are in the grip of a compensation culture. A great deal of this is due to the activities of 'claims farmers' cold-calling injured people, stopping them in shopping centres and charging referral fees, investigation charges and insurance premiums intended to be claimed from defendants. However, courts have cut the amounts of the premiums claimed, and declared part of the payments charged by claims farmers to be illegal.

As a consequence, claims management companies have suffered serious reverses. Market leader Claims Direct collapsed in 2002, followed by the next largest The Accident Group last year. Other companies have followed. However, they remain a feature of the personal injury legal market, with aggressive marketing tactics. There are now calls for them to be properly regulated.

Recent research has shown that the compensation culture is a myth, with numbers of claims in fact decreasing rather than rising. It found that 'the compensation culture is a myth but the cost of this belief is very real'. Whether that will be enough to convince a public saturated with compensation culture stories remains to be seen.

COSTS WAR

The introduction of changes to the conditional-fee agreement (no win no fee) – with the lawyer's success fee and the insurance premium (for cover against liability for the defendants' costs) being recoverable from the defendant in successful cases – led to a costs war. Defendant insurers were furious at the extra liability for costs and embarked upon a relentless campaign to avoid payment by raising technical points on the Conditional Fee Agreement rules.

Matters are beginning to settle down, with some issues being settled by industry agreement achieved through mediation and the Court of Appeal deciding test cases. However, an atmosphere of distrust remains and there are calls for contingency fees instead. This is a worrying development in a system where damages are barely sufficient, and there is no guarantee that these would be increased if costs were to be deducted from damages.

Fixed fees have been introduced for small, road-traffic cases (that is, below £10,000 [$25,700]) which settle without proceedings, and there remains a constant pressure for this to be extended to other areas.

Courts are also now looking at costs capping to monitor costs and there is pressure for 'costs budgeting'.

MEDIATION

There is increasing use of mediation in England. Courts have penalised parties in costs for failing to go to arbitration, although in the most recent case of *Halsey v Milton Keynes General NHS Trust* [2004] EWCA (Civ) 576, the Court of Appeal held that mediation should not be compulsory.

However, two pilot schemes are being run at present, one of which is a random automatic referral scheme and virtually compulsory.

DAMAGES

There has been pressure for some time for an amendment to the law to allow courts to award damages in instalments instead of the traditional lump-sum payments. Up until now the only way this could be achieved was by entering into a structured settlement which could not be imposed and which has a number of disadvantages – in particular that a sum is set for a future loss and then an annuity is purchased which may not produce the regular amount needed.

The *Damages Act* 1996 has been amended to give judges the power to order payment of awards by instalments (periodical payments) for the first time. The new rules are not yet in force but are likely to be introduced in October 2004.

The court will be required to consider these where there is a claim for future pecuniary loss and it may make such an award. It is not yet known how these will be used and what guidelines will be produced for the courts, in particular, as to how and in what circumstances they will be amended.

AKIHITO HAGIHARA
REPORTS FROM JAPAN

NEGLIGENCE AND BURDEN OF PROOF

Once a court ruling has revealed negligence, the established ruling is as follows. If the health professional acted in a manner that was widely accepted as standard care at the time of health service, he or she does not incur a liability with respect to negligence. However, if the criteria of standard care vary, depending on the area, decisions may differ in relation to the same negligent behaviour. This has been a significant problem in the past. However, as healthcare has become more uniform in recent years in Japan, interpretation of negligence rarely causes a legal problem at the present time.

What continues to be an important problem in Japan, however, is the burden of proof, which stands at a high >>

level. When a medical malpractice case is filed with a court, as a principle of tort law it is the responsibility of the plaintiff to show that the patient was given substandard care. If this rule is strictly enforced, it is extremely difficult for a plaintiff to demonstrate substandard care or negligence.

To resolve this problem, two suggestions have been made. First, once indirect evidence of injury associated with medical malpractice is demonstrated by the plaintiff, this implies that the injury has been caused through the negligence of the physician (res ipsa loquitur). Second, is the suggestion that medical malpractice cases should be judged under contract law, and not under tort law. However, with respect to the level of the burden of proof, in an actual litigated case there is little difference between the requirements of tort and contract law.

MEDICAL EXPERTS

To resolve the problems associated with the introduction of testimony by a medical expert witness, the following proposals have been made:

(1) A list of medical experts willing to support a civil court as medical expert witnesses, as well as an indication of their specialties, should be prepared. This list should be updated regularly.

