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Defensive medicine in general practice: Recent trends and the impact of the Civil Liability Act 2002 (NSW)

ABSTRACT

This article presents the results of a survey conducted among New South Wales medical practitioners to assess the extent to which the enactment of the Civil Liability Act 2002 (NSW) has reduced the practice of defensive medicine. The new legislation was intended in part to reduce the practice of defensive medicine, both assurance-type measures, such as performing additional tests to assure patients they have received all possible care, and avoidance-type measures, such as avoiding the treatment of patients who may be at a higher risk for adverse outcomes and therefore at higher risk for filing lawsuits. However, the results of the survey reveal that many medical practitioners in New South Wales remain unaware of the legal reforms and the consequent reduction in their legal liability and continue to practise defensive medicine. This article argues therefore that while the ultimate aim of reducing litigation has been achieved in New South Wales through the introduction of the Civil Liability Act, the underlying and arguably more important aim of providing medical practitioners with a more secure environment in which to practise their profession effectively has not been achieved. The apparent failure to disseminate the legal changes to the medical profession illustrates the limitations of law reform to effectively engender social change without the active use of educative and other implementation initiatives.

(2009) 17 JLM 235 at 236

Introduction

A series of high-profile cases in the tort of negligence and dramatic increases in professional insurance premiums were documented extensively in the Australian media throughout the late 1990s. Although there was no evidence of an 'explosion of litigation' in recent years, the New South Wales Parliament voiced serious concerns that health professionals, fearing the legal consequences of medical errors, were resorting to defensive medicine. Defensive medicine can be defined as the combination of, on the one hand, assurance-type measures, such as performing additional tests to assure patients they have received all possible care or, on the other hand, avoidance-type measures, such as avoiding the treatment of patients who may be at a higher risk for adverse outcomes and therefore at higher risk for filing lawsuits. The potential of defensive medicine to impact significantly on the provision of health care has been extensively documented in the literature. Commentators argue that defensive medicine

- escalates the costs of health care delivery;
- increases the risk of iatrogenic injury;
- worsens the risk of psychological harm to patients;
- damages the important relationship of trust between the medical practitioner and the patient;
- encourages the concealment of errors;
- reduces access to health services; and
- hinders the adoption of new technologies.

In response to the perceived litigation and insurance crisis, including its potential impact upon the medical profession, the Ipp Panel was established by the Commonwealth Government to make recommendations on how to reform the common law of negligence in order to limit liability and quantum of damages arising from personal injury and death. In the ensuing report, Review of the Law of Negligence (the Ipp Report), the Ipp Panel proposed a raft of changes to common law negligence and recommended that they be incorporated into a single statute to be enacted in each jurisdiction. The Civil Liability Act 2002 (NSW) (Civil Liability Act), although enacted before the release of the Ipp Report, incorporates many of the changes recommended by the Ipp Panel and now determines the extent of liability in the tort of negligence in New South Wales.

This article begins with an overview of the key limitations placed on medical negligence actions by the enactment of the Civil Liability Act. While it might be anticipated that the reforms, which have led to a significant reduction in negligence claims in New South Wales, have resulted in a rise in civil liability actions, a survey of New South Wales medical practitioners conducted in 2004 demonstrated that medical practitioners were not aware of the new laws and reforms and continued to practice defensive medicine in response to perceived legal threats.
South Wales, would, as a corollary, reduce the practice of defensive medicine, this article presents the results of a survey conducted among New South Wales medical practitioners that indicates otherwise. Indeed, the results of the survey reveal that many medical practitioners remain unaware of the legal reforms and the consequential reduction in their legal liability and continue to practise defensive medicine. This article argues therefore that although a significant reduction in tort litigation in New South Wales has resulted from the introduction of the Civil Liability Act, this has not, despite the ancillary aims of the reforms, led to a reduction in the practice of defensive medicine. The apparent failure to convey the (beneficial) ramifications of the tort law reform changes to the medical profession reinforces the need to complement law reform with appropriate educational and informational measures.

The article overviews the tort of negligence and the impact of the Civil Liability Act reforms on medical negligence actions and examines the significant reduction in medical negligence actions in

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New South Wales since the introduction of the new legislation. It then defines defensive medicine and presents the key results of a survey conducted among New South Wales medical practitioners. The survey revealed that defensive medicine continues to be prevalent since the enactment of the Civil Liability Act and, additionally, that medical practitioners have limited knowledge and understanding of the reforms and their impact. In conclusion, it is suggested that the reforms have failed to reduce the practice of defensive medicine.

