Cardiologists' Seminar
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Surfers Paradise, Gold Coast

"Public professions: liabilities and immunities"

The Hon Paul de Jersey AC, Chief Justice of Queensland

We hail from professions seemingly distinct. Yet they share a number of features – particularly, focus on public service, and an overriding concern effectively to maximise public access to the services provided. And today our professions face not dissimilar challenges. Doctors and lawyers serve an increasingly critical if not sceptical public, while at the same time dealing with their own particular professional pressures. In short, for each profession, serving the public now involves greater personal cost than in days gone by.

You are all, of course, keenly aware of the pressures affecting the medical world. They were recently described in the *Sydney Morning Herald* by Mr Padraic McGuiness as involving a "fourfold assault" on doctors.[1] First, competition is being levelled at traditionally-qualified practitioners by the "quasi-doctor" industry – patients being promised dramatic results through a combination of emotional care and a variety of worthless, and sometimes even dangerous methods and medicines. Second, doctors are being challenged over traditional practices by the Australian Competition and Consumers Commission (the ACCC). Third, pressure is also felt from what McGuiness describes as "a new class of "consumer protection" bureaucrats … who treat doctors as profit-oriented, errant and untrustworthy charlatans who need to be watched carefully and punished frequently". And then fourth, there are "plaintiff

[1] McGuiness, P.P. "Quasi-doctors a thorn in the side of the health system", *Sydney Morning Herald*, 21 December 2000

lawyers", representing what will be my initial focus this morning – the "cross" for you doctors that is medical negligence litigation.

I rather coyly call it a "cross" – it might better be described, in one aspect at least, as a crisis for the public health system and practitioners alike. Last year medical litigation cost the Queensland State Government $7.6 million.[2] The fear of suits for negligence reportedly spreads to all medical fields. The high cost of insurance can be prohibitive – it was one of the causes to which young doctors' declining interest in training for neurosurgery was attributed in a Sydney Morning Herald article last year.[3]

Recent interpretation of the law by the High Court may have added to this fear, whether or not that fear is rationally justified. I will mention briefly three of the High Court cases which I hear have inspired terror in some within medical ranks. The cases are *Rogers v Whitaker*[4], *Chappel v Hart* [5], and *Naxakis v Western General Hospital*.[6]

Rogers v Whitaker concerned the obligation of a medical practitioner to advise on material risks. The duty to exercise reasonable care extends not only to examination, diagnosis and treatment, but also to the provision of appropriate information. The issue here was whether a surgeon should, in advance of an eye operation, have warned

[2] see Queensland Health Annual Report, 2000
[3] Whelan, J. "High costs force doctors to shun neurosurgery", *Sydney Morning Herald*, 21 December 2000
[4] (1992) 175 CLR 479
[5] (1998) 195 CLR 232
[6] (1999) 197 CLR 269

of the risk of sympathetic ophthalmia, a risk shown to eventuate in one in 14,000 such operations.

Mrs. Whitaker was almost totally blind in one eye. She wanted to have some scar tissue removed from that eye. She presented to Dr Rogers as keenly interested in the outcome, concerned about the risk of any accidental interference with her good left eye. She incessantly questioned him. He conducted the operation with the requisite skill. But she did develop sympathetic ophthalmia in the left eye, and it led to blindness.

Despite Mrs Whitaker's clear anxiety, the doctor had given her no warning of the risk. Dr Rogers led evidence from a body of reputable medical practitioners that they would not have given the warning. (There was other, contrary evidence.)

Invoking the protection of *Bolam*[7] (that is, that a doctor will be taken to have met the required standard of care if his or her actions were in accord with the practice of a reasonable body of medical practitioners) Dr Rogers contended that he was ipso facto therefore not negligent. The High Court held, however, that he was, because he knew that had he warned Mrs. Whitaker about this risk, she would have regarded it as significant.

[7] (1957) 1 WLR 582, 586

The Court formulated the duty as follows[8]:

> "The law should recognise that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or
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> if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This duty is subject to the therapeutic privilege."
>
> (my underlining)

(That refers of course to the doctor's being excused from the need to make the disclosure if the doctor reasonably believes the disclosure would prove damaging to the patient.)

The essence of *Rogers v Whitaker*: Mrs. Whitaker with apparent anxiety sought to be informed of all the relevant risks and was not. She was not informed of a risk so significant, if it materialised, as to lead to almost total blindness. As the High Court put it, the question having been asked, it should have drawn "a truthful answer".

I find it difficult to regard the result as remarkable. In terms of legal theory, the case is significant in confirming that doctors cannot rest their defences solely in the support

[8] at 490

of a body of medical opinion. In the area of advice and information in particular, the approach of the particular patient must be addressed, even if thought to be unreasonable. And so the matter falls within that almost clichéic category of "communication" – and the need to be conscious of forestalling the old charge of paternalism: "leave it to doctor, he knows best".