(2) To achieve the first goal, civil courts and medical societies should establish close ties and collaborate in order to develop a system that would provide civil courts with appropriate information.

RONALD BOBROFF
WRITES FROM SOUTH AFRICA

Prior to 1994, South Africa was widely regarded as having one of the finest public healthcare systems in the world. First-world medical care was available free, or at little cost, to all South African citizens – to such an extent that prime ministers and members of cabinet would choose to receive medical care for themselves and their families at state hospitals. That the world's first heart transplant surgery took place at a state Cape Town hospital was testament to the extremely high level of expertise available.

Since 1994 – assisted by a Minister of Health whose peccadilloes include the belief that garlic, grated beetroot and lemon juice is an effective cure for AIDS – the situation has deteriorated to the extent that public healthcare facilities have effectively collapsed, even in the major centres. Consequently, any South African of means, or who has medical cover, has no choice but to utilise private healthcare facilities.

The problem is that invariably these facilities require patients to sign an admission agreement that includes a waiver clause, by whose terms the institution as well as all of its staff are absolved from any liability with respect to damages caused to patients flowing from negligence – including gross negligence.

With the advent of South Africa's Bill of Rights in 1997, it was hoped that the right of every South African to receive proper medical healthcare would be interpreted by the courts horizontally – that is, that negligence would be deemed to negate that right, and that waiver clauses, which effectively encourage lower standards and lack of accountability in healthcare, would be proscribed by the courts.

In the celebrated case of *Strydom vs Afrox Health Care* [2001], the court recognised this principle. It held that the waiver clause in question was inconsistent with the values in South Africa's Constitution and Bill of Rights, and was against public policy, as well as conflicting with the principles of good faith.

Sadly, this landmark case has been overruled on appeal to the Supreme Court of Appeal (SALR 2002 Vol 6, p21), which adopted a strict-law approach to the effect that 'the elementary and basic general principle was that it was in the public interest that contracts entered into freely and seriously by parties having the necessary capacity should be enforced'.

Having regard to the fact that some 80 per cent of South African citizens are functionally illiterate and therefore quite

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unable to understand, let alone read, most hospital admission contracts, the decision is surprising. Nevertheless, it has largely closed the door to actions against hospitals, leaving claimants with little choice other than to sue negligent staff, most of whom are persons of limited means and would be quite unable to satisfy any judgment.

SABINA ROSSETTI
WRITES FROM ITALY

With a plethora of legislation in Italy, and no specific Act covering medical negligence, court decisions are the best indicator of principles being used. In a decision this year,[1] the Supreme Court stated that contractual law is the appropriate system for medical negligence cases. One benefit of this is the fact that this system provides a limitation period of ten years, compared to five in tort law.

Since contractual law states that claimants are only required to prove that the outcome of a professional act – cure, surgery or whatever – is different from what it was supposed to be (a sort of presumption of fault), defining the standard of care is not the main issue, as it is in tort. The plaintiff has only to show the existence of the agreement with the professional.

It is too early to say whether or not this Supreme Court decision will be the leading one in the future, though it assists in the resolution of present cases by reducing the possible definitions of standard of care.

FAIL TO WARN

Failure to warn is a much-debated concept and to establish what a claimant would or would not have done if properly informed about risks related to a medical procedure remains a big issue. There is no doubt that the duty of disclosure is a burden for the professional – if one fails to warn, courts tend to consider this misconduct an added factor in working out the value of damages.

EXPERT EVIDENCE

Judges may appoint their own medical experts as well as the medical experts instructed by the parties.

DAMAGES[2]

As well as pecuniary losses (earnings and medical expenses), determined by the court according to the circumstances of the case, there are various types of non-pecuniary losses – for biological damage, that is, loss of physical and/or mental integrity (*danno biologico*); loss of quality of life (*danno esistenziale*) and non-pecuniary losses for infringement of rights protected by the legal system (*danno non patrimoniale da lesione di posizione garantita dall'ordinamento*); and pain and suffering (*danno morale*).

In Italian legislation there are neither higher-end caps on general damages for pain and suffering, nor lower-end thresholds to prevent 'small' claims. Previous interpretation by the Constitutional Court was that 'pain and suffering' derived from a crime, and could be caused only by criminal conduct or behaviour. Recent judgments[3] have shifted to a wider interpretation. A professional's misconduct no longer has to be evaluated as a crime to entitle the plaintiff to claim for pain and suffering.

Only some forms of mental suffering arising from negligence can be classified as psychiatric damage – to obtain compensation the plaintiff must prove that a recognised psychiatric disorder, or disease, has resulted.