The impact of the Civil Liability Act 2002 (NSW) on medical negligence actions

The impact of the Civil Liability Act 2002 (NSW) on medical negligence actions

The Civil Liability Act introduced a number of significant changes to the tort of negligence, which, in the modern industrial era, is the main avenue for compensatory redress for personal injuries. Prior to the enactment of the legislation, negligence actions in New South Wales were primarily governed by the common law and had undergone considerable expansion in terms of potential defendants, potential plaintiffs and in relation to the forms of injury that could give rise to compensation. Medical negligence, in particular, had also rapidly expanded its scope with a number of landmark cases extending the liability of medical practitioners in a range of ways, including the following:

- the expansion of the duty of care to make liable public authorities, including public health institutions in an increasing range of circumstances;
- holding medical practitioners to the standard of care of the reasonable practitioner when they render assistance to someone while off-duty;
- the denial of the Bolam principle (which had previously enabled a practitioner to escape liability if he or she could provide evidence of a body of practitioners who would have acted similarly in similar circumstances) in situations of a negligent failure to warn of a risk;
- liability for a failure to warn a patient of a medical risk, even when the risk was small, if the plaintiff could show that she or he would not have gone ahead with the procedure had the warning been given;
- the awarding of damages in wrongful birth actions (when a medical practitioner is negligent in the administration of a sterilisation procedure or abortion and an unplanned birth results) originally for the costs of the pregnancy and the birth but subsequently extended to the costs of raising the child until maturity or independence; and
- finally (and importantly) the expansion of the scope of the law of damages in a range of ways. This included dramatic increases in awards for non-economic losses such as pain and suffering and loss of amenities, and the recognition of new heads of damages such as gratuitous attendant care services, when an injured person’s need for care and assistance as a result of their injuries is met by relatives and friends without payment or the expectation of payment.

Indeed, the introduction of the Civil Liability Act brought to a halt the rapid expansion of the law of negligence in the New South Wales jurisdiction. The legislation ushered in a range of reforms which were intended to achieve, and appear to have been successful in achieving, considerable limitations on the ability of plaintiffs to sue in negligence generally and also in medical negligence. The reforms that particularly limit medical negligence actions are detailed in the following section and include:

- limiting the duty of care owed by public authorities, including health authorities;
- the introduction of a modified Bolam principle;
- the exclusion of the plaintiff’s evidence in establishing causation in failure to warn actions;
- the prohibition of damages for the costs of child rearing in wrongful birth actions;
Limiting the duty of care owed by public health authorities

Limiting the duty of care owed by public health authorities

The High Court of Australia has adopted the approach that all persons, corporations and authorities, public or otherwise, are subject to the general law of negligence and therefore are liable to compensate those whom they injure through their lack of reasonable care and to whom they owe a duty of care. While different considerations are balanced when determining who owes a duty to whom and which factors are to be considered when determining the necessary standard of care, or breach of a duty of care, broadly speaking, public and other authorities are subject to the same principles of liability as persons generally. The scope of the duty of care owed by public authorities, including public health institutions, however, in relation to their discretionary powers is more complex and underwent enormous expansion in the High Court in the late 1990s and early 2000s, culminating in a series of high-profile cases in which considerable damages payouts were highlighted in the media. In New South Wales this trend culminated in Presland v Hunter Area Health Service [2003] NSWSC 754, where the plaintiff was taken to hospital by police following an episode of irrational and violent behaviour and then subsequently examined and discharged by a psychiatric registrar. Within six hours of the discharge, he had killed his brother’s fiancée. After being acquitted of the murder on the grounds of mental illness, Presland initiated a civil claim arguing that the Hunter Area Health Service and the psychiatrist had been negligent in failing to detain him as an involuntary patient. Although the successful action in the New South Wales Supreme Court, which extended the potential liability of both mental health professionals and statutory bodies entrusted with administering health services to acts committed by their patients, was subsequently overturned in the Court of Appeal, it prompted the New South Wales Parliament to announce two days later that it would change the law to close the legal loophole.

(2009) 17 JLM 235 at 239

Although the Civil Liability Act prior to Presland had already made it considerably more difficult to find liability in a public authority, a new section was inserted into the Act which, although not yet subject to extensive judicial interpretation, grants a statutory immunity to all public and other authorities with respect to the exercise of their special statutory powers unless it was so unreasonable that no authority having the special statutory power in question could properly consider the act or omission to be a reasonable exercise of, or a failure to exercise, its power. Although the meaning of special statutory power is not yet judicially defined and will be determined in relation to the particular material facts of the case at hand, it is likely that the power to detain under the Mental Health Act 2007 (NSW), eg, is such an extraordinary or special power that, in a similar situation to Presland, an immunity would apply.