The facts of *Chappel v Hart* were not dissimilar. Mrs. Hart was a teacher. She was inconvenienced by a pharyngeal pouch, and surgery was inevitable. When Dr Chappel proposed removing the pouch, she raised with him the risk of damage to her voice. As she said "I don't want to wind up like Neville Wran". Dr Chappel assured her there was no risk. The operation proceeded, and the oesophagus was perforated – leading to infection and laryngeal damage, permanent impairment of her voice, and an early retirement.

The doctor had failed to warn her of that risk. Had he done so she would, on the evidence, have postponed the operation and secured the most experienced surgeon in the field. And on the evidence, that would have lessened the risk.

The High Court accepted that the impairment of her voice was the consequence of the doctor's negligence in failing to disclose the risk. The Court approached the issue of causation in a commonsensical way, largely by adopting what lawyers call the "but for" test: but for Dr Chappel's failure to give the advice, Mrs. Hart would not then

have undergone the operation which led to her injury, and would have postponed it and secured another surgeon with a lessening of the risk.

The present significance of this case is that it again exemplifies the burden which follows when medical practitioners do not comprehensively respond to inquiries seriously made and plainly relevant to the operation to be undertaken.

In the third case, *Naxakis v Western General Hospital*, the High Court reiterated what is no doubt an unpopular principle in medical circles – that a negligence claim is not rebuffed simply by showing the questioned treatment accorded with accepted medical practice. In this case, 12-year-old Paraskevas Naxakis was admitted to Western General Hospital after he collapsed following a school-boy altercation. He was treated by the hospital's senior neurosurgeon for a subarachnoid haemorrhage, said to have been caused by a head blow. After gradually improving, he was discharged from hospital, only to collapse at home two days later. At the Royal Children's Hospital, a burst aneurysm was found to have caused a major intracranial bleed – and this aneurysm had in fact been the cause of his earlier symptoms.

The aneurysm was clipped, but Paraskevas was nonetheless permanently physically and intellectually impaired. He sued, amongst others, the Western General Hospital and the neurosurgeon Jensen, for negligently failing to consider alternative diagnoses and failing to perform an angiogram to ascertain the cause of his condition.

Evidence was heard at trial before a civil jury, following which the defendants submitted there was no case for the jury to consider. The trial Judge ruled in favour of the defendants, entering judgment accordingly. Paraskevas unsuccessfully appealed to the Victorian Court of Appeal, but did succeed on further appeal to the High Court. It was found a case had existed to go to the jury, and a new trial was ordered.

Relevantly here, where an expert medical witness had given evidence directly suggesting Mr Jensen, the neurosurgeon, had not been negligent, a majority of the Justices specifically emphasised that negligence could nonetheless be found. In the words of Justice Kirby, "whilst evidence of acceptable medical practice is a useful guide for the courts in adjudicating on the appropriate standard of care, the standard to be applied is nonetheless that of the "ordinary skilled person exercising and professing to have that special skill"".[9] Thus the evidence led, that Mr Jensen had not displayed negligence, was but a guide – to be considered by, but not to bind, the jury.

The unease this approach has engendered among doctors has not passed unnoticed. One of the members of the High Court, Justice McHugh, in *Naxakis*, noted that to "many doctors, judges and lawyers" this aspect of the law "must seem unsatisfactory".[10]

[9] at 297-8, quoting from *Rogers v Whitaker* at 487
[10] at 286

In practice, I suggest, under this method of assessing the relevant standard of care, the role of expert medical witnesses is in fact therefore not diminished, but even more critical – without fully and properly informing the judge of the minutiae of the relevant medical procedure, an unrealistic standard of care may end up being imposed. The court must, in short, be comprehensively and compellingly "educated".

The English law relating to medical negligence, still overall more deferential to the position of doctors than our own, has nonetheless over recent years undergone similar development. In fact, your English counterparts in general face issues similar to your own, recently reportedly feeling "under siege"[11] as criticism levelled by legal and church officials did little for flagging public confidence.

Criticism from the legal world came in the form of Lord Woolf's inaugural Provost's Lecture at University College, London. The Lord Chief Justice there welcomed the courts' changing attitude to the medical profession, from one of "excessive deference" to "a more critical approach". He attributed that change to a number of factors. These included the adoption of a less deferential approach to authority figures in general – in part engendered by growth in the courts' judicial review function; growth in litigation; an increased social focus on individuals' and thus patients' rights; a number of recent, well-publicised medical scandals; increasing scrutiny of the medical profession in other jurisdictions; an increasing need to reform medical negligence litigation in general; the courts recently deciding cases involving issues of medical ethics such as

the right to terminate life; and the incorporation into English domestic law of the European Convention of Human Rights.