The real issue on damages for *danno biologico* concerns decisions on basic monetary values for conditions, and their uniformity at the national level. Many local courts have adopted their own tables for determining biological damage. Assessments of *danno esistenziale* and *danno morale* by the courts are generally based on precedent.

CHRISTINE PROEMMEL
REPORTS FROM GERMANY

In Germany numbers of medical negligence cases have been increasing over the past 30 years – from about 6,000 claims a year in the '70s, to roughly 35,000 claims a year now being reported to insurance companies.[4] In about 35 per cent of these an error is found in treatment. However, this is not seen as unusual or distressing. In relation to other comparable professions it is quite normal,[5] and in light of the great number of daily medical treatments made by more than 250,000 practising doctors, the number of claims is relatively low.[6]

It is noteworthy that damages awarded are generally below 30,000 Euros ($1,750). However, in recent years amounts have increased, and damages of more than 200,000 Euros ($345,000) are no longer a rarity.[7] In cases of the most severe injuries, amounts of one million Euros ($1,725,000) for pain and suffering, in addition to a monthly pension, are reached and exceeded.[8]

REFORM

German law does not have any special rules or regulations for medical malpractice claims and medical malpractice is based on case law. Thus the demands of scrupulousness, the obligation to respect the patient's right of self-determination and the subsequent obligation to inform the patient before treatment, as well as the >>

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duty of documentation and duty to allow discovery and inspection, have been modified by court decisions. Calculation of compensation for personal injury is based on the case law of the German civil courts.

Since the law amending legislation on damages in 2002, an injured patient can claim compensation for damages not only by the law of torts, but also via contractual liability. A consequence is that if an error in treatment is determined, a doctor has to prove that they are not guilty of negligence.[9] However, in practice there have been few cases where the court found an error in treatment without negligence.[10]

Another effect of this reform is equalising the statute of limitation periods. The usual statute of limitations in Germany is three years. Claims for damages in respect to injury to the body or health, such as medical malpractice cases, are an exception – in these the limitation period is 30 years, as in contractual liability. The statute of limitations for minors is the same as for adults unless the minor has no representative – it is usually a parent – when the limitation period does not run out until the minor reaches the age of majority. In practice, these modifications do not have much impact either, as prevailing case law has already tried to answer important questions in the same way.[11]

FAILURE TO WARN

Medical surgery is still seen as physical injury by the German courts and only legalised by the patient's consent. This consent takes effect only if the doctor informs the patient about all necessary actions, their urgency, and possible alternative treatments. The patient's individual situation at the time of treatment is the deciding factor.

Giving information about the planned process and risks of planned surgery forms a central part of the duty to inform patients. Informing patients about alternative procedures is also part of risk warning. Formerly, claimants complained about unexplained risks. Nowadays, patients in Germany complain mainly about not being informed of alternatives. The reason for liability in these claims is

that only if the patient is adequately informed about the planned treatment is he or she able to understand what's going on and thus able to deliberate about advantages and disadvantages of the treatment.

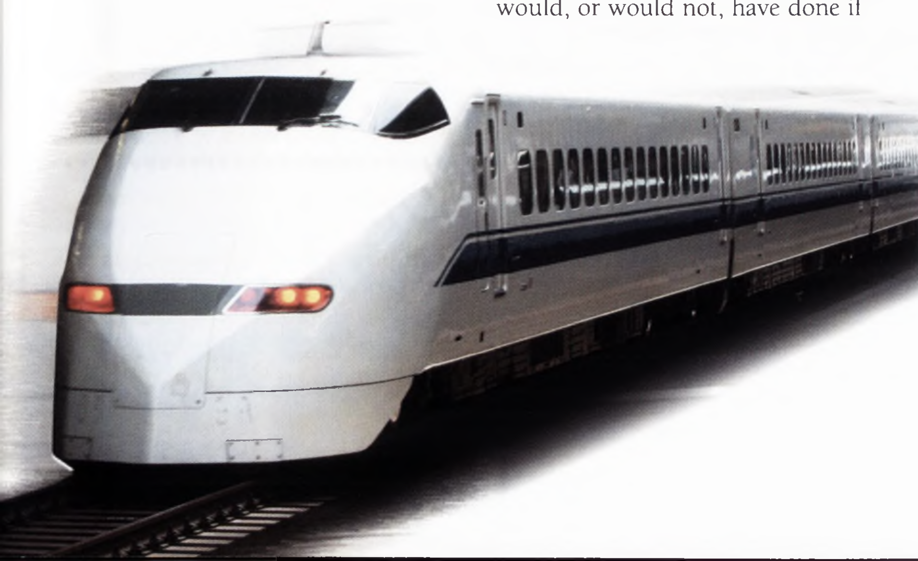
The time frame in which the clarification is given is important. The German Federal Supreme Court states that informed consent is effective only if patients are free to make up their mind under the given circumstances. If someone gets clinical treatment, clarification only one day before the surgery is too late. The amount of time required between clarification and surgery depends on its urgency and severity.