The second part of the provision, which provides immunity unless the exercise or failure to exercise is so unreasonable that it could not be considered reasonable, is clearly a very difficult test to satisfy. Indeed, Lord Diplock, in applying the same test in public law matters, stated that a failure to act would have to approach the bizarre in order for the immunity not to be invoked. Public health authorities in New South Wales, with respect to their exercise or non-exercise of special statutory powers, therefore now have a level of immunity that the common law in Australia would not otherwise grant. Additionally, the New South Wales Parliament (also in a direct response to the Presland case) introduced at the same time a provision into the Civil Liability Act that specifically limits the damages that may be recovered for non-economic or certain economic losses resulting from an act that would have been a crime but for mental illness. Premier Iemma explained that the new provisions were aimed at countering the risk that doctors will behave too conservatively, detaining patients unnecessarily, out of fear that they can be sued by the patient for anything he or she does if not detained, an explicit reference to the practice of defensive medicine by medical practitioners.

The introduction of a modified Bolam principle

The introduction of a modified Bolam principle

Medical practitioners must carry out their professional responsibilities at a particular standard in order to avoid liability in medical negligence. The Bolam principle, first articulated in England and subsequently adopted in Australia, made that standard a matter of determination by medical practitioners themselves rather than the judiciary, so that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In Rogers v Whittaker (1992) 175 CLR 475 the High Court denied the defendant medical practitioner the use of the Bolam principle in relation to a failure to warn of a risk, and although the court accepted that, in relation to diagnosis and treatment, professional opinion will have an influential and often decisive role to play, it determined that the ultimate decision lay with the court. The rejection of the Bolam principle marked a significant point in the increasing liability of medical practitioners in medical negligence actions. The Civil Liability Act, however, has incorporated a modified form of the Bolam principle and restored to the medical profession the authority, in the areas of treatment and diagnosis, which some considered it had unfairly
lost as a result of Rogers v Whitaker,\textsuperscript{[37]} the ability to draw on the support of other practitioners to avoid liability for a negligent act. A professional avoids liability in relation to the provision of a professional service if he or she acts in a way which is widely accepted in Australia by peer professional opinion as competent professional practice. Although the application of the provision is limited – it does not apply to the duty to warn of a risk and it does not apply to an opinion if the court deems it to be irrational – it clearly and explicitly reinstates the Bolam principle to the benefit of medical practitioners in the areas of diagnosis and treatment. As such, it represents a significant reduction in the scope of their liability for medical negligence. \textsuperscript{[38]}

Excluding the plaintiff’s evidence in establishing causation

Excluding the plaintiff’s evidence in establishing causation

An action in negligence requires the plaintiff to establish that the defendant’s breach of duty caused the injuries suffered by the plaintiff. In a situation where the negligence is the failure of the medical practitioner to warn about a potential risk, causation is difficult to determine since it is necessarily contingent on what the plaintiff would have done had the warning been given. If the plaintiff would have abstained from the procedure, then the injuries would not have occurred. However, if he or she would have gone ahead despite the warning, then the injuries would not have been averted. In Rogers v Whitaker, subsequently reaffirmed and more fully articulated in Rosenberg v Percival (2001) 205 CLR 434, it was determined that the test was subjective and that therefore the critical question was what the particular plaintiff (rather than the hypothetical plaintiff) would have done had she or he received the warning. In Rogers v Whitaker the plaintiff, who was blind in her right eye, had questioned her doctor closely about possible complications including possible damage to her left eye. There was a remote risk, of which she was not told, that the operation to the right eye could affect her left eye. This, in fact, eventuated, leaving her totally blind. She succeeded on the element of causation at trial, in the New South Wales Court of Appeal, and in the High Court where all of the judges accepted that, had the warning been given, the plaintiff would not have proceeded with the operation. In contrast, in Rosenberg v Percival, where a dental surgeon failed to warn his patient appropriately about risks associated with an osteotomy to correct a malocclusion of her jaw, the court held that, in response to the question of whether, if she had been made aware of the risk, she would have declined the surgery, she would have gone ahead with the surgery despite her express evidence to the contrary. \textsuperscript{[39]} Although the medical practitioner was not held liable in Rosenberg v Percival, it was primarily because the court did not find the plaintiff credible, and the case still affirmed the ability of a plaintiff to establish causation in a contextual situation where, arguably, it is never possible to prove causation in fact. The Civil Liability Act, while retaining the subjective test has, on the recommendations of the Ipp Panel, made it more difficult for a plaintiff to establish causation in failure to warn cases by excluding any evidence from the plaintiff regarding whether he or she would have gone ahead with the procedure had the warning been given.\textsuperscript{[40]} The Panel considered that the judge’s view of the plaintiff’s credibility is likely to be determinative, and that the question of what the plaintiff would have done if the defendant had not been negligent should be decided on the basis of the circumstances of the case and without regard to the plaintiff’s own testimony.\textsuperscript{[41]} The Civil Liability Act therefore, in relation to the element of causation in instances of negligence through a failure to warn, provides more extensive protection against liability for medical practitioners than was previously afforded by the common law.\textsuperscript{[42]}