The changing approach of the English courts was illustrated recently by the House of Lords' case, *Bolitho v City of Hackney Health Authority*[12]. Departing from the traditional explanation of the *Bolam* test, Lord Browne-Wilkinson, who gave the only speech, emphasised the inclusion in that test of the need for a doctor to conform to a "reasonable" or "responsible" body of medical opinion. He thus inferred that in rare situations negligence could be found where a doctor's actions conformed to a professional opinion or practice "not capable of withstanding logical analysis"[13].

This probably subtle shift in focus, which I note nonetheless leaves the English position still less scrutinising of doctors than Australian law, was welcomed by Lord Woolf, who finished his speech with "the important moral …. It is unwise to place any profession or other body providing services to the public on a pedestal where their actions cannot be subject to close scrutiny."

The Lord Chief's message was not unanimously well received! Dr Thomas Stuttaford, writing in *The Times*, reacted strongly : "To have such an important, respected and

[11] "Doctor in Court" (editorial), *The Times*, 19 January 2001
[12] [1998] AC 232
[13] at 243

obviously thoughtful and decent man as the Lord Chief Justice eroding the trust that patients feel for their doctor is verging on the irresponsible."[14]

Now medical practitioners may feel a particular sense of chagrin in seeing their own liability potentially expand, while barristers, as but one example on the other 'side', retain immunity from suit in negligence. You may be intrigued, then, to hear that this, too, is in something of a state of flux. Lord Woolf was accurate when he described the English courts' decreased deference for all professions – in that jurisdiction, barristers no longer enjoy the advocates' immunity. While it continues to exist in Australia, it does so in limited form only, and its imminent end has been predicted by some[15] - whether with prescience only time will tell.

Immunity for advocates from suit in negligence was asserted by the House of Lords for reasons of public policy in 1969, in the case of *Rondel v Worsley.*[16] Its English demise came in July last year, when the House of Lords delivered judgment in *Arthur JS Hall & Co v Simons.*[17] That case involved appeals from three decisions of the English Court of Appeal. Each was a building matter, two of the three also involving family proceedings. The clients in each matter brought a claim against their respective solicitors for negligence, while each firm of solicitors relied on advocates' privilege.

[14] Stuttaford, T. "When doctors know best", *the Times*, 19 January 2001
[15] see for example Lauchland, K. 2000. "Advocates' immunity: going, going, how far gone?", *The Queensland Lawyer*, vol 21, pp 45 - 48
[16] [1969] 1 AC 191
[17] [2000] 3 WLR 543

While at trial, each claim had been found unsustainable, the clients successfully appealed to the Court of Appeal. The solicitors then appealed to the House of Lords.

In deciding the case, the House of Lords considered the public policy grounds traditionally underlying the immunity. These included first the "cab rank" rule – the fact that ethically, barristers are constrained not to choose their clients, and thus cannot protect themselves against clients likely to bring vexatious claims; and second, the analogy between the immunity and the general protection against civil liability of all court participants, including judges, witnesses and court officials. Third, strong public policy existed against enabling clients effectively to re-litigate matters already decided, by alleging negligence on the part of their legal representatives. This attempt to guard against "collateral attack" was particularly relevant in criminal matters, where a finding that defence counsel had acted negligently would cast grave doubt on a guilty verdict. Fourth, where advocates owed a divided loyalty – to the courts and to their clients, a threat of suit in negligence could, it had been argued, tempt practitioners to compromise their allegiance to the court.

The House of Lords emphasised it was not overturning its decision in *Rondel v Worsley*, but after considering those traditional justifications for the immunity, found they no longer warranted the broad immunity in the altered, contemporary public circumstances. It was unanimously held that changes to the law of negligence, the legal profession, and public values rendered those grounds of insufficient current weight to support a continued immunity in regard to civil proceedings. Should

denying immunity give rise to vexatious claims, these could be struck out under procedural rules, or applying legal doctrines such as abuse of process. In regard to criminal proceedings, however, the House of Lords was divided. The majority (Lord Steyn, Lord Browne-Wilkinson, Lord Hoffman, Lord Hutton and Lord Millett) held that in this jurisdiction, too, the immunity was unjustified in the present day. Their Lordships found that where civil action was brought as a means of collaterally attacking a criminal conviction, such action could be struck out as an abuse of process. Accordingly, a general immunity was not needed to prevent such challenges.