NEGLIGENCE/EXPERT EVIDENCE/DAMAGES

Significant in considering an error in treatment is whether the service provided was widely accepted by peer professional opinion as competent professional practice at the time.

As opposed to the Australian system, the medical expert is appointed by the court and the court determines the scope of the expert opinion. The expert's opinion is not binding on the court. However, it will usually base its decision on the findings of the medical expert, and rely on their expertise.

Most damages are awarded as a single payment under German law. Benefits from private insurance policies or public insurance do not affect the amount of these awards. There are no higher-end caps nor lower-end thresholds on general damages for pain and suffering.



BILL MADDEN
REPORTS ON AUSTRALIA

Until a series of civil liability statutes in Australia in 2002 and 2003,[12] the task of defining the duty of care to be exercised by a medical professional had been left to the courts. However, the medical profession felt, rightly or wrongly, that courts were on occasion too willing to supplant their own views of what appropriate medical practice should be, rather than listen to the experts. Concerns were also raised by isolated cases where perhaps a generalist doctor was judged to the standard of a specialist, or to a standard applied elsewhere but not in Australia.

So we have seen attempts to redefine the standard, such as in NSW's *Civil Liability Act* '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'.

FAILURE TO WARN

The courts have been, and still are, required to determine what a claimant would, or would not, have done if properly informed and warned of risks prior to a medical procedure. Recent reforms have not substituted an objective test of what a reasonable person would have done.

However, the evidence of the claimant as to what they would have done, if so warned, is no longer admissible – unless the claimant concedes the warning would have made no difference to their decision.[13] Such evidence was otherwise thought to be so self-serving as to deserve no weight. It seems the courts must instead approach their task in such cases as a 'matter of hypothesis based upon an evaluation of circumstances that did not in fact occur, rather than an assessment of whether the respondent was telling the truth about her postulated belief'.[14]

Again, it is not yet apparent if this represents any real departure in substance from the pre-existing common law.

AD HOC LEGISLATION

Some of the more 'tort-reform oriented' jurisdictions have fallen into a habit recently of prompt statutory enactments should courts deliver decisions that appear contrary to the government's views on when compensation ought to be awarded. Unsurprisingly, this follows controversial cases. Two examples will suffice, in the medical context.

In a recent case[15] a person suffering psychiatric illness was not properly treated (and possibly detained) in a hospital. Soon after, in a delusional state, he assaulted and killed another person. He went on to claim compensation for the consequences of that for him (as no doubt the victim could have also, had she survived). A statutory amendment followed,[16] precluding such claims.

Similarly, after the success of a claim seeking the costs of raising a child without disability,[17] following a failed sterilisation procedure, a statutory amendment followed.[18]

LIMITATION PERIODS

Roughly, those jurisdictions that had six-year limitation periods have seen them reduced to three. >>

More importantly, it was previously the case that the limitation period for a child would not commence until their majority – that is, 18 years plus three years. If the claim was for a childbirth injury, the claim might not be brought for up to 21 years, which insurers found troublesome. Now, over-simplifying, the three-year limitation period will also apply to a child,[19] though there are exceptions,[20] and provisions for extension in some circumstances.[21]

EXPERT EVIDENCE

This remains an area prone to heated debate with allegations, particularly by defendant medical practitioners, of claimants using 'hired gun' biased witnesses, and persons of limited competence being prepared to give evidence outside their field of expertise. Claimants, on the other hand, complain of their difficulty in retaining medical practitioners who are prepared to criticise the negligence of others. These issues persist, despite many courts having implemented codes of conduct to help expert witnesses understand their roles and duties.

Provision often exists now for pre-trial conferences between experts, and for the parties or the court to seek the opinion of a single 'joint' expert for both parties. However, in practice, cases that proceed to trial still usually do so in the traditional way, with experts giving opinion evidence for one party or the other, leaving the court to reach a decision. Whether this is really a problem remains in the sphere of anecdotal argument.

DAMAGES

The changes referred to above may be justified on legal or philosophical grounds.