Wrongful birth: Prohibiting damages for child rearing

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The expansion of liability for medical practitioners in relation to wrongful birth, which refers to the situation where an act of medical negligence causes the birth of an unplanned child, has been considerable in recent years.\textsuperscript{[43]} Although the first wrongful birth cases involved disabled children, subsequent cases determined that, regardless of whether the child is healthy (non-disabled) or disabled, the parent or parents can sue a medical practitioner in negligence in respect of the resultant damage from the pregnancy and birth.\textsuperscript{[44]} While the recoverable compensable damage originally included only pregnancy and birth costs such as the pain, suffering and economic loss associated with pregnancy, including labour pains, medical bills, maternity clothes, loss of income during pregnancy, and (less commonly) the cost of moving or extending the house in anticipation of accommodating an extra member,\textsuperscript{[45]} it was extended to upbringing costs in relation to the child in the High Court decision of Cattanach v Melchior (2003) 215 CLR 1. In Cattanach a sterilisation was performed by the medical practitioner on only one fallopian tube, since the mother (falsely) believed her other tube had been removed as a child. The plaintiff subsequently became pregnant and gave birth to a healthy child. While it was held that Dr Cattanach had not been negligent in the performance of the surgery, he was found to have been negligent by failing to positively confirm the absence of the right fallopian tube before (or after) the operation. As a result, the plaintiff ceased using contraception, thinking she could not conceive, and because the second tube was in fact present, a son was later conceived and born. The High Court held that the plaintiff could recover damages for the costs of raising the child from birth to maturity or independence, including amounts spent on food, clothes, education, presents and entertainment, plus loss of income through...
looking after the child, and the cost of moving or extending the house to accommodate an extra member. Cattanach marked the high point of the expansion of wrongful birth actions in Australia. While medical practitioners can still be liable in an action for wrongful birth, the Civil Liability Act provides that no damages may be awarded in any such proceedings for costs associated with rearing or maintaining a child that the claimant has incurred or will incur in the future, or any loss of earnings that the claimant might suffer from raising and maintaining a child who suffers from a disability. [46] The amount of damages therefore that can be awarded in a wrongful birth action has been considerably limited by the Civil Liability Act.

Capping economic and non-economic damages

Capping economic and non-economic damages

Personal injury awards increased substantially throughout the 20th century. Loss of earnings emerged as a new compensable injury in response to the dramatically changed social conditions of a capitalist economy. [47] Gratuitous attendant care services were recognised as recoverable [48] and then recoverable at the market cost of the services. [49] There were substantial increases in the amount of damages awarded for non-economic damages, typically consisting of pain and suffering, loss of amenities and disfigurement, and expanding recognition of the forms of loss which could give rise to damages for loss of enjoyment of life. [50]

While retaining all the different heads of damages, the principle that an injured plaintiff should be restored as much as possible in monetary terms to their pre-injury state, which has long underscored the common law of damages, [51] was rejected by the Civil Liability Act. Instead, caps were introduced limiting the maximum amount of award in relation to all heads of damages except medical expenses. Non-economic damages were restricted by a threshold placed at both the lower and upper ends of the award. At the lower end, unless there is an assessment by an independent medical practitioner that the injury amounts to 15% of a most extreme case, no award of damages can be made. [52] The rationale underscoring this measure is that reducing the number, and the cost of resolving, smaller claims could make a significant contribution to reducing the overall cost of the system. [53] This was coupled with the view that a key driver of the recent growth in public liability insurance costs was an increase in the number of smaller claims in the range of $20,000 to $50,000. [54] As well as a cap on the lower end of claims, a threshold has also been placed on the upper end of non-economic awards, originally set at $350,000 but to be indexed annually by reference to average weekly earnings of full-time adults in New South Wales. [55]

Economic damages consist typically of past and future loss of earnings, past and future medical expenses and gratuitous attendant care services. The Civil Liability Act placed a cap on damages for loss of future earning capacity at three times the average annual full-time adult ordinary time earnings in New South Wales. [56] Full-time adult ordinary time earnings in New South Wales at May 2009 was $1,197.50 per week. The cap would, according to the Ipp Panel, provide high earners with a desirable incentive to insure against loss of the capacity to earn more than the amount of the cap. [57] Damages for gratuitous attendant care services were also capped at both the upper and lower ends. Such awards previously often represented a large portion of the total award, on average, about 25% of the total award in claims for more than $500,000. [58] At the upper end no more than 40 hours per week at no more than the average weekly total earnings of all New South Wales employees can be claimed and at the lower end no award can be made unless the gratuitous attendant care services are required for more than six months and more than six hours per day. [59]