In Australia, the existence of the advocates' immunity was confirmed by the High Court in the 1988 case *Giannarelli v Wraith*[18]. There, negligence was alleged on the part of four legal practitioners who had failed to argue, while defending their clients against charges of perjury before a Royal Commission, that under provisions of the *Royal Commissions Act 1902* (Cth), evidence given to the Royal Commission was inadmissible in the criminal proceedings. The immunity was justified by the High Court on policy grounds similar to those considered in *Arthur JS Hall v Simons*. The immunity, which attached to the nature of advocacy and thus also extended to solicitors engaged in such activity[19], extended only to in-court advocacy, and work out of court "so intimately connected with the conduct of the case… it [could] fairly be said to be a preliminary decision affecting the way that cause is to be conducted."[20]

[18] (1988) 165 CLR 543
[19] at 577

The High Court has not recently had occasion to reconsider this case. Although an opportunity appeared to arise in 1999 in *Boland v Yates Property Corporation Pty Ltd*[21], the Court found no negligence on the part of the solicitors and junior counsel there sued, and it was therefore not necessary to re-examine the question of immunity.

The case had arisen out of original proceedings to determine the compensation payable to a company whose land had been resumed for the purposes of the Darling Harbour Authority. The solicitor and junior counsel sued had appeared for the company, Yates Property Corporation Pty Ltd, throughout those proceedings. Yates subsequently sued these legal representatives for negligently failing adequately to present the aspect of its claim relating to the land's "special value" to Yates alone. Where this claim was not upheld by the High Court, only Justice Kirby considered the immunity in depth.

In his Honour's opinion, the principle of immunity from suit espoused in *Giannarelli* should be strictly limited. His grounds for avoiding its expansion upon application included the immunity's "derogation from the normal accountability for wrong-doing … an ordinary feature of the rule of law and fundamental civil rights"[22], its original basis on, and development in, social and economic circumstances quite distinct from present Australian reality, and the fact that, in his opinion, the reasons given for the

[20] at 560
[21] (1999) 167 ALR 575
[22] at 611

immunity "do not … always bear close analysis"[23], particularly in relation to out-of-court functions, albeit ones intimately connected with litigation. Comparisons with other jurisdictions suggested narrowing the boundaries of the immunity would not create a flood of negligence claims, and after examining the scope of immunity originally set in *Gianarelli*, he concluded, "I would confine the scope of the legal immunity from suit to immunity for a legal practitioner advocate in respect of in-court conduct during proceedings before a court or like tribunal."[24]

What the immunity's ultimate scope will be in Australia is, as yet, unknown. For now, some limited privilege is enjoyed by practitioners. But remain equable! I mentioned at the outset, doctors' and lawyers' similar experience of modern day public service. Just as doctors incur great personal cost in order to prop up insufficient public insurance, so the legal profession has its own albatross. Where access to justice is restricted, for example by critically insufficient available legal aid, lawyers increasingly are called to provide their services pro bono, while maintaining their work at the highest standard.

Of course the people I speak of are <u>professionals</u> – doctors who have pledged to heal the sick, and lawyers who have promised to support the weak, marginalised and friendless. It is only right, then, that such professionals should <u>expect</u> to give of themselves.

[23] at 613
[24] at 618

But the call for selflessness in practitioners today is nevertheless perhaps greater than in days past. Regrettably, I am not sure a demanding public sufficiently recognises that, a public segments of which are sceptical and apparently influenced too by the so-called "tall poppy syndrome".

We doctors and lawyers may ourselves have a part to play in changing public attitudes – Emeritus Professor Michael Oliver, a past president of the Royal College of Physicians of Edinburgh, responded to declining public trust of doctors in England with a call for better communication with the public. He argues statements about, and examples of, the continuing high standards in hospitals should regularly be published by medical leaders to balance negative media hype.[25] I am sure lawyers would also do well to follow his advice.

Effectively serving the public requires great personal commitment. Professional life is not the privileged experience it may outwardly seem. But I hope you may share my own experience – that the ultimate reward, where the public is well served, provides ample reassurance!

The medical profession is subject to criticism for lack of what some, with great conviction, feel to be reasonable – a perhaps unreasonably high level of expertise,

[25] "Good doctors, bad communication", letter to editor from Professor Emeritus MF Oliver, *The Times*, 27 January 2001, p 25

such that any 'error' must denote incompetence. We judges, and the public, must not lose sight of the fact that mistake does not ipso facto equate with negligence, or with the level of performance a doctor must guarantee.

Doctors are also still criticised for paternalism.

Some of the response to the High Court's decisions may be explained by these considerations. On careful analysis, however, those decisions should not be terrifying responsible professionals out of their callings – if reports of these reactions are not exaggeration.

Our "professions", being such, rest on proper public accountability – essentially, meeting reasonable public expectations – performing to the requisite standard. Bastions of material privilege, social rank, public adulation – they may no longer be, but they remain publicly indispensable, in fact, and the challenge is to persuade a sometimes sceptical public to reasonable acknowledgment of that.