However, the changes made to the law regarding quantification of damages are for the most part justified purely on economic grounds – to reduce the quantum of claims and hence to reduce medical indemnity insurance premiums.

So most Australian jurisdictions have seen:

- higher-end 'caps' on general damages for pain and suffering;
- lower-end 'thresholds' for the award of general damages for pain and suffering, to prevent small claims;
- caps on recoverable loss of wages, at a multiple of average weekly earnings, no matter what the actual loss may be;
- limitations on damages recoverable for the value of care provided gratuitously, by friends or family (again by reference to average weekly earnings);
- abolition of interest recoverable for some past losses; and increase of the discount rate on future losses (in effect implying a higher assumed interest rate net of inflation upon investment of a lump sum).

Long-term care costs remain the single biggest component for major claims, which has led to much discussion, though no implementation yet, of a long-term care scheme. The suggestion is that a successful claimant would be able to make use of such a scheme rather than receive a lump-sum amount with which to make their own arrangement for the provision of such care.

COURT SYSTEM

Perhaps partly for the reasons touched on above regarding expert evidence, the medical profession has continued to lobby for fundamental change to the court system. Various proposals have been made, generally for a panel of doctors, rather than a judge or jury, to determine the merit of medical negligence claims. So far such proposals have not found favour with governments. ■

Notes: **1** Supreme Court, n. 10297, 28 May 2004. **2** *Personal Injury Compensation in Italy* by Marco Bona. **3** nn. 8827 e 8828 del 2003, Corte di Cassazione, n. 233 del 2003, Corte Costituzionale. **4** Giesen Arzthaftungsrecht Rn. 313, Katzenmeier S. 41; Deutsch Medizinrecht Rn. 173. **5** Hirte Berufshaftung insbes. S. 146f. **6** Laufs, Arztrecht Rn. 552: Klagen weit geringer als 1 Promille; Schlund in Laufs/Dierks/Wienke/Graf-Baumann/Hirsch „Die Entwicklung der Arzthaftung" S. 333 (334); Krumpaszky/Sekte/Selbmann VersR 1997, 420 (427); Katzenmeier S. 43. **7** Stein in Mü/Ko § 847 Rn. 8; Scheffen ZRP 1999, 189ff. **8** Jung in Laufs/Dierks/Wienke/Graf-Baumann/Hirsch S. 85 (94); Jahn Kümper MedR 1993, 413 (414). **9** Deutsch JZ 2002, 588; Katzenmeier VersR 2002, 1066, Heinrichs in Palandt, § 280, Rn. 42. **10** Heinrichs in Palandt, § 280, Rn. 42. **11** Hart in Jura 2000, 14 und 64/70; Katzenmeier Arzthaftung S. 81. **12** For simplicity, I will refer mostly to the NSW *Civil Liability Act* (CLA NSW). There are variations in the seven Australian jurisdictions. **13** Section 5 D (3) CLA NSW. at *www.austlii.edu.au/au/legis/nsw/consol_act/cla2002161/s5d.html*. **14** *Hoyts v Burns* [2003] HCA 61. **15** *Presland v Hunter Area Health Service* [2003] NSWSC 754. **16** Section 54A CLA NSW at *www.austlii.edu.au/au/legis/nsw/consol_act/cla2002161/s54a.html*. **17** *Cattanach v Melchior* [2003] HCA 38. **18** Section 71 CLA NSW at *www.austlii.edu.au/au/legis/nsw/consol_act/cla2002161/s71.html*. **19** Section 50C *Limitation Act* NSW at *www.austlii.edu.au/au/legis/nsw/consol_act/la1969133/s50c.html* **20** Section 50E *Limitation Act* NSW. **21** Section 50D *Limitation Act* NSW.

Ronald Bobroff *is senior partner at Ronald Bobroff & Partners and current Vice-President of the Law Society of South Africa.*
Akihito Hagihara *is Associate Professor of Social Medicine at the Kyushu University Graduate School of Medicine, Japan.*
Bill Madden *is a partner, professional negligence, at Slater & Gordon, Sydney.* **PHONE** *(02) 8267 0600.* **EMAIL** *wmadden@slatergordon.com.au.*
Frances McCarthy *is head of personal injury at Pattinson & Brewer, London, and President of the Association of Personal Injury Lawyers (APIL), UK.*
Christine Proemmel *is a lawyer in Germany.*
Sabina Rossetti *is an advocate in Italy.*

Correspondents who have contributed to this article can be contacted via Bill Madden.