The sum of the expected total future losses and expenses has always been offset in the common law by the use of a discount rate in order to counter the opportunity the plaintiff has to invest the lump sum and receive a stream of income from the investment. While the Ipp Panel recommended that the discount rate be retained at the previous common law determined rate of 3%, the Civil Liability Act has set the discount rate at 5%. [60] The Act also prohibits awards for either exemplary (or punitive) damages or aggravated damages in actions for personal injury or death caused by negligence. [61] The purpose of exemplary damages is to punish the defendant, to act as a deterrent to the defendant and others who might behave in a similar way, and to demonstrate the court's disapproval of the defendant's conduct. Aggravated damages are damages awarded to compensate the plaintiff for increased mental suffering caused by the manner in which the defendant behaved in committing the tort. [62] While such awards are uncommon in medical negligence cases, [63] nevertheless this represents another aspect of reduced liability in medical negligence actions. It is the limitations placed upon damages awards by the Civil Liability Act and, in particular, the caps on awards that have had the most significant impact on medical negligence claims.

Exclusion of liability for negligent acts if done in good faith

Exclusion of liability for negligent acts if done in good faith
At common law there is no general legal duty on a medical practitioner to attend upon a person who is sick, even in an emergency, if that person is one to whom the doctor has not and never has been in a professional relationship of doctor and patient. Once assistance is given, however, a relationship is established and a legal duty is created. The common law standard of care required of a medical practitioner who does render assistance is that of the reasonable practitioner although the court will consider how the reasonable medical practitioner would perform in an emergency, without equipment and hospital facilities. The possibility of legal liability has long been considered as a deterrent to medical practitioners rendering medical assistance when they are off-duty.

New provisions in the Civil Liability Act, however, now provide protection to a person who, in good faith and without expectation of payment or other reward, comes to the assistance of a person who is apparently injured or at risk of being injured. A Good Samaritan does not incur any personal civil liability in respect of any act or omission done or made by the good samaritan in an emergency when assisting a person who is apparently injured or at risk of being injured. However, there is an exception if it was their intention or negligence that caused the injury or risk of injury in the first place, or if her or his ability to exercise reasonable care and skill was significantly impaired by the influence of alcohol or a drug voluntarily consumed and if he or she failed to exercise reasonable care and skill. It also excludes a person who impersonates a health care or emergency services worker or police officer, or if he or she falsely claims to have skills or expertise regarding the provision of emergency assistance.

Trends in medical negligence claims after the Civil Liability Act 2002 (NSW)

A primary objective of the tort law reforms in New South Wales was to decrease the number of claims against negligent actors, including doctors, and to cap and reduce compensation payouts. In this respect the legislative changes have been successful. The number of actions in negligence lodged with the District Court of New South Wales increased rapidly between 1996 and 2002, although this increase can be in part attributed to a transfer of load from other New South Wales District Court registries during this time. However, a definite substantive increase can be identified in 2001 and 2002 attributed by some commentators to spate filing, which refers to the rush to lodge claims in anticipation of the introduction of the Civil Liability Act. In 2002, after the commencement of the Act, there were 12,686 matters registered compared to 20,784 in 2000, a reduction of 40%, and since the enactment of the Civil Liability Act, the rates of personal injury litigation have declined markedly and steadily, by as much as 60%.

A report released by the Medical Indemnity Industry Association of Australia has specifically analysed claim trends in medical indemnity for the period 1996 to 2006 and indicates that between 2003-2004 and 2005-2006, there have been lower numbers of medical negligence claims, although there was a slight increase in claims in 2006. Despite the overall reduction in medical negligence actions, there have been some much-publicised medical negligence cases which have resulted in large payouts. While these cases have no bearing on the actual overall reduction in the liability of medical practitioners, they could produce a perception that large payouts are still prevalent in the post Civil Liability Act climate. In Dobler v Halverson (2007) 70 NSWLR 151; PD v Harvey (2009) 7 JLM 235 at 244, a general practitioner who failed to refer a patient for an ECG or to a cardiologist was held not to have exercised reasonable care and skill and was ordered to pay a total of $8,797,500 to the defendant and members of his family; in Tabet v Mansour (2007) NSWSC 36, a practitioner was ordered to pay $610,000 for the loss of the security in the practice of their profession and, in particular, for the reforms had successfully provided medical practitioners with added security in the practice of their profession and, in particular, whether the reforms had reduced the practice of defensive medicine.

The practice of defensive medicine in New South Wales

The stated aim of the tort law reforms was to reduce compensation awards and the number of negligence actions in New South Wales so as to restore an appropriate balance between personal responsibility for one’s own conduct and expectations of proper compensation and care. The aim of reducing litigation has undoubtedly been achieved. However, the reforms were also expected to provide security for professional groups and, in particular, for medical practitioners who were either having difficulty in obtaining liability insurance or constraining their medical practices because of the threat of litigation. It was hoped that the practice of defensive medicine would markedly decline in response to the reforms. The survey of medical practitioners presented in the sections to follow was aimed at gauging whether the reforms had successfully provided medical practitioners with added security in the practice of their profession and, in particular, whether the reforms had reduced the practice of defensive medicine. The findings suggest that this has not been achieved.

Study population and methodology
Study population and methodology

This article presents the results of a survey conducted among general practitioners working in the South Eastern Sydney and Eastern Sydney Divisions of General Practice. A (largely) qualitative online questionnaire was distributed in August 2008 to the general practitioners of the two divisions. The questionnaire aimed to gauge medical practitioners’ practices and attitudes to defensive medicine within general practice and their familiarity with, and perception of, medical negligence law in New South Wales. In particular, the survey sought to assess whether the introduction of the Civil Liability Act had resulted in a reduction in the practice of defensive medicine as intended and expected by the New South Wales legislature. The questionnaire contained a total of 32 questions and was divided into four parts:

• opinions on general medico-legal issues in general practice;
• questions to determine the prevalence of defensive medicine, both positive and negative;
• questions to determine practitioner’s knowledge of the law; and
• questions to assess medico-legal fears and concerns.

The majority of the questions were answered by selecting from a choice of options towards a given statement. For example, in response to the question If applicable how frequently do concerns about malpractice liability cause you to suggest procedures unnecessarily?, the respondents could answer Never, Rarely, Sometimes or Often or Always. For a small number of questions there was an opportunity for respondents to add a short comment explaining their selection. The questionnaire required approximately five minutes to complete. Of the 515 general practitioners who received a request to respond to the questionnaire, 90 respondents completed the questionnaire. A further six general practitioners partially completed the questionnaire. The responses were collected over the period from October 2008 to January 2009. It should be noted that the response rate (17%) and sample size were relatively low. There are a range of possible reasons for this. Unlike many questionnaires sent to general practitioners, there were no incentives (like gifts or prizes) offered except for the satisfaction of contributing to new research. Additionally, the online format of the questionnaire might have discouraged general practitioners unfamiliar with computer technology. It should also be noted that the questionnaire was distributed to two Sydney general practitioners divisions which practise in relatively affluent parts of Sydney and who may have had a greater exposure to more litigious patients. There was no identified conflict of interest.

The prevalence of defensive medicine

The prevalence of defensive medicine

Defensive medicine includes both positive measures, such as ordering tests, performing diagnostic procedures and referring patients for consultation, and negative measures, such as the avoidance of procedures that are perceived as elevating the probability of litigation, including eliminating procedures prone to complications, such as trauma surgery, and avoiding patients who have complex medical problems or are perceived as litigious.

While it is difficult to pinpoint the prevalence of defensive medicine accurately because of methodological concerns that respondents might overstate its prevalence for political gain or alternatively underestimate its prevalence due to a failure to identify certain practices as defensive medicine, studies worldwide have consistently indicated a high level of defensive medicine. A study of New South Wales general practitioners in 2000 found that 89% of respondents believed that because of the current medico-legal climate, GPs are more likely to recommend tests or treatments that may not have worthwhile medical benefits.

The survey distributed in this research aimed at estimating the extent of defensive medicine practices, both positive and negative, due to the threat of litigation by asking a series of related questions which resulted in the following findings. A significant proportion of the respondents agreed that they did practise both positive and negative defensive medicine. In relation to negative defensive medicine practices, 52% stated they had avoided certain procedures because of the potential threat of malpractice litigation and 29% stated that they had avoided caring for high-risk patients because of the potential threat of malpractice litigation. In relation to positive defensive medicine practices, the following findings resulted. In response to a potential threat of malpractice litigation,

• 83% stated that they sometimes or often referred patients to specialists unnecessarily;
• 70% stated that they sometimes or often prescribed more medications than medically indicated;
• 83% stated that they sometimes or often ordered more tests than medically indicated;
• 49% stated that they sometimes or often suggested procedures unnecessarily; and
• 66% stated that they often sought the advice of another physician.

While respondents on the whole did not practise negative defensive medicine as readily as positive, the results show overall a very high rate of conscious defensive medicine practices as a direct result of the threat or fear of litigation. The survey could not quantify
The prevalence of unconscious defensive medicine, defined as when a permanent concern about liability exists and routine non-specific tests are performed without self-criticism on the part of the physician. Overall, therefore, the survey has revealed that defensive medicine practices continue to be significant and are largely fuelled by a fear of litigation. These results seriously detract from the purported favourable outcome of the reforms.

The impact of defensive medicine on the quality of health care

Defensive medicine, particularly positive defensive medicine if it is associated with a more thorough and careful administration of health care such as seeking the views of another physician, may not always have a negative impact on health care. Indeed, some commentators argue that provided informed consent is given for any additional tests and there is no breach of the standard of care and no abandonment of patients, defensive medicine does not violate ethical responsibilities to the individual patient. However, the consequences of defensive medicine, both positive and negative, are well documented in the literature:

- Positive defensive medicine may increase the costs of health care through an increased reliance on medical technology and the ordering of tests that are unjustified.
- The excessive and unnecessary use of tests and procedures and the practice of over-treating, particularly when not clinically indicated, increase the risk of iatrogenic injury. Some testing is inherently detrimental or risky. Extra testing can also increase the risk of psychological harm to patients since it elevates the possibility of false positives and the related ensuing anxiety.
- There is always a level of uncertainty inherent in all medical investigations and additional unnecessary tests may confuse rather than clarify a diagnostic hypothesis.
- The practice of defensive medicine may damage the important relationship of trust between the medical practitioner and the patient.
- The fear of litigation may lead medical practitioners to cover up errors and not admit to mistakes which may have serious consequences.

The fear of litigation and its consequences, cited as a primary reason for the practice of defensive medicine by many commentators, was revealed as prevalent in the survey. Such a finding is contrary to the considerable changes (described previously) introduced by the Civil Liability Act which have significantly reduced the liability of medical practitioners. It is also contrary to the fact that only 6% of respondents stated that they had themselves been the subject of malpractice litigation in Australia (of which only two cases resulted in successful litigation). Additionally, 77% of respondents surveyed feared being liable for things out of their control, even though the common law standard, reaffirmed in the Civil Liability Act, has always been (post Bolam) one of reasonableness and any unavoidable risk would never have led to liability. Moreover, despite the dramatic decrease in litigation following the enactment of the Civil Liability Act, 59% of respondents indicated in the survey that they believed that over the last five years, lawsuits against medical practitioners in New South Wales had, in fact, increased. Astonishingly, 71% of respondents had never heard of the Civil Liability Act. Of those respondents who had heard of the Civil Liability Act, half considered it to be ineffectual in reducing the number of lawsuits against practitioners and limiting damages.

Research has indicated that, almost inevitably, medical practitioners in response to a perceived threat of litigation will structure their medical practice, whether consciously or unconsciously, around techniques to avoid being sued. It is unsurprising therefore, since the survey has revealed a strong fear of litigation among respondents and a lack of knowledge and understanding of the New South Wales tort law reforms, that such high results for both positive and (to a lesser extent) negative defensive medicine have been observed in this study. The significance of this finding is considerable since it is clear that the reforms were aimed not only at
reducing the costs associated with litigation and the costs of insurance premiums but also at providing medical practitioners (and other professional bodies) with an environment in which they could carry out their professional responsibilities without an ongoing fear of litigation. Other results of the survey also confirm the findings of other studies which suggest that the fear of litigation impacts upon medical practitioners not only professionally and economically but also emotionally and psychologically. The survey revealed that 60% of respondents either agreed or strongly agreed that other physicians would doubt their ability if they knew they were being sued, while 82% of respondents agreed or strongly agreed that their enjoyment of medicine was substantially lessened because of the threat of lawsuits.

**Conclusion**

This article has detailed the limitations placed on medical negligence actions following the enactment of the Civil Liability Act 2002 (NSW). While it might be anticipated that the reforms, which have led to a significant reduction in negligence claims in New South Wales, would have reduced the practice of defensive medicine, this article has presented the results of a survey conducted among New South Wales health professionals that suggest that it has not. The survey has revealed that defensive medicine continues to be practised by general medical practitioners in New South Wales but also, significantly, that there is limited understanding in the medical community of the recent tort law reforms and their impact on the legal liability of medical practitioners. The continuing practice of defensive medicine and the perception of practitioners that the threat of litigation remains has, this article suggests, a negative and unacceptable impact upon the provision of health care in New South Wales. Importantly, it leaves unfulfilled a key aim of the reforms: to provide medical practitioners with an environment in which they can undertake their professional responsibilities without an ongoing fear of litigation. It seems critical, therefore, that the medical community is made aware of these changes so that the ultimate aims of the tort reform measures can be achieved.

**Footnotes**

10. See Kachalia et al, n 6 at 422.
13. This article focuses on the Civil Liability Act 2002 (NSW) as amended by the Civil Liability Amendment (Personal Responsibility) Act 2002 (NSW) and the Civil Liability Amendment Act 2003 (NSW). Note that the Health Care Liability
Act 2001 (NSW) is repealed but continues to apply to proceedings lodged between 5 July 2001 and 19 March 2002. See Luntz H, "Damages in Medical Litigation in New South Wales" (2005) 12 JLM 280 at 280.


See Underwood, n 2 at 10.

Presland v Hunter Area Health Service [2003] NSWSC 754.

Rogers v Whitaker (1992) 175 CLR 479.

Rogers v Whitaker (1992) 175 CLR 479.


Griffiths v Kerckemeyer (1977) 139 CLR 161.


New South Wales, Parliamentary Debates (13 November 2003) (Hon R Carr MP) p 4980.


See Swain v Waverley Municipal Council (NSWSC No 20261/2000). The plaintiff was rendered an incomplete quadriplegic when he dived into the surf and struck a sandbar in a flagged area at Bondi Beach. The evidence indicated that the sandbar was visible from the vantage point of the lifesavers on duty and the council was held liable. In Municipality of Waverley v Bloom [1999] NSWCA 229 the plaintiff was injured in the surf at Tamarama Beach where he was body-surfing between the flags, 60 or 70 metres from the beach, when he was struck in the neck by a fibreglass surfboard. The surfboard-rider paddled off and the plaintiff struggled to the beach and collapsed on the sand. The plaintiff was awarded an amount of $39,911.81 plus costs on the basis of the local authority's negligence. See also Waverley Council v Lodge (2001) 117 LGERA 447; [2001] NSWCA 438; and Council of the Municipality of Shellharbour v Carter (unrep, NSWCA, 5 February 1985).


Civil Liability Act 2002 (NSW), s 43A.

See Watson, n 29 at 164.

Council of Civil Service Unions v Minister for the Civil Service [1984] 3 All ER 935.

Civil Liability Act 2002 (NSW), s 54A.


Bolam v Friern Barnet Hospital Management Committee [1957] 1 WLR 582.

Sidaway v Board of Governors of Bethlem Royal Hospital [1985] AC 871.

Mockler D, Practice and Procedure in Relation to the Civil Liability Changes (Personal Injury Revisited 03/05, Continuing Professional Education Seminar Papers, College of Law, 15 February 2003) p 201.

Note, however, that in the recent case of Halverson v Dobler [2006] NSWSC 1307 the New South Wales court did not accept that the views of the body of practitioners called to the court by the defendant represented a widely accepted peer professional opinion.


See Civil Liability Act 2002 (NSW), s 5D(3): If it is relevant to the determination of factual causation to determine what the person who suffered harm would have done if the negligent person had not been negligent: (a) The matter is to be determined subjectively in the light of all relevant circumstances, subject to paragraph (b), and (b) Any statement made by the person after suffering the harm about what he or she would have done is inadmissible except to the extent (if any) that the statement is against his or her interest.

Ipp Report, n 12, See Recommendation 29 and the commentary at [7.40].


For example, in the recent New South Wales case of Brown v Simpson [2008] NSWDC 57 at 100 Sidis DCJ awarded considerable damages for loss of enjoyment of life when the plaintiff, after negligent surgery for bowel cancer which injured his left, and only functioning, ureter, disguised the bags provided for the collection of urine by placing them into a shopping bag, and carried one such bag as if it were a handbag so that he looked like a girl. As a result he stopped going to his club, sat in the car at the shops and missed two family weddings. He was unable to visit his granddaughter when she was in hospital because he could not travel. He was unable to drive. He was unable to play with his grandchildren.


Civil Liability Act 2002 (NSW), s 16(1).

Ipp Report, n 12 at [13.5].


Civil Liability Act 2002 (NSW), ss 14, 17.

Civil Liability Act 2002 (NSW), s 12.

Ipp Report, n 12 at [13.64].

Trowbridge Consulting Ltd, n 2.

Civil Liability Act 2002 (NSW), s 15(3).

Civil Liability Act 2002 (NSW), s 14(2).

Civil Liability Act 2002 (NSW), s 21.


Civil Liability Act 2002 (NSW), s 56.

Civil Liability Act 2002 (NSW), s 57.

Civil Liability Act 2002 (NSW), s 58(2).

Civil Liability Act 2002 (NSW), s 58(3).


See Drabsch, n 70.


Later overturned in Gett v Tabet (2009) 254 ALR 504; [2009] NSWCA 76, and currently on appeal to the High Court.


See Studdert et al, n 4.

See Studdert et al, n 4. The authors surveyed more than 800 physicians and found that nearly all (93%) practised defensive medicine. In Britain a 1999 study revealed that 69.5% of general practitioners were likely to order additional diagnostic tests, 72.7% to refer patients for follow-up, and 51.1% to avoid the treatment of risky conditions: Summerton N, "Trends in Negative Defensive Medicine Within General Practice" (2000) 50 British Journal of General Practice 565.


Kachalia et al, n 6.


See Lovett, n 8.

See Samuels, n 9.

See Kachalia et al, n 6.


See Brase, n 11.

See De Ville, n 